BORNO STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Borno State Ministry of Health

2010-2015

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
AOP	Annual Operational Plan
ARV	Anti-Retroviral
ATBU	Abubakar Tafawa Balewa University
ATBUTH	Abubakar Tafawa Balewa University Teaching Hospital
BACATMA	Bauchi State Agency for the Control of AIDS, TB & Malaria
BASEEDS	Bauchi State Economic Empowerment & Development Strategy
BASICS	Basic Support for Institutionalizing Child Survival
BASSHDP	Bauchi State Strategic Health Development Plan
BEOC	Basic Emergency Obstetric Care
BMS	Breast Milk Substitute
CBO	Community Based Organization
CDAs	Community Development Associations
CEDPA	Center for Development & Population Activities
CEOC	Comprehensive Emergency & Obstetric Care
COMPASS	Community Participation for Action in Social Sector
CONTISS	Consolidated Tertiary Institutions Salary Structure
CIET	Community Information for Empowerment and Transparency
CIDA	Canadian International Development Agency
DOTS	Direct Observe Therapy Short course
DPHC/DC	Department of Primary Health Care and Disease Control
DRF	Drug Revolving Fund
EU-PRIME	European Union- Promoting Routine Immunization
FAO	Food and Agriculture Organization
FHI	Family Health International
FGN	Federal Government of Nigeria
FP	Family Planning
FMOH	Federal Ministry of Health
GHAIN	Global HIV/AIDS Initiative Nigeria
HATISS	Harmonized Tertiary Institution Salary Structure
HIV	Human Immuno-deficiency Virus
HMB	Health Management Board
HMIS	Health Management Information System
HRH	Human Resources for Health
HSDP	Health System Development Project

IDRC	International Development Research Centre
IMR	Infant Mortality Rate
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide Treated Net
LGA	Local Government Authority
LLIN	Long Lasting Insecticide Net
MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MSS	Multi-Stakeholder System for Information and Planning
MTCT	Mother To Child Transmission
M&E	Monitoring and Evaluation
NDHS	National Demographic & Health Survey
NEHSI	Nigerian Evidence-based Health System initiative
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
NPopC	National Population Commission
NSHDP	National Strategic Health Development Plan
OI	Opportunistic Infection
OOP	Out-Of-Pocket
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PITC	Provider-Initiated Testing & Counseling
PLWH	People Living With HIV
PMTCT	Prevention of Mother To Child Transmission
PPFN	Planned Parenthood Federation of Nigeria
PPP	Public Private Partnership
PRS	Planning Research and Statistics
RH	Reproductive Health
RI	Routine Immunization
SCD	Sickle Cell Disease
SFH	Society for Family Health
SHS	School Health Services
SMOH	State Ministry of Health
SOP	Standard Operating Procedure
SPHCDA	State Primary Health Care Development Agency
SSHDP	State Strategic Health Development Plan
STI	Sexually Transmitted Infections
TAG	Technical Advisory Group

TB	Tuberculosis
TFR	Total Fertility Rate
TSHIP	Targeted States High Impact Project
U5	Under-5
U5MR	Under-5 Mortality Rate
UNICEF	United Nations Children Funds
USAID	United States Agency for International Development
WB	World Bank
WHCMP	Ward Health Care Minimum Package
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 harmonized and costed NSHDP.

Special appreciation goes to the members of the State Steering Committee, members of the State Planning Team and all those who contributed to the development of Borno State Strategic Health Development Plan

Preface

Following the advent of the Yar'Adua Administration and in consonance with the Health Sector objective of the seven points Agenda, the Hon. Minister of Health Prof. Babatunde Oshotimehin constituted a think-tank to come up with idea that would enable Government respond appropriately to the apparent crisis in the Health sector.

The result was the National Strategic Health Development Plan which necessarily would require input from State and Local government Areas. Hence the development of the Borno State Strategic Health Development Plan (BSHDP).

Coming at a time when the vision 2020 is being packaged, one cannot but observe that the present Government at the Federal and State levels are desirous of lifting the socio-economic status of Nigerians in general and Borno in particular. This also could not have come at a better time considering the quest for Nigeria to attain the health related Millennium Development Goals by 2015. This is in consonance with the State Government's belief that a healthy nation is a wealthy one.

The process of developing this plan was as painstaking as it was extensive, and as robust as it was engaging, often resulting in the team working very late for several days. The very broad strata of participants involved in the processes gives the confidence that the final product meets the aspiration of stakeholders in the State. Indeed, if there is any home grown health sector plan for this State since its inception in 1991, it is this.

It is our hope that the very tireless efforts put in by all participants from the Ministry of Health, Ministry of Finance, Budget and Planning Local Government and Chieftaincy Affairs, the LGAs, Development Partners and the private sector as well as the Consultant will bear the desired fruits when the implementation of the plan commenced next year.

This is indeed a worthy exercise and a testimony to our collective sense of purpose and patriotic zeal. It is our hope, that with this document in our hands and Almighty God as our guide, we are on the way to achieving our health sector related Millennium Development Goals.

Long live Borno State, long live the Federal Republic of Nigeria.

Hon. Commissioner for Health
Borno State

Executive Summary

Executive Summary

Borno State was created from the North Eastern State with the capital in Maiduguri in 1976.. With a growth rate of about 3.0%, the current population in the State is

estimated at about 4.5 million (2006 census). The population of children under five years of age is estimated at about 907,224 (20% of the total population)

The State shares borders with Cameroon and Chad to the East, and Niger Republic to the North. Borno State has 27 Local Government Areas (LGAs). The major tribes include Kanuri, Babur and Shuwa Arabs who are predominantly farmers and fishermen. The northern part consists of Sahel Saharan-type, drier climate, dispersed, scattered population compared to the southern part which has thicker, Savanna-type vegetation

The main economic activities are farming and fishing. The majority of the population are peasant farmers/fishermen, and live below the poverty level. The predominant religions are Islam and Christianity.

The State belongs to a zone with one of the worst mortality indices in the country. Infant Mortality stands at 109/1000LB[1] while under five Mortality is 222/1000LB[1]. Maternal Mortality ratio is taken as 545/100000LB[2]. Within the Health Sector, the state has 32 General Hospitals, 1 Specialized Hospital and 1 fully equipped Hospital with a combined bed capacity of 3430 beds [name and type of level of care]. The federal institutions are located in Maiduguri. The University of Maiduguri Teaching Hospital has 1000-bed capacity, the Neuropsychiatry Hospital,100-bed capacity and the Police Hospital, 30 bed capacity. There are about 449 PHC facilities owned by LGAs consisting of Primary Health Centre (48), and Health Clinics (140), Dispensaries and Health Posts (195) and Maternal & Child Clinics (34). In addition, there are 36 private health clinics, and three Missionary/NGO owned clinics.

Critical factors limiting effective implementation of identified intervention activities include:

i. Inadequate Human Resources
ii. Under utilization of services as a result of cultural/religious barriers, poverty and/or lack of awareness
iii. Inadequate funding
iv. Lack of efficient PPP coordination and collaboration with Partner agencies

In order to fast-track our commitment to improve the health status of our people, this plan has adopted and adapted the national minimum package of care to reflect priority areas of needs of the state. Cost effective and evidence based high impact interventions will be scaled up to all members of the state in an integrated manner. These interventions will include those aimed at improving Maternal, Newborn and Child Health looking interventions at those delivered through Family/Community; Population/Outreaches and Clinical/Individual targeted services. Others include

[1] Zonal average, NDHS 2008

[2]NationaL Average, NDHS 2008.

specific interventions for Malaria and HIV/AIDs control as well as management of communicable and non-communicable diseases

The strategic orientations or priority areas are:

i. To ensure universal access to an essential package of care
ii. To increase access to health care services
iii. To improve the quality of health care services
iv. To increase demand for health care services
v. To provide financial access especially for the vulnerable groups
vi. To strengthen specific communicable and non-communicable disease control programs
vii. Strengthen Emergency Response & Preparedness procedures for epidemics
viii. Strengthen the three schools through relevant accreditation to be able to train a critical mass of mid-level work force required i.e. Midwives, Community health officers and community health extension workers (CHEW) to be deployed to PHC facilities
ix. Embark on systematic training of staff to obtain an annual 10% increase of staff cadres to meet at least 60% staff needs by 2015
x. State to review and commence participation of its workforce in the NHIS program by 2010
xi. Decentralize decision-making process through increased autonomy of health facilities
xii. Regular (quarterly) monitoring progress and supervision by the State Monitoring & Advisory Team (SMAT) (15No persons) & MAC at LGA level (8No)
xiii. Evaluate SSHDP and LGA-SHDP implementation results, identify problems and solutions; and incorporate lessons learned into strategies

The total estimated cost for planned activities (2010-2015) is based on the 2009 MOH and all the 27 LGAs budgetary allocations amounting to about N77bn

Summary of estimated total budget:

Total Personnel Costs	=	N**37, 605,080,317**
Total Goods & Non personal services	=	N**26, 646,255,300**
Total Capital Projects	=	N**12, 499,400,000**
Total	=	**N76, 750,735,617**

The SHDP plan will be jointly implemented by SMOH, HMB, HSDP II, MLG, LGAs, International Development Partners, NGOs and their coalitions. Oversight for the entire strategic plan lies with the SMoH.

All components of the strategic plans will be regularly (quarterly) monitored,

supervised and evaluated to ensure the strategic plans on track. A multi-sectoral 15-member State Monitoring & Advisory Team (SMAT) is proposed. Membership will include officials from MOH, HMB, MOF, Budget & Planning, MLG, NGOs, NMA, PSN, NNMA, UNIMAID and Donor Agency at the State level & at LGA Level. An 8-member Monitoring & Advisory Committee (MAC) with membership to include officials from LGA Council (Councilor Health), Departments of Health, Planning, Finance, 2 Representatives of Health Development Committee, Traditional ruler and a Partner Agency working in the LGA. In addition to field monitoring and supervision, these monitors meet regularly to review SSHDP & LGA-SHDP implementation, identify & rectify gaps in financing, through advocacy, outsourcing etc. The SMAT is also to develop health research policies and strategies for the State and LGA

Vision, Mission and the Overarching Goal of the State Strategic Health Development Plan

Vision

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

Mission

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

Goal

The overarching goal of the Borno SHDP is to significantly improve the health status of Borno people through the development of a strengthened and sustainable health care delivery system.

Chapter 1: Background and Achievements

1.1 *Background*

Borno State was created from the North Eastern State with Maiduguri as the capital in 1976; successive creation of states in the Country gave rise to Adamawa, Bauchi, Taraba, Gombe, and Yobe States. With a growth rate of about 3.0%, Borno States' current population is estimated at about 4.5 million (2006 census). The State is a Border State through which Nigeria shares boundary with three French- speaking African Countries of Cameroon &Chad to the East, and Niger Republic to the North. Borno State has 27 Local Government Areas. The major tribes include Kanuri, Babur and Shuwa Arabs who are predominantly farmers and fishermen.

The efforts of the State Government to increase access to health facilities with the ultimate goal of reducing disease burden remain quite a big challenge. Most of the health indices for the state continue to be low compared to the National and even the

North East zonal averages. The Immunization coverage levels are amongst the lowest[3] ;there is low Maternal care services and high Maternal, Childhood & Infant Mortality rates (NHDS, 2008); low proportion of households with at least 1 mosquito treated net to prevent malaria and above all, there exists evidence suggesting high level of underutilization of health services.
Moreover, the state is amongst states prone to epidemic attacks of bacterial and viral origin such as meningitis, cholera and measles- recently, a suspected cholera epidemic in some states of the North East claimed many lives including about 70 people in Biu Local Government of the state.

1.2 Achievements

The present political administration in the State has Healthcare Development as one of its priorities. The State had previously initiated and implemented various intervention activities aimed at reversing the worsening health indices - working through the National Health Policy documents, the Health Sector Reform and the State's Economic Empowerment on health documents.Consequently, it has constructed and equipped several health facilities, upgraded and renovated existing ones, designated 6 referral hospitals in each of the six development zones, continues to provide drugs under the Drug Revolving Fund Scheme, has a Maternal Child Health free-drug policy, embarked on an aggressive recruitment of Specialist Doctors (Egyptian Doctors Program), ensures the staff welfare through prompt payment of salaries and allowances and, above all, increased the Annual Budgetary allocation on Health to about 10% of the Total State Budgets.

To attain its vision of providing qualitative, accessible and affordable healthcare services to the teeming population by 2015 Borno State Government recognizes the urgency to strengthen its health system, scale-up existing gains in the health sector, expand and adequately plan its pro-poor and vulnerable population intervention programs aimed at achieving the state's health targets, including the maternal and child Millennium Development Goals (MDGs). This would be pursued through the development and implementation of a six-year Borno State Strategic Health Development Plans (BSSHDP); identification of key intervention areas within the 8 thematic strategic priority areas of the NSHDP framework that are very relevant, realistic and implementable in Borno State to achieve improved health services delivery as provided in the state health vision and mission.

[3] National Immunization Coverage Survey, **NICS, 2006**

Chapter 2: Situation Analysis

2.1 State Profile, socio-economic context

With a growth rate of about 3.0%, Borno States' current population is estimated at about 4.5 million (2006 census). The population of children below 5 years age is estimated at about 907,224 (20% of the total population)

The major tribes include Kanuri, Babur and Shuwa Arabs who are predominantly farmers and fishermen

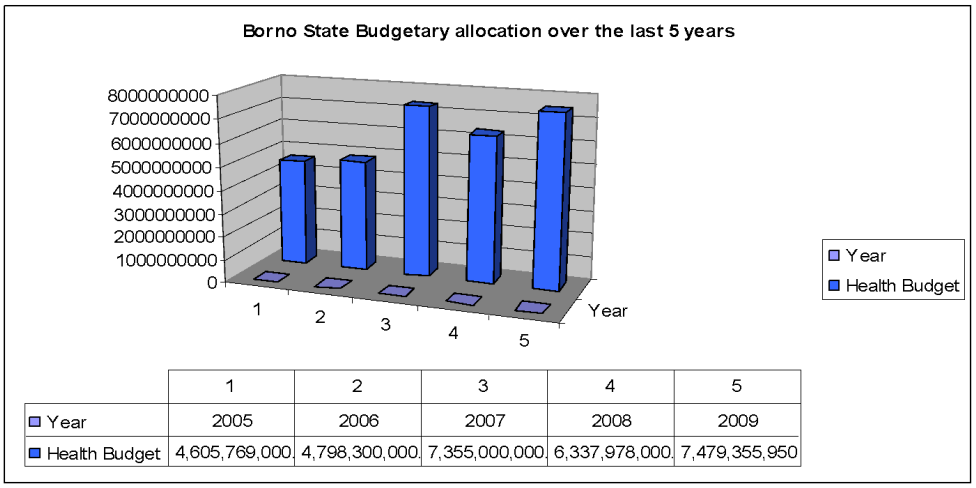
The northern part consists of Sahel Saharan-type, drier climate, dispersed, scattered population compared to the southern part which has thicker, Savanna.

The predominant religions are Islam and Christianity

2.2 Borno State Healthcare and Health Status Indicators

The present political administration in the State has Healthcare Development as one of its priorities. Consequently, it has constructed and equipped new health facilities, upgraded and renovated existing ones, continues to provide drugs under the Drug Revolving Fund Scheme, ensures the staff welfare through prompt payment of salaries and allowances and, above all, increased the Annual Budgetary allocation on Health to about 10% of the Total State Budgets.

Figure 1 : Borno State Health Budget over the last five years



	1	2	3	4	5
Year	2005	2006	2007	2008	2009
Health Budget	4,605,769,000	4,798,300,000	7,355,000,000	6,337,978,000	7,479,355,950

It should be mentioned however that, although the annual budgetary allocations to health has been increased and maintained at an average of 10% over the last 5 years, the corresponding funds releases, does not by all means match the budget allocation, and so, remains a big challenge.

2.3 Health Services provision

The state has 32 General and 2 Specialist Hospitals with a combined bed capacity of 3430 beds. The federal institutions- University of Maiduguri Teaching Hospital, Neuropsychiatry and Police Hospitals all in Maiduguri have 1000, 100 and 30 beds, respectively.

There are about 420 PHC facilities owned by LGAs consisting of about 48Primary Health Centres, 140 Health Clinics, 195 Dispensaries and Health Post and over 34 Maternal & Child Clinics. There are 36 private clinics and 3 Missionary/NGO owned clinics.

Recently, 3 Hospitals were upgraded to Referral Status and more are on the pipeline. The state has designated 6 referral hospitals in each of the six zones.

The SMOH/HMB key health staff comprises of about 74 medical officers, 13 pharmacists, 975 nurses & midwives, 18 laboratory medical scientists, 32 laboratory technicians, 3 radiographers, 110 CHOs and 1 radiologist.
The tertiary facility (UMTH), Psychiatric and Police Hospitals, and other private clinics in the state account for 133 doctors, nearly all in the state capital, Maiduguri.

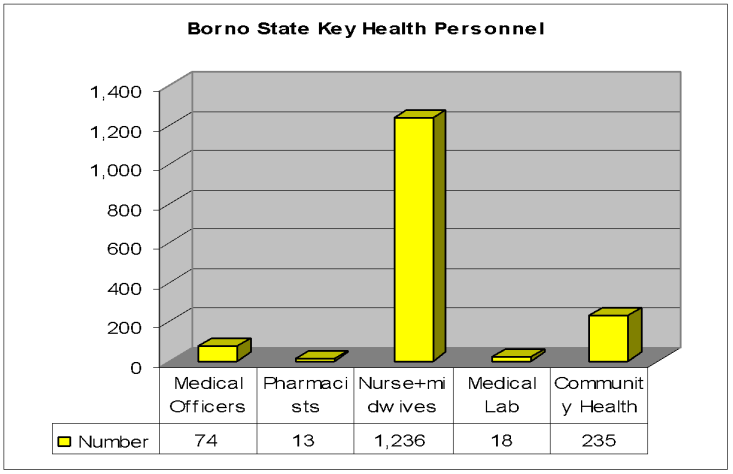
The 27 LGAs collectively have a total of about 125 CHOs, 1200 CHEWs, 172 Nurses, 89 Midwives, 530 Environmental Health Officers/Assistants, 31 TBAs, 77 Lab Tech/Assistants and 18 medical Record personnel.

The big challenge in human resources in health is therefore the quantity and right mix of health personnel; the distribution is non-uniform- for instance, Midwives seem to be absent in some LGAs such as Mobbar and Kalabalge, compared to the conspicuous concentration in urban/metropolitan MMC which has 40. Over 50% of the LGAs do not have Medical Record personnel and only about 20% of the LGAs seem to have recorded presence of TBAs.

The State has of recent been recruiting Egyptian specialist Doctors through an aggressive policy aimed at drastically addressing the health staff shortage. However, the state human resource for health is still hovering around 25% of the WHO standard.

Records indicate that the following key personnel are working under the public services (State & LGAs): 74 Doctors, 13 Pharmacists, 1236 Nurses/Midwives, 18 Medical Lab Scientists and 235 Community Health Officers.

Figure 2: Borno State number of Key Health Personnel



Wide ranging curative and preventive services are offered at both the State and LGA health facilities; 2-way referral systems exist –the University of Maiduguri Teaching Hospital, Umaru Shehu Ultra-modern Hospital and the Specialist sHospital all in Maiduguri are appropriately equipped to handle complicated referral cases. Six more

hospitals are being upgraded to referral status in each of the six development zones of the state.

2.4 Health Status of the Population

The common causes of morbidity and mortality are not very much different from the national and are essentially due to malaria and diarrhea, especially amongst children. Moreover, Borno state is amongst the states prone to epidemic attacks of bacterial and viral origin such as meningitis, cholera and measles. A suspected cholera epidemic in and around Biu LGA recently claimed many lives (over 70) -during the development of this strategic health plans. Preventive disease control through routine vaccination is carried out in the various health facilities in the state; supplemental vaccinations such as NIDs and IPDs are undertaken during specified times of the year.
Non communicable diseases such as diabetes and hypertension are also increasingly becoming public health problems, especially among the affluent urban population.

The state has been operating a Drug Revolving Fund Program and partial cost recovery schemes for surgeries, laboratory and other services. The exemption policy for paupers, road traffic victims and other less privileged in the society is centrally controlled by the ministry, presumably to limit abuses.

The state implements free-drug policy to pregnant mothers and children under 5 years, even though with varying success. This is because funds meant for the program are inconsistent, and mostly not available.
Although data on hospital deliveries are incomplete, it thus seem that the outlook is not positive as even the training support of traditional birth attendants (TBAs) is almost non-existent as evidenced by their number (37) observed in the LGAs. The State benefits from Partner support in strengthening maternal and child health especially in the areas of capacity building and equipping the facilities.

Borno State contributes to the 2-6% North East Zonal range of HIV / AIDS prevalence rate[4]. The Borno State Agency for the Control of HIV/Aids and Malaria (BOSACAM) in collaboration with other donor agencies is actively involved in the control of AIDS in the state through identification / diagnosis, counseling, provision of ARVs and capacity building for the health personnel.

Referral system for complicated cases is usually through the 32 General Hospitals spread across the state, amongst which 6 have been specifically designated to take care of the 6 Development Zones of the State; very severe referral cases end up at the

[4]Nigeria Health System Assessment, 2008,

UMTH, Specialist Hospital or the newly commissioned Umaru Shehu Ultra-Modern Hospital – all, in Maiduguri. There are some hard-to-reach and inaccessible riverine areas such as Marte and Kukawa where canoe boats and other means of transportation have to be employed to ferry referred cases.

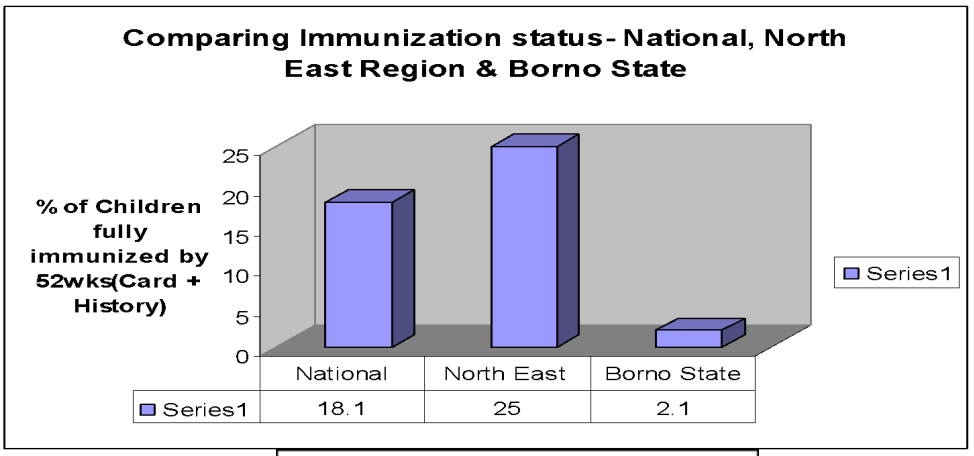
Health services utilization seems to be one of the major challenges of the state: many structures were constructed and equipped by the present administration but found to be severely underutilized due to factors that could largely be attributable to both the community and leadership.

2.4The Health Indicators

The efforts of the State Government to increase access to health facilities with the ultimate goal of reducing disease burden remain quite a big challenge. Most of the health indices for the state continue to be low compared to the National and even the North East zonal averages.

- The Immunization coverage levels are amongst the lowest as indicted by children who have been fully immunized[5].

Figure 3: Comparing fully immunized children – National, North East and Borno State



Adapted from NICS, 2006

- Uptake of immunization services continue to be low as indicated by the values for key immunization indicators of BCG, OPV3/DPT3 & Measles

[5] National Immunization Coverage Survey, **NICS, 2006**

Figure 4 Key immunization Indicators

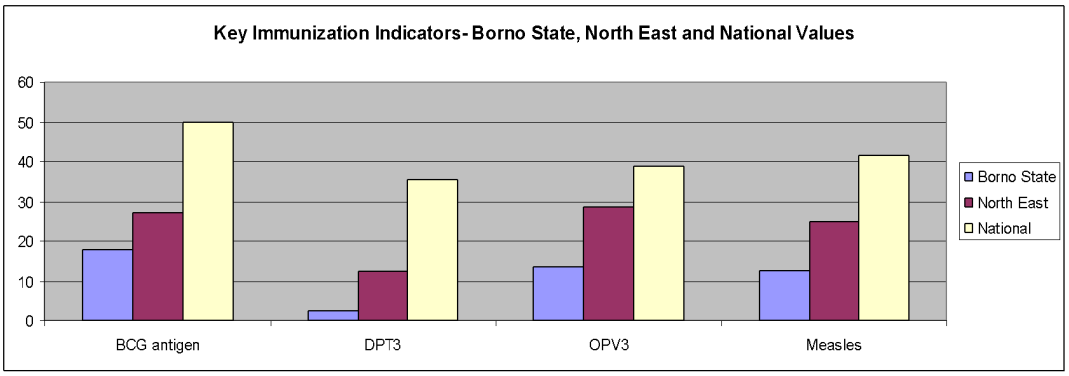


Table 1 : List of some Health Indicators

	Name of Indicator	Item	Borno State	North East	National
A	Immunization coverage	BCG antigen	17.9	27.2	49.7
		DPT3	2.5	12.4	35.4
		OPV3	13.4	28.6	38.7
		Measles	12.5	24.8	41.4
B	Nutritional Status	Height-for-age (stunting-chronic malnourishment)	49.2	48.6	41.7
		Weight-for-height (wasting-acute deficiency in nutrition)	13.4	22.2	14
C	Maternal Care services	% Antenatal Care received from a Health Professional	32.6	43	57.7
		% Delivery by Health Professional	13.2	15.5	38.9
		% Delivery received from Health Facility	11.8	12.8	35

		Maternal Mortality ratio			545/100000LB
D	Early Childhood Mortality	Infant Mortality Rates		109/1000LB	75/1000 LB
		Child Mortality Rates			88 deaths / 1000 live births
		Under five Mortality Rates		222/1000LB	157 deaths / 1000 live births
E	HIV/AIDS Awareness-knowledge	Knowledge of HIV/AIDS existence	84.6	81.4	90.5
		Knowledge of Condoms use to prevent of HIV/AIDS	31.4(women),	38.6(women),	
		Limiting sexual intercourse to prevent HIV/AIDS	47.1(women),	62.3(women),	
		Abstinence from sexual intercourse to prevent HIV/AIDS	65.7(women),	70.1(women),	
F	Availability of insecticide treated nets	Percent of households with at least one insecticide treated net (ITN)	0.9	3.8	4

- The state has weak maternal healthcare services as indicated by the poor ante-natal attendance, low delivery rates by a professional and only about 12% of delivery are done in designated health facilities compared to the National average of 35% [6]
- Although no State-specific data was sighted, it has been observed that Borno State contributes greatly to the frightening National under 5 Mortality Rate (157/1000)[7] and Maternal Mortality (1100/100000) figures for the country[8]
- Inspite of high morbidity and mortality caused by malaria, preventive measures to curtail mosquito bite through the use of insecticide treated nets by

[6] Nigeria Demographic & Health Survey, 2008

[7] ibid

[8] World Health Organization, 2007

households is discouragingly low for Borno State (0.9%) compared to the National (4.0%) and North East (3.8%) averages

- the state is amongst states prone to epidemic attacks of bacterial and viral origin such as meningitis, cholera and measles [70 deaths recorded in recent Biu Local Government cholera outbreak].
- Key health professionals are insufficient, and the absence of required mix of staff glaringly evident.
- Based on projected 2009 population figure of 4,536,121, each of the identified key personnel will have thousands of people to take care of viz: Doctors (61,299), Pharmacists (348,932) Nurses Midwives (3,670), Medical Lab Scientists (252,007) and Community Health Officers (19,303), as indicted in figure xii. These figures exclude personnel working in federal institutions and private clinics.

- Borno state population is mostly rural-based and the poverty level very likely to be in tandem with the North East Zonal Poverty Incidence figures of 72 % [9]

- The State Illiteracy level (in western education) is discernably high and, certainly a major challenge.
- The fertility rate amongst women is quiet high (North East average of 7.0 [10]

2.6 Key Issues and Challenges

Based on our Desk review and opinions gathered through interviews and interactions with stakeholders involved in healthcare provision and uptake, the following seem to play significant role in the overall health outcomes for Borno state.

i) General, systemic lack of uptake of healthcare services by the populace. Substantial numbers of people do not present themselves to access healthcare services such as immunizations services provided. It has been observed that many centres built by Government are deserted and the infrastructures left to deteriorate.

Some of the major reasons identified for low immunization levels[11] included:

- No faith in immunization due to religious/cultural biases
- Socio-cultural/religious issues
- Lack of information issue
- Service Delivery Issue- long distance to health facility and

[9] Nigeria Health System Assessment, 2008

[10] ibid

[11] National Immunization Coverage Survey, NICS, 2006

- Economic / poverty

The major challenges is therefore to adequately engage, convince and mobilize the communities to access healthcare and willingly participate in the provision of health services delivery in the state

ii) Inadequate key health professionals -the state can boast of only 0.2% of the about 35000 doctors present in the country under its public service, and about (0.6%) inclusive of all doctors in private and federal institutions. Moreover, there is lack of right-mix of health personnel. Only 25% of the key health personnel requirements (WHO standards) are presently obtainable in Borno state. Consequently, some of the hospitals do not have a pharmacist and or a medical laboratory scientist; some of the PHC facilities do not have midwives. Generally, the state does not have adequate middle-level health personnel required to effectively provide primary healthcare services to the teeming rural population.

The challenge is to entrench a deliberate and systematic training program at the 3 state-owned institutions to produce by 2015, at least 60% of the middle-level health personnel requirements, address the issue of acute gaps in key health personnel such as doctors, pharmacists and midwives as well as reduce to the lowest, staff attrition rate through incentive packages.

iii) Strengthen healthcare delivery system through financial risks protection. State workforce participation in the National Health Insurance Scheme NHIS will attract capitation funds which will be available for health system revitalization as well as motivate the workers for improved performance and productivity.

The major challenge is for the leadership to appreciate the numerous benefits and commence the formal sector NHIS earnest in 2010 and encourage the various communities to set up cooperatives that will facilitate non-formal sector NHIS in due course.

iv) Delayed release of funds to adequately service healthcare services. Many vital recurrent activities such as fuelling and maintenance of generators, vehicles, laboratory equipment and crucial capital projects would have been affected by lack of funds. Similarly, essential projects such as State policy of free-drug to pregnant mothers and their children (MCH drugs) are bound to suffer implementation seizures due to irregular release of funds. .

The main challenge to address this issue is to evolve an evidence-based, realistic and workable budget and for the leadership to have the political will to ensure its

faithful implementation through timely release of funds to realize the set targets.

v) Improving coverage, quality and utilization of healthcare services in the state. Provision of healthcare facilities should ideally reflect the needs of the people, geographical spread, reach etc. Some facilities were found to be inadequately sited and therefore grossly underutilized. Proper sitting would engender optimum service utilization and facilitate efficient referral system.

The challenge is therefore to rationalize health facilities and set criteria for sitting of new facilities and, involve as much as possible, the beneficiary communities in some aspects of the project such as identification of location-site for construction of new facilities.

vi) Improved coordination and collaboration. There are many stakeholders / healthcare providers in the state – these include private providers and donor partners actively involved in healthcare provision throughout the state. A lot more could have been achieved with streamlined coordination and harmonization of activities.

The challenge here is for the Ministry of Health to proactively take leadership in all health matters and ensure effective collaboration with other MDAs, Partner Agencies and Private health providers in the state.

vii) Revitalize data collection, transmission and usage to improve health program performance.

The challenge is to acquire, print and disseminate the nationally designed forms, develop capacity of data entrants, conduct workshops for health mangers on the importance of data as management tools and establish linkages for collection of community-based data.

viii) Driving the State strategic health plans through adequate monitoring and supervision. Encourage inter- sectoral linkages and ensures faithful implementation of strategies and identified intervention activities by effective monitoring & supervision.

The challenge is for the state to appoint a 15-member watchdog (SMAT) comprising of officers from MOH, MLG, Finance, Budget and NGOs to oversee and drive strategic health plans implementation through regular monitoring, supervision and advocacy to other stakeholders.

Chapter 3: Strategic Health Priorities

3.1 Priority Area 1: Leadership and Governance for Health

3.1.1 Context:

The poor performance of the health system is not helped by the lack of clearly defined roles and responsibilities which results in duplication of efforts. This is compounded by inadequate political commitment especially at lower levels, poor coordination, lack of communication between various actors, lack of transparency and poor accountability. In addition, the private sector, a major contributor to health care delivery in the country, is poorly regulated due to weak capacity of the State government to set standards and ensure compliance. All these factors have led to the lack of strategic direction and an inefficient and ineffective health care delivery system. This priority area of the NSHDP Framework seeks to streamline and empower the State Ministry of Health and the LGA Health Departments to reposition their organisational and management systems to provide the strategic and tactical leadership and governance for health. Recommended interventions to address these include appropriate legislation and regulatory frameworks; consensus building through state councils on health and State Executive council; effective decentralization of decision making processes; intergovernmental, multi-sectoral collaboration and coordination of all stakeholders including Public-Private Partnership; strengthening stewardship role of government with proper accountability and transparency and empowering the community and civil society as health sector watch dogs.

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

3.1.3 Strategic Objectives.

3.1.3.1 To provide clear policy directions for health development

3.1.3.2 To facilitate legislation and a regulatory framework for health development

3.1.3.3 To strengthen accountability, transparency and responsiveness of the State health system

3.1.3.4 To enhance the performance of the State health system

3.1.4 Interventions

Descriptions of evidence-based intervention-activities contributing to the achievement of each specific objective are presented below

3.1.4.1 Intervention 1: Improved Strategic Planning at the State level

Activities:

3.1.4.1.1 Strengthen the SMOH and Health Departments of LGAs to take strategic leadership on health policy & development in the State

3.1.4.1.2 Establish inter-sectoral linkages on strategic health policy development and implementation

3.1.4.1.3 Develop and re-orientate the human resource capacities on strategic health plans

3.1.4.1.4 Involve wider stakeholders in the development & implementation of strategic health plans

3.1.4.1.5 Monitor the implementation of the state and LGAs health plans through specific intervention programs as well as conduct annual review of the State and LGAs strategic health development plans

3.1.4.2 Intervention 2: Strengthen regulatory functions of government

Activities:

3.1.4.2.1 Work with the FMOH to review and update existing health laws and regulations in the country

3.1.4.2.2 Work through the State Assembly to Enact laws specific to State requirements, where necessary

3.1.4.2.3 Strengthen the Capacity of the Inspectorate Unit of the Ministry of Health- aid supportive supervision at state and LGA levels; review, update and enforce public health acts and laws; and revise and streamline regulatory institutions roles and responsibilities to align with the national health billthrough the provision of 2no. 4-wheel drive vehicles for effective supervision; procurement of 2No. 4-wheel drive vehicles, fuelling & maintenance

3.1.4.2.4 Engage & disseminate reviewed laws to all the stakeholders (Private Practitioners) in the State

3.1.4.2.5 Establish protocols for monitoring and enforcement of health laws and regulations in the State

3.1.4.3 Intervention 3: Framework for PPP implementation

3.1.4.3.1 Establish PPP units at State and LGA levels to promote, oversee and monitor PPP initiatives
3.1.4.3.2 Strengthening of the PPP through taking stock of the private partners in the State and engage them in quarterly forums.
3.1.4.3.3 Sensitization of the public on PPP to dispel the notion of Privatization- through print media, print and electronic & Printing of leaflets

3.1.4.4 Intervention 4: To improve accountability and transparency

Activities:

3.1.4.4.1 Undertake sensitization/advocacy campaigns aimed at empowering beneficiary communities
3.1.4.4.2 Reconstitute the Hospital Management Committees/PHCs with memberships from diverse interest groups - Rep of Health Development Committees, NGOs, Cultural / Social organizations, etc
3.1.4.4.3 Strengthen the capacity of the various health facilities to operate- adequate funding (increase running costs proportionate to their needs and set criteria- No. of Beds, services rendered etc.
3.1.4.4.4 Decentralize decision-making process –grant autonomy to the health facilities
3.1.4.4.5 Establish an annual joint review mechanism with different stakeholders

3.1.4.5 Intervention 5: Improving the workforce of the State to acceptable Standards

Activities:

3.1.4.5.1 Rehabilitate all the three state-owned health training institutions (SON, MW& SHT)- Provide funds for maintenance of building infrastructure, Teaching aids and other materials and vehicle maintenance
3.1.4.5.2 Facilitate the schools' Accreditation by relevant bodies
3.1.4.5.3 Ensure regular staff training & re-training program
3.1.4.5.4 Map out strategies for employment of staff

3.1.4.6 Intervention 6:Improving and maintaining Sectoral Information base to enhance performance

Activities:

3.1.4.6.1 Establish and convene a 15-member State Monitoring & Advisory Team (SMAT)- drawn from public and private establishments, MOH, MOF, Budget & Planning, NGOs, UNIMAID, Rep of NMA, Rep of PSN, Rep of Nurse/Midwives & at LGA Level an 8-member Monitoring & Advisory Committee (MAC) with membership to include officials from LGA Council (Councilor Health), Departments of Health, Planning, Finance, Administration, 2 Representatives of Health Development Committee, Traditional ruler and a Partner Agency working in the LGA- Meet regularly (6months) to review SSHDP & LGA-SHDP implementation, identify & rectify gaps in financing through advocacy, outsourcing etc., develop health research policies and strategies for the State and LGAs

3.1.4.6.2 Establish research-based program's review mechanism to enhance healthcare performance –and recommend funding for research activities

3.1.4.7 Intervention 7:Monitoring, Evaluation & Supervision

Activities:

3.1.4.7.1 Regular (quarterly) monitoring & supervision by the State Monitoring & Advisory Team (SMAT) (15No persons) & MAC at LGA level (8No) evaluate SSHDP and LGA-SHDP implementation progress, problems and ways out; vehicle fuelling, Honorarium/allowance, monitoring tools, 6days/quarter SMAT, 2days/quarter –MAC

3.1.4.7.2 Create forum through advocacy, with political leaders, to ensure faithful implementation of SSHDP

3.1.4.7.3 Create a forum for outsourcing assistance, where necessary

3.1.4.7.4 Procurement of monitoring vehicles -1 No. bus for SMAT and 27 4-wheel Drives for each LGA -MAC, maintenance, fuelling

3.2 Priority Area 2: Health Service Delivery

3.2.1 Context:

Borno State Health service delivery is characterized by inequitable distribution of resources, poor management of human resources for health, negative attitude of health care providers, weak referral systems; poor coverage with high impact cost-effective interventions, lack of integration and poor supportive supervision.

Interventions recommended include strengthening health services management; implementing the ward minimum health care package; increased access to quality health services; maintenance & rehabilitation of health infrastructure, sustainable procurement system for health commodity and services; rational use of drugs; strengthening referral system; attitudinal reorientation through SERVICOM; institutionalizing staff motivation and establishing quality assurance mechanisms.

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

3.2.3 Strategic Objectives**:**

3.2.3.1 To ensure universal access to an essential package of care
3.2.3.2 To increase access to health care services
3.2.3.3 To improve the quality of health care services
3.2.3.4 To increase demand for health care services
3.2.3.5 To provide financial access especially for the vulnerable groups

3.2.4 Interventions

Descriptions of evidence-based intervention-activities contributing to the achievement of each specific objective are presented below

3.2.4.1 Intervention 1: To review, cost, disseminate and implement the minimum package of care in an integrated manner

Activities:

3.2.4.1.1 Obtain from FMOH, Review and Cost the Minimum Package; cost of transportation to Abuja to obtain, DSA
3.2.4.1.2 Print copies of Minimum Package, print 1500 copies @ N350 each
3.2.4.1.3 Disseminate the concept through orientation workshops, 3days-provide for 3people from each of 27 LGA; DSA, transport, tea break &

lunch, workshop materials, 3 facilitators, DPHC MLG, DPHC MOH (total 90 people); LGAs to conduct LGA level trainings for all PHCs

3.2.4.1.4 Distribute and Implement the Package in all facilities in the State; 3 Officers 1-to each zone for 2days, LGAs to distribute to all facilities; fuelling of vehicle, 3 drivers DSA

3.2.4.1.5 Establish and enforce mechanism for regular monitoring & evaluation; 5 officers, fuelling, DSA,3days/outing-every six months

3.2.4.2 Intervention 2: To strengthen specific communicable and non-communicable disease control programmes

Activities:

3.2.4.2.1 Conduct a stakeholders review meeting with Partners on special programmes in the State including- Immunizations, Rollback Malaria, Onchocerchiaasis, Guinea worm, Schistosomiasis, TB &Leprosy and HIV / AIDS with a view to standardize implementation; provide for 15pers- from MOH, MLG, Partner Agencies; tea break & lunch, sitting allowance, 3days

3.2.4.2.2 Involve wider stakeholders through workshop, advocacy and IEC; Opinion and Religious leaders, NGOs - to strategize on implementation, 3days, 35 people, sitting allowance, tea break & lunch; to be followed by appropriate sensitization and awareness campaigns,

3.2.4.2.3 Provide adequate funds for capacity building / manpower training, procurement of drugs, reagents and equipment, logistics, vehicle maintenance to implement on-going programmes, as strategize

3.2.4.2.4 Establish and implement protocols for regular joint - monitoring and evaluation; every 4 months, transport, 2 vehicle fuelling, DSA 10 persons, vehicle maintenance

3.2.4.2.5 Strengthen Emergency Response & Preparedness procedures for epidemics- ensure adequate surveillance to control outbreaks of measles, cholera, CSM, diarrhea, vomiting and natural disasters; train officers and even communities through workshops and IEC on emergency response procedures; provide funds for procurement of drugs and medical supplies, logistics and staff welfare

3.2.4.3 Intervention 3: To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels

Activities:

3.2.4.3.1 Obtain Reviewed SOPs and guidelines from FMOH

3.2.4.3.2 Conduct TOT Orientation/workshops for health personnel; State level, 2days- 3 officers from each 27 LGAs, DPHC-MOH, DPHC-MLG, PS, (total 90pers) DSA, transportation, tea break & lunch, 3 facilitators honorarium, workshop materials. LGAs to sponsor the LGA levels training

3.2.4.3.3 Print copies of SOPs for distribution to facilities; State to print 2300 copies @ N350 each; for State &LGA

3.2.4.3.4 Commence implementation of SOPs in the State

3.2.4.3.5 Ensure compliance through adequate monitoring; every 6 months, transport, vehicle fuelling, DSA 5 persons, vehicle maintenance

3.2.4.4 Intervention 4:To improve geographical equity and access to health services

Activities:

3.2.4.4.1 Mapping of all Health facilities in the state- MOH facilities and all the LGA facilities , provide lump sum professional fees

3.2.4.4.2 Establish GIS for all health facilities in the state, provide lump sum professional fees.

3.2.4.4.3 develop criteria for sighting of new health facilities at all levels- including factors such as needs, reach, geographical spread and equity

3.2.4.4.4 Construction, Renovation & Equipping of state health facilities; 10 No PHCs Renovation and equipping of 6 Hosp, Renovation & equipping of Nursing Home, Chest Clinic & Dental Hospital and provide for maintenance of 34 hospitals and other health facilities; LGAs- Construction of 32 Primary Health Centre, 50 Health Clinics, 80 Dispensaries / Health Posts b) Renovation of Primary Health Centres 31, Health Clinics 40 and Dispensaries / Health Posts 60, 25Toilets, 10 Cold stores and Drilling of 20 Boreholes.

3.2.4.4.5 provide for maintenance of all health facilities in the State, buildings, utility charges, generators, consumables, vehicle maintenance and Canoe Boats in inaccessible riverine areas (such as Marte&Kukawa, etc.), fuelling, fumigations, cleanings, etc.

3.2.4.5 Intervention 5:To ensure availability of drugs and equipment at all levels

Activities:

3.2.4.5.1 Review the State Essential drug list, determine quantities – Formulary Committee

3.2.4.5.2 Establish a system of procurement of drugs and distribution; engage with reputable manufacturers/distributors to supply annually; provide for advertisement in a national daily, logistics, improve / strengthen storage/cooling condition of the Central Medical Stores and LGA stores, procure 87 ACs(6MOH, 3LGA), 29 Refrigerators (2MOH, 1LGA), procure and maintain 28No. 4-wheel drive vehicles(1 each to MOH & LGA) to improve distribution

3.2.4.5.3 Liaise with FMOH to obtain Equipment List based on the levels of care, provide transportation & DSA to obtain list from Abuja

3.2.4.5.4 Develop/review an equipment list for different levels of health facilities

3.2.4.5.5 Procure and distribute equipment based on need, advertise in National daily, logistics

3.2.4.6 Intervention 6::To establish a system for the maintenance of equipment at all levels

Activities:

3.2.4.6.1 adopt the National Health Equipment Policy from FMOH

3.2.4.6.2 Disseminate and implement the NHEP guidelines

3.2.4.6.3 Provide for budget lines of for the maintenance of equipment and supervision

3.2.4.6.4 Enter into Public-Private Partnership in Maintenance of medical equipment and furniture

3.2.4.6.5 Ensure compliance to agreement through regular monitoring, every six months, 10days; procure 1No monitoring vehicle, fuelling, maintenance, DSA for 4 Bio-medical Engineers

3.2.4.7 Intervention 7:Intervention: To strengthen referral system

Activities:

3.2.4.7.1 Mapping out network linkages for a 2-way referral system as per National guidelines

3.2.4.7.2 Ensure the provision of adequate transportation system for referrals in the State, explore the possibility of Central Ambulance Pooling System, incorporated with free-toll GSM System (CAPS) after mapping & GIS; purchase of 6(MOH)+27(LGA) ambulances

3.2.4.7.3 Upgrade 3more hospitals to referral status

3.2.4.7.4 Provide guidelines for management of emergencies e.g. EmOC, complicated malaria and RTA

3.2.4.7.5 Establish a system of monitoring referral outcomes

3.2.4.8 Intervention 8:To foster collaboration with the private sector

Activities:

3.2.4.8.1 Mapping out of all private healthcare providers by operational level and location in the State

3.2.4.8.2 Liaise with FMOH to Review/Develop guidelines and standards for regulation of their practice and their registration

3.2.4.8.3 Develop guidelines for Partnership with private providers, training and outsourcing of services

3.2.4.8.4 Develop Joint performance monitoring mechanism for the Private sector, every six months

3.2.4.8.5 Acquire, Adopt and implement the National Policy on Traditional Medicine

3.2.4.9 Intervention 9: To strengthen professional regulatory bodies and institutions

Activities:

3.2.4.9.1 Liaise with the FMOH, adopt and implement operational guidelines of all regulatory bodies at all levels, transport to & from Abuja, DSA for 4days

3.2.4.9.2 Build capacity of regulatory staff to monitor compliance of providers to regulatory standards; staff to undertake 2-wks training locally; tuition, DSA, transportation, 5staff in 2batches

3.2.4.9.3 Create budget lines and provide necessary resources

3.2.4.9.4 Ensure regular monitoring exercises with appropriate documentation & feedback

3.2.4.9.5 Empower the regulators through the provision of necessary security

3.2.4.10 Intervention 10: To develop and institutionalize quality assurance models

Activities:

- 3.2.4.10.1 Liaise with FMOH and adopt agreed Model for Quality Assurance
- 3.2.4.10.2 Use FMOH developed training modules to build capacity of public and private health providers in the State
- 3.2.4.10.3 Institutionalize and implement Quality Assurance Improvement Initiative in the State
- 3.2.4.10.4 Implement SERVICOM guidelines on capacity building in all facilities of the State
- 3.2.4.10.5 Monitor Quality care implementation in the State, biennially

3.2.4.11 Intervention 11: To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms

Activities:

- 3.2.4.11.1 Liaise with the FMOH to acquire developed guidelines for ISS
- 3.2.4.11.2 Strengthen the capabilities of State and LGA Health Managers & Teams through team building and leadership development programs
- 3.2.4.11.3 Institutionalize a comprehensive ISS at all levels of healthcare in the State
- 3.2.4.11.4 Develop capacities of program Managers at all levels on the ISS
- 3.2.4.11.5 Develop ISS Tools & Guidelines specifying modalities and frequencies of the ISS visits at all levels of facilities

3.2.4.12 Intervention 12:To create effective demand for services

Activities:

- 3.2.4.12.1 Develop a comprehensive BCC strategy for health promotion in the state
- 3.2.4.12.2 Regular airing of health promotion messages and drama in the state electronic media in two major local languages and English in Borno Radio & Television BRT rates
- 3.2.4.12.3 Develop IEC materials on health promotion in two major local languages and English, State capitals and throughout LGAs; concept

development, T-shirts, Hijabs, Posters, materials, artisans fees, for 2 years running; create demand for health through the provision of 1m free Long Lasting Insecticide Treated Nets (LLITN)

3.2.4.12.4 Conduct regular (biennial) health promotion campaign on; personal hygiene, hand washing, proper waste disposal, de-worming, IYCF-exclusive breast feeding, promotion of micronutrient deficiency control, IMNCH activities, etc.; provide funds for the logistics N250000 every 6months for 3years

3.2.4.12.5 Inculcate importance of healthy living in school curriculum

3.2.4.13 Intervention 13:To improve financial access especially for the vulnerable groups

Activities:

3.2.4.13.1 Liaise with FMOH to develop models for financial protection for the vulnerable groups-pregnant women, children, orphans and aged; DSA, transport to obtain document

3.2.4.13.2 Adopt agreed models for implementation in the State

3.2.4.13.3 State & LGAs to scale up MCH through construction of (26) new MCH facilities and renovation of (25) LGA MCH facilities

3.2.4.13.4 State Government to ensure that all civil servants are registered on the NHIS

3.2.4.13.5 State Government to facilitate community cooperatives for community health financing through the NHIS non-formal sector, as soon as it comes on board

3.2.4.14 Intervention 14:Increase women& child health services

Activities:

3.2.4.14.1 Increase number of outlet providing family planning services in the state

3.2.4.14.2 Increase number of facility providing ANC, Delivery, EmNOC and PNC services.

3.2.4.14.3 Provide free IMNCH for pregnant women &Under fives in all secondary health facilities

3.2.4.14.4 Increase demand for health through provision of free Mama kits for every woman that delivers in a health facility and Ready-to Use Therapeutic Foods (RUTF) for malnourished children

3.2.4.14.5 Train health workers on condom programming, syndrome management of STI, HCT, PMTCT,, RHHIV integration, Sex work & HIV, 1-day, tea break lunch, transport, workshop materials

3.3 Priority Area 3: Human Resources For Health

3.3.1 Context:

The state faces a serious challenge of ensuring equity and access to healthcare due to inadequacy of personnel; only 25% of HRH requirements in key Personnel are available and those available are also suffering from quality issue due to inappropriate mix. Again, there is mal-distribution as majority of the personnel prefer urban postings.

Recommended interventions to address these include implementation of the National Human Resource Policy, entrenching a deliberate and systematic training program at the 3 state-owned institutions to produce by 2015, at least 60% of the middle-level health personnel requirements, addressing the issue of acute gaps in key health personnel by employing doctors, pharmacists and midwives, attitudinal reorientation of staff through SERVICOM guidelines, establishing a system of continuing professional development reducing to the lowest, staff attrition rate through staff incentive packages and institutionalizing quality assurance mechanisms.

3.3.2 To plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care

3.3.3 Strategic Objectives:

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

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

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

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

3.3.4 Interventions

Descriptions of evidence-based intervention-activities contributing to the achievement of each specific objective are presented below

3.3.4.1 Intervention 1: To develop and institutionalize the Human Resources Policy framework

Activities:

- 3.3.4.1.1 adopt the National Policies on HRH on Training & recruitment of health personnel
- 3.3.4.1.2 Review and adopt the National Policy guidelines on task shifting
- 3.3.4.1.3 Establish health professional forum to meet on regular basis to discuss HRH problems

3.3.4.2 Intervention 2:To reappraise the principles of health workforce requirements and recruitment at all levels

Activities:

- 3.3.4.2.1 Develop, introduce and utilize staffing norms based on work load, service availability and health sector priorities
- 3.3.4.2.2 Establish coordinating mechanisms for consistency in HRH planning and budgeting by MOH, Finance, Education, Civil Service Commission and other stakeholders
- 3.3.4.2.3 Strengthen the capacities of State and LGAs to access and implement Federal Government circulars, guidelines and policies related to HRH
- 3.3.4.2.4 Review the entry criteria into training institutions for health providers to conform with State needs and peculiarities

3.3.4.3 Intervention 3:To review and adopt relevant training programs for the production of adequate number of community health oriented professionals based on national priorities

Activities:

- 3.3.4.3.1 State to obtain FMOH reviewed guidelines on training program for community-oriented health professionals
- 3.3.4.3.2 Reviewed training programs will be adopted in all of the three institutions in the State- SON,SMW &SHT

3.3.4.3.3 Empower the three schools through relevant accreditation to be able to train the critical mass of middle level work force required i.e. Midwives, Community health officers and community health extension workers CHEW to be deployed to PHC facilities

3.3.4.3.4 Ensure compliance of training institutions through adequate monitoring and evaluation

3.3.4.4 Intervention 4: To strengthen health workforce training capacity and output based on service demand

Activities:

3.3.4.4.1 Inadequate facilities in all of the three training institutions to be upgraded

3.3.4.4.2 Capacity building and continuing professional development of staff will be enhanced -5 tutors each from the 3 schools for 2 weeks training outside Maiduguri, 2times(total of 30 staff to be re-trained); tuition fees, DSA, transport

3.3.4.4.3 Post Graduate training programs (local & international) for medical personnel will be pursued to achieve professionalism in critical areas, budget line exists

3.3.4.4.4 Quarterly staff re-training program: re-orientation through workshops of health workforce on attitudinal change including training and retraining in interpersonal communication (IPC) skills and work ethics-

3.3.4.5 Intervention 5: To achieve equitable distribution, right mix of the right quality and quantity of human resources for health

Activities:

3.3.4.5.1 Only 25% of the required health work force available currently in the State by WHO standard. Embark on systematic training of staff to obtain an annual 10% increase of staff strength beginning from 2011- to achieve at least 60% staff needs by 2015

3.3.4.5.2 State to embark on special recruitment exercise to correct the imbalance in some critical areas- doctors 10, pharmacists 12, midwives 30 and CHOs 10 for immediate redeployment

3.3.4.5.3 Ensure that each LGA employs at least one medical Doctor before end of 2011

3.3.4.6 Intervention 6: To establish mechanisms to strengthen and monitor performance of health workers at all levels

Activities:

3.3.4.6.1 Establishment of active monitoring and evaluation procedure for a continuous assessment and monitoring of HRH with a view to reporting on the pattern of changes to assist in further planning

3.3.4.6.2 State to institute mechanisms of retaining its workforce through other incentive packages including special allowances for rural postings

3.3.4.6.3 State needs to make some provision for taking over the Midwives Service Scheme after federal Government has stopped funding the scheme.

3.4 *Priority Area 4: Financing For Health*

3.4.1Context:

Hhealth care is financed in Borno State through a mixture of budgetary allocations from the Federal, States and LGAs, private out-of-pocket expenditure, external development funding, grants from corporations and charities and a small but growing social health insurance contributions. Lately, the state implements programs aimed at protecting vulnerable groups from the financial risk of ill-health, such as free maternal and child health services. Revenues from the federal oil revenues cannot be guaranteed as the result of instability of the markets and other factors

The recommended interventions include ensuring sustainable funding to health sector through increasing government annual allocation to 15% and being faithful in releasing funds, improve internally generated revenues through participation of state workforce in the NHIS and initiating mechanisms to organize communities to participate in the non- formal sector NHIS, and improving funding through pooling funds using common basket approaches by all actors involved in financing health in the state as well as strengthening the financial management skills of staff.

3.4.1 To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels

3.4.2 Strategic Objectives:

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

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

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

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

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

3.4.4 Interventions

Descriptions of evidence-based intervention-activities contributing to the achievement of each specific objective are presented below

3.4.4.1 Intervention 1: To develop and implement evidence-based, costed health financing strategic plans at LGA and State levels in line with the National Health Financing Policy

Activities

3.4.4.1.1 State to constitute a 15-member State Monitoring & Advisory Team- with membership to include officials from MOH, HMB, MOF, Budget & Planning, MLG, NGOs, NMA, PSN, NNMA, Unimaid, and Donor,& at LGA Level an 8-member Monitoring & Advisory Committee (MAC) with membership to include officials from LGA Council (Councilor Health), Departments of Health, Planning, Finance, 2 Representatives of Health Development Committee, Traditional ruler and a Partner Agency working in the LGA- Meet regularly to review SSHDP & LGA-SHDP implementation, identify & rectify gaps in financing, through advocacy, outsourcing etc.-

3.4.4.1.2 SMAT-State and MAC-LGA to meet regularly and assess BSSHDPs performance embark on advocacy for faithful budget implementation, possible outsourcing of assistance and other issues.

3.4.4.1.3 Establish and Maintain an Office Secretariat - MOH to provide 1 Office Secretary and 2 Clerical Officers, 1No. computer & accessories, stationeries-materials;

3.3.4.2 Intervention 2:To strengthen systems for financial risk health protection

Activities:

3.3.4.2.1 State to review and commence participation of its workforce in the NHIS program by 2010

3.3.4.2.2 State to encourage and organize communities form associations with a view to facilitate the non-formal sector NHIS in due course

3.3.4.2.3 State to scale up implementation of social protection measures against financial risks associated with ill health, pauper patients, free MCH drugs program, HIV/AIDS, etc

3.3.4.2.4 Provide free IMNCH for pregnant women &Under fives in all health facilities, explore collaboration with Partners and donors for subsidized care services

3.3.4.3 Intervention 3: Promotion of Nutrition activities

Activities

3.3.4.3.1 Promote Infant and Young Child feeding Practices (IYCF)- such as Exclusive Breast Feeding, Complementary Feeding, Growth monitoring, etc, using the new guideline

3.3.4.3.2 Promotion of Micronutrient deficiency control (e.g. Vitamin A, Iron, Iodine and Zinc) using awareness creation, supplementation, fortification, and dietary diversification strategies

3.3.4.3.3 Establishment of supplementary feeding centres state wide

3.3.4.3.4 Procurement of RUTF, Nutrition equipments and materials

3.3.4.3.5 Management of moderate and severe acute malnutrition using Ready to use therapeutic Foods (RUTF)

3.3.4.4 Intervention 4: To improve financing of the Health Sector

Activities

3.3.4.4.1 Encourage Policy Makers, to increase the State budgetary allocation to at least 15% by the year 2015- (a minimum annual 1% increase), and to ensure faithful releases of health -budgets through sustained advocacy, refreshments, transport, sitting allowance

3.3.4.4.2 Liaise with the FMOH to assist States and LGAs benefit from alternative new sources of financing, such as VAT, Tobacco tax, donations charities from Corporations, etc

3.3.4.4.3 Explore External sources of financing healthcare such as providing counterpart funding, with World Bank, ADB, bi- and multi- lateral institutions

3.3.4.4.4 Explore other sources of financing healthcare through Internal Intervention Agency such as MDG & International Donor Partners.

3.3.4.4.5 Encourage Public-Private Partnership and Ownership of health institutions through advocacy

3.3.4.5 Intervention 5: To improve coordination of donor funding mechanisms

Activities

3.3.4.5.1 State will adopt donor - government coordination mechanisms / guidelines from FMOH

3.3.4.5.2 State will avoid duplications and maximize donor funds utilization

3.3.4.6 Intervention 6: To improve Health Budget execution, monitoring and reporting

Activities

3.3.4.6.1 The State ensures funds releases are as per budgetary allocation to execute identified health plans

3.3.4.6.2 SMAT/ MAC shall monitor implementation and ensure proper recording and accounting expenditures are maintained, every 6 months

3.3.4.6.3 State to establish Joint - Monitoring of health budget execution; budget execution strengthened at the State and LGA levels through biennial joint field monitoring by Commissioners of MOH,MOF, Budget & Planning & MLG- 3 days, fuelling, DSA for 5 officers

3.3.4.6.4 Credible mechanisms will be put in place to increase financial transparency such as State Health Accounts (SHAs) and Public Expenditure Reviews (PERs) will be encouraged

3.3.4.7 Intervention 7: To strengthen financial management skills

Activities:

3.3.4.7.1 Capacity of 20(state) and 2LGA- Officers- Accountants, Statisticians, Planning & Budget Officers will be strengthened annually to ensure proper accountability, transparency in tracking of health expenditures, DSA, tuition fees, transport

3.5 ***Priority Area 5: National Health Information System***

3.5.1 Context:

The NHMIS/M&E remains weak and fragmented with numerous vertical programs and systems, which are mostly donor driven. In addition, there are multiplicity of data collection tools, too many indicators, and reluctance of developmental partners and

the vertical programs which they support (including programs within the FMOH), to utilize national tools. Furthermore, there is no national M&E policy, framework and plan and there is lack of integration between the NHMIS and M&E systems. Even though the private sector provides 60% of healthcare in the country, there is very limited capture of their data into the NHMIS. Other major problems include lack of forms; incomplete, untimely, and largely incorrect reporting of data; grossly inadequate capacity to analyze and utilize data for decision making at all levels; and poor feedback mechanisms

The recommended interventions include advocacy for funding, capacity building at all levels for data collection and interpretation, availability of data collection tools at all levels, collaboration with the private sector, harmonization of data collecting systems with key indicators and dissemination and utilization of data to inform policy formulation and programming

3.5.2 Goal: To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care.

3.5.3 Strategic Objectives

3.5.3.1 To improve data collection and transmission.

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

3.5.3.3 To strengthen sub-systems in the Health Information System

3.5.3.4 To monitor and evaluate the NHMIS

3.5.3.5 To strengthen analysis of data and dissemination of health

3.5.4 Interventions

Descriptions of evidence-based intervention-activities contributing to the achievement of each specific objective are presented below

3.5.4.1 Intervention 1: To ensure that NHMIS forms are available at all health service delivery points at all levels

Activities

3.5.4.1.1

3.5.4.1.2 Create budget lines for the provision of data tools

3.5.4.1.3 Print adequate Data tools to last for 6-months; Form 001-009, Registers, cards etc, to be printed every six months

3.5.4.1.4 Distribute NHIMS tools/forms to health facilities -

3.5.4.1.5 Monitor utilization of the forms by the facilities

3.5.4.2 Intervention 2: To periodically review of NHMIS data collection forms

Activities:

3.5.4.2.1 Monitor & Establish regular feedback mechanism from the field on the appropriateness of the NHIMS forms - feedback meeting every 4 months- data producers 27(M &E), 3for 1 day- transport, tea break/lunch, DSA

3.5.4.2.2 Participate in the National Annual periodic review of the NHMIS forms by the FMOH and other stakeholders, Com - trip by air, DPRS, HIMS trip to Abuja by road,

3.5.4.3 Intervention 3: To coordinate data collection from vertical program

Activities

3.5.4.3.1 State to obtain guidelines from FMOH on revitalization of Health Data Consultative Committee

3.5.4.3.2 Establish State Consultative Committee for collaboration with other Agencies on data collection

3.5.4.3.3 Adopt and implement the integration/harmonization of HIS with M & E System in all facilities to ensure coherence

3.5.4.4 Intervention 4: To build capacity of health workers for data management

Activities

3.5.4.4.1 Develop training materials on data collection, analysis and utilization

3.5.4.4.2 Data collection mechanism at State and LGA levels will be strengthened through orientation workshop for data collectors at the State capital,

3.5.4.4.3 Train and re-train health service providers (managers) importance of HIMS tools on programs / policy formulation; 33 PMOs, i/c PHCs,

3.5.4.5 Intervention 5: To provide a legal framework for activities of the NHMIS program

Activities

3.5.4.5.1 Adopt National Health Bill at the State and LGA levels

3.5.4.5.2 Mechanisms for drafting State bye-laws to be enacted through the State Assembly, where necessary

3.5.4.5.3 Sustained advocacy at the State and LGA levels for policy makers and other leaders on the importance and usefulness of health data

3.5.4.6 Intervention 6: To improve coverage of data collection

Activities

3.5.4.6.1 Strategize to improve data collection in all Public and Private health facilities in the State

3.5.4.6.2 Improve the collection of community-based data

3.5.4.6.3 Support the National Population Commission to strengthen vital statistics register of birth and death in all the LGAs of the State- provide technical support

3.5.4.7 Intervention 7: To ensure supportive supervision of data collection at all levels

Activities:

3.5.4.7.1 Provide appropriate logistics to officials to supervise data collection at lower levels- provide for proper maintenance of 1 No. vehicle

3.5.4.8 Intervention 8: To strengthen the use of information technology in HIS

Activities

3.5.4.8.1 Strengthen the use of information technology in Health Information System (HIS)

3.5.4.8.2 FMOH to assist the State with Software on data collection

3.5.4.8.3 Pursue Public-Private Partnership in the management of data warehouse

3.5.4.8.4 Promote use of e-health - electronic Management Intelligence Information System, websites, Patient information system, etc.

3.5.4.8 Intervention 8: To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management

Activities

3.5.4.8.1 Acquire and Adopt FMOH -guidelines on NHMIS Minimum Package

3.5.4.8.2 Advocacy for State and LGAs to provide basic infrastructure for data storage, analysis and transmission - computers, power supply and internet-

3.5.4.8.3 Deploy provided hard wares obtained to facilities in the State and LGAs

3.5.4.8.4 Train Technical staff at all levels on data software

3.5.4.9 Intervention 9: To strengthen the Hospital Information System

Activities:

3.5.4.9.1 Liaise with FMOH to Develop guidelines on technical specifications for the establishment and strengthening of patient Information System

3.5.4.9.2 Liaise with FMOH to Develop guidelines on technical specifications for the establishment of disease mapping in the State and LGAs

3.5.4.10 Intervention 10: To strengthen the Disease Surveillance System

Activities:

3.5.4.10.1 Ensure regular reporting of notifiable diseases by all the State and LGA health facilities

3.5.4.10.2 Initiate and strengthen community-based surveillance to improve Disease Surveillance System

3.5.4.11 Intervention 11: To establish monitoring protocol for NHMIS program implementation at all levels in line with stated activities and expected outputs

Activities:

3.5.4.11.1 Encourage LGAs to provide logistics - vehicles/motor cycles and costs of maintenance for SHMIS

3.5.4.11.2 Promote use of NHMIS Quality Assurance - Print and Distribute HIS (QA) Manual, provide for printing of 100 copies @ N325

3.5.4.11.3 Ensure Quarterly Review meeting at the LGA level and Bi-annual Review of the HIS at the State level; provide for State level meeting -

3.5.4.12 Intervention 12: To strengthen data transmission

Activities:

3.5.4.12.1 Obtain, Promote guidelines and monitor on regular basis to ensure monthly transmission of SHMIS data

3.5.4.13 Intervention 13: To institutionalize data analysis and dissemination at all levels

Activities:

3.5.4.13.1 Establish training program on data analysis and dissemination for SHMIS Officers

3.5.4.13.2 Develop guidelines on data analysis and dissemination

3.5.4.13.3 Promote use of data to inform decision making

3.5.4.13.4 Produce periodic Health Data Bulletin and Annual Reports - Health Data Consultative Committee to produce bulletin,

3.5.4.13.5 Training of program managers, CSOs & NGOs in the integration of population issues in development planning;

3.6 *Priority Area 6: Community Participation And Ownership*

3.6.4 Context

There is a general, systemic lack of uptake of healthcare services by the populace; there is a lack of clear policy framework to empower the community as the draft Community Development Policy is yet to be finalized. The National efforts at promoting community participation through PHC contained prescriptive guidelines

which resulted in little or no efforts in the identification and strengthening of existing local social organizations, thereby pre-empting a crisis of legitimacy. There is minimal constructive engagement of communities in needs identification, planning and implementation of health programs. Inadequate community participation has also resulted in inappropriate sitting of PHC facilities in inaccessible or unacceptable locations and also, gross underutilization of the services rendered.

Recommended activities to address this challenge is therefore to adequately engage, convince and mobilize the communities to access healthcare and willingly participate in the provision of health services delivery in the state. Measures include building Capacity of local consultants on community mobilization, Creating an enabling environment for community participation in health development through proper implementation of mobilization activities in all 311 wards, developing & implementing IEC materials in local languages - Radio & TV jingles, dramas, banners & posters at State and LGA levels and Skills Acquisition workshops to re-orient the community development committees and community-based health care providers on their roles, responsibilities.

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

3.6.3 Strategic Objectives:

3.6.3.1 To strengthen community participation in health development.

3.6.3.2 To empower communities with skills for positive health actions.

3.6.3.3 To strengthen the community - health services linkages.

3.6.3.4 To increase State capacity for integrated multisectoral health promotion.

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

3.6.4 Interventions

Descriptions of evidence-based intervention-activities contributing to the achievement of each specific objective are presented below

3.6.4.1 Intervention 1: To provide an enabling policy framework for community participation

Activities:

3.6.4.1.1 Obtain and adopt the FMOH Policy framework on Community Participation- to suit State peculiarity, transport to Abuja, DSA for 4days

3.6.4.1.2 Building Capacity of local consultants on community mobilization- State-wide 3-days Orientation workshop for 27 Local Government consultants/resource persons; 3 Facilitators (Community mobilization, IEC & IPC experts), other stakeholders, Opinion Leaders- Muslim and Christian leaders, NGOs 2, MLG 2, MOI 1 & MOH Officials

3.6.4.1.3 Create an enabling environment for community participation in health development through proper implementation of mobilization activities in all 311 wards; 27 LGA Consultants + 2 local resource persons in each LGA -undertake sensitization/advocacy of each ward for 2days supervised by 3 State facilitators- 1 in each senatorial zone, LGA to continue on sustained basis sensitization-mobilization -target all the LGA population, provide transport, staff allowance and refreshment for sensitization/advocacy (N3000)/sitting at least once every month continuously for 3 years

3.6.4.1.4 Develop & Implement IEC materials in local languages - Radio & TV jingles, dramas, banners & posters at State and LGA levels-Develop concept, test-run, implement, professional fees, Radio & TV dramas, rates/slots, for 3 quarters, artists

3.6.4.1.5 Reconstitute through election/selection leadership of the various community development unions at the wards and LGA levels - to be supervised by Local Consultants in 2 days, local artisans, posters

3.6.4.2 Intervention 2: To provide an enabling implementation framework and environment for community participation

Activities:

3.6.4.2.1 Guidelines for establishing community development unions would be reviewed and made flexible to reflect situation on ground

3.6.4.2.2 Adequate sensitization/advocacy campaigns on ownership would be carried out at the community levels, carrying them along – throughout the state 311 wards, 2days/ward/ 3facilitators

3.6.4.2.3 Participatory approaches to involve wider members of the community put in place

3.6.4.2.4 Establish inter-sectoral linkages

3.6.4.3 Intervention 3: Strengthen Community Ownership and Participation

Activities:

3.6.4.3.1 Undertake advocacy visit to community gate-keepers and the entire community to increase awareness and understanding in using health facilities,

3.6.4.3.2 Review the policy framework for community participation and integrate with other activities such as religious, cultural, administrative and management system of the community; 10 No., sitting allowance, refreshments,

3.6.4.3.3 Identify and reconstitute the existing development committees at the state and LG Areas giving greater participation and control to the members of the community in order to give them sense of ownership

3.6.4.3.4 Inaugurate the Health Development Committees at well attended ceremony at the LGA Secretariat chaired by LGA Chairmen; artisans, posters, T-shirts & women Hijabs @ N1000, 500 No./LGA, (public address system, chairs, benches, canopies, posters, banners, refreshments- provide lump sum N300000/LGA)

3.6.4.4 Intervention 4: To build capacity within communities to 'own' their health services

Activities:

3.6.4.4.1 Develop and upgrade existing participatory tools for mobilizing communities in planning and management

3.6.4.4.2 Identify and map out key community stakeholders functions and their health capacity-needs

3.6.4.4.3 Biennial Skills Acquisition workshops to Re-orient the community development committees and community-based health care providers on their roles, responsibilities and empower them with Health Knowledge, capacity in management and basic health data interpretation;

3.6.4.4.4 Establish dialogue between communities and government structures at all levels- in program planning, implementation and monitoring, through IEC and other suitable medium of communication for maximum impact

3.6.4.4.5 Provide funding for community activities

3.6.4.5 Intervention 5: To restructure and strengthen the interface between the community and the health services delivery points

Activities:

3.6.4.5.1 Review the existing health delivery structure and assess their level of linkages with the community in the State and LGAs

3.6.4.5.2 Develop guidelines for strengthening the community-health services linkage

3.6.4.5.3 identify and restructure health delivery structure in order to promote community participation in health development at all levels

3.6.4.5.4 Provide enabling environment for exchange of experiences & ideas between community development committees

3.6.4.5.5 Sensitization of religious leaders, Politicians, Law enforcement agents, traditional and community leaders on GBV;

3.6.4.6 Intervention 6: To develop and implement multi sectoral policies and actions that facilitates community involvement in health development

Activities:

3.6.4.6.1. Increase community's awareness towards health development through community participation

3.6.4.6.2. Develop health promotion guidelines on community involvement and strengthen the health promotion components in the community

3.6.4.6.3. Empower communities with health knowledge, skill and behavioral communication- through IEC-dramas, radio &tv jingles, posters

3.6.4.6.4. Facilitate action plans aimed at development of health promotion capacities at community levels linking health with other sectors

3.6.4.6.5. Training of teachers on family life health education; 2-day, 27 No, 3 facilitators, DSA, Honorarium, tea+lunch break

3.6.4.7 Intervention 7: To develop and implement systematic measurement of community involvement

Activities:

3.6.4.7.1 Conduct Research to Measure the impact of approaches, methods and community initiatives after a specified time (6-months)

3.6.4.7.2 Document and share the findings - disseminate lessons learnt and best practices to other communities

3.6.4.7.3 Develop continuous monitoring and evaluation of the program for sustainability

3.7 ***Priority Area 7: Partnership for Health***

3.7.1 Context

Health is a multidimensional issue and government alone cannot meet all the health needs of the people in Nigeria. Partnership with the private sector, non-governmental

organizations, communities and development partners (donors) as well as other social and economic sectors is essential to deliver health services that can meet the needs of the population on a sustainable basis. There is lack of efficient coordination and collaboration with Partner agencies, private health providers and communities. The challenge here is for the Ministry of Health to proactively take leadership in all health matters and ensure effective collaboration with other MDAs, Partner Agencies, Private health providers and communities

Recommended activities include creating a PPP Unit at SMOH to deal directly with all Private Partners, enumerate all Private Partners operating in the health sector in the State by category- to include all private health facilities(registered or not), NGOs providing health services, Partner Agencies in health, hospitals/clinics, pharmacies, patent medicine stores, nursing homes and even the traditional healers, conducting workshops on the development of framework for the harmonization and alignment of development partner's support, etc.

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

3.7.3 Objectives:

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

3.7.4. Interventions

Descriptions of evidence-based intervention-activities contributing to the achievement of each specific objective are presented below

3.7.4.1 Intervention 1: To promote Public Private Partnerships (PPP)

Activities:

3.7.4.1.1 Create a PPP Unit at SMoH to deal directly with all Private Partners - to be headed by Deputy Director, 1 middle management staff and 3 junior staff, one time activity- Staff available, assign mandate

3.7.4.1.2 Enumerate all Private Partners operating in the health sector in the State by category. To be updated once every year (in the first quarter) - to include all private health facilities(registered or not), NGOs providing health services, Partner Agencies in health, hospitals/clinics, pharmacies, patent medicine stores, nursing homes-(to liaise with Inspectorate unit), 9 staff, 5days, DSA, transport

3.7.4.1.3 Workshop for policy makers on the role of partner Agencies.Total to be sensitized, all law makers plus 10 support staff. 1 Day meeting in the House of Assembly - special workshop bags N1000, projector, facilitator, refreshments for 40people- another one in 2011 after elections

3.7.4.1.4 Joint budgeting between State MOH and Partner Agencies. To be done once a year in the 3rd Qtr of 2010

3.7.4.1.5 Workshop to put in place mechanism to encourage the private sector set up health facilities in rural and under-served areas. 35 people targeted for two days at a hotel, venue, advert in NTA & BRT

3.7.4.2 Intervention 2:To institutionalize a framework for coordination of Development Partners

Activities:

3.7.4.2.1 Workshop on the development of the framework for the harmonization and alignment of development partner's support- all partners operating in the State-WHO, UNICEF, UNFPA, FHI/GHAIN, WB,ADB…, MOH, MOF, MLG, Budget, 38pers, 2 facilitators, bag, venue, training materials,

3.7.4.2.2 Conducting Development Partners Forum comprising of only health development partners, quarterly involving

3.7.4.2.3 Conduct Health Partners Coordinating Committee (HPCC) meeting biennially to discuss programs implementation and resource coordination through basket funding; refreshments, sitting allowance

3.7.4.3 Intervention 3:To facilitate inter-sectoral collaboration

Activities:

3.7.4.3.1 Conduct inter-sectoral ministerial forum comprising Officials from different ministries such as Health, Finance, Water, Agric etc. with a purpose to share common goals and experience; tea brake/lunch, sitting allowance, 30 people1 day - twice per year (State level) and once per year (LGA), 9 people, sitting allowance, refreshments

3.7.4.4 Intervention 4:To engage professional groups

Activities:

3.7.4.4.1 Conduct yearly meetings with Professional groups through which standards of training by health institutions are jointly set, subsequent practice and professional competency assessments will be finalized. To involve 25 people for 3 days, transport, sitting allowance, refreshments

3.7.4.4.2 Conduct yearly review meetings with professional groups on planning, implementation, monitoring and evaluation of health plans and programs involving 20 people for 2 days

3.7.4.4.3 Produce biennial joint publications/magazine to enhance relationships between professional groups and State MOH -1000 copies @ 325

3.7.4.4.4 Promote linkages with academic institutions to undertake research, education and monitoring through existing networks. Yearly meeting involving 16 people, MOH, HMB, Uni Maid, UMTH, SON&MW,SHT

3.7.4.4.5 Pay advocacy visit to State House of Assembly to lobby for enacting of regulation and legislation to allow for competency-based practice by all types of health professionals according to the principles of "continuum of care" 40 people involved, transport, advocacy refreshments

3.7.4.5 Intervention 5: To engage with communities

Activities:

3.7.4.5.1 Introduce weekly Radio program on health matters- personal hygiene, preventive, curative and emergencies and role of health community development associations; To be facilitated by the Health Education Unit of the MOH; for about 6 months

3.7.4.5.2 Print posters targeting community consumption including rights of beneficiaries, means of accessing care at health facility and minimum standards of quality health services; lump sum N500000 and N100000 at the LGA level

3.7.4.5.3 Workshop on development of indicators on health system performance at State, LGA and facility levels to improve transparency and accountability.

3.7.4.5.4 Cascaded training on Quality health care delivery and mechanism for rewarding best performance at State, LGA and health facility levels; State level TOT,

3.7.4.5.5 Training of Volunteer Community Health Workers to manage priority health conditions through appropriate self-mediated mechanisms 40 community volunteers every six months,

3.7.4.6 Intervention 6: To engage with traditional health practitioners

Activities:

3.7.4.6.1 Register traditional medicine practitioners into bodies / organizations that are easy to regulate and actually regulate their practice

3.7.4.6.2 Conduct research activities to gain more insight, understanding and evaluation of Traditional healers

3.7.4.6.3 Adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful

3.7.4.6.4 Advocacy for legislation to ban traditional practitioners from advertising themselves and making false claims in public media

3.7.4.6.5 Annual retreat of traditional practitioners aimed at promoting health programs in such priority areas like nutrition, environmental sanitation, personal hygiene, immunization and family planning;

3.8 Priority Area 8: Research for Health

3.8.1 Context

Despite the existence of a national policy, implementation remains slow with limited funding. There is little or no research activity in the state.

The recommended interventions include strengthening the capacity for research at all levels, establishment of an expert group (State Monitoring and Advisory Team) to identify research needs for effective implementation of BSSHDP, creating adequate budgetary provision for research activities and ensuring researches are used to formulate policies in health sector.

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

3.8.3 Strategic Objectives:

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

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

3.8.4. Interventions

Descriptions of evidence-based intervention-activities contributing to the achievement of each specific objective are presented below

3.8.4.1 Intervention 1: To finalize the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels

Activities:

- 3.8.4.1.1 Adopt the NHRP
- 3.8.4.1.2 Develop State Health Research Strategies

3.8.4.2 Intervention 2: To establish and or strengthen mechanisms for health research at all levels

Activities:

- 3.8.4.2.1 Strengthen capacities of Department of Planning Research & Statistics in the MOH and LGAs to coordinate research activities
- 3.8.4.2.2 Provide Technical assistance to develop and strengthen the capacity of Health Research Unit of the DPRS to undertake operations research and other research-related activities

3.8.4.3 Intervention 3: To institutionalize processes for setting health research agenda and priorities

Activities:

3.8.4.3.1 Establish / strengthen functional institutional structures to implement the Essential National Health Research program

3.8.4.3.2 To broaden the research agenda to include broad and multi-dimensional determinants of health

3.8.4.4 Intervention 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

Activities

3.8.4.4.1 Develop and disseminate guidelines for a collaborative research agenda

3.8.4.4.2 Establish a forum of Health Research Officers at MOH and LGAs

3.8.4.4.3 Convene a multi-stakeholders forum to identify research priorities for harmonization of research efforts

3.8.4.4.4 Support development of collaborative research proposals and their implementation

3.8.4.5 Intervention 5: To mobilize adequate financial resources to support health research at all levels

Activities:

3.8.4.5.1 Encourage the State & LGAs to allocate about 2% of their health budget to research

3.8.4.5.2 Reach out to Partner Agencies and other organizations for funding in health research

3.8.4.6 Intervention 6:To establish ethical standards and practice codes for health research at all levels

Activities:

3.8.4.6.1 State to adopt National guidelines on research

3.8.4.6.2 Develop and promote guidelines on ethical standards for research in health

3.8.4.6.3 Establish Ethical Review Committee and in tandem with what obtains in higher institutions

3.8.4.6.4 Establish mechanisms to monitor, evaluate and regulate research and the use of research findings

3.8.4.7 Intervention 7: To strengthen identified health research institutions at all levels

Activities

3.8.4.7.1 Cooperate with FMOH to strengthen research institutes and other research-based organizations for better health outcomes

3.8.4.8 Intervention 8:To create a critical mass of health researchers at all levels

Activities

3.8.4.8.1 State will Encourage and support its indigenes acquire higher degrees in healthcare through scholarships

3.8.4.8.2 Provide research grants to prospective researchers, especially PhDs in healthcare

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

Activities

3.8.4.9.1 State will encourage use of research findings to achieve evidence-based policy formulation

3.8.4.10 Intervention: To undertake research on identified critical priority areas

Activities

3.8.4.10.1 provide funding to undertake periodic operational research

3.8.4.10.2 State to provide funds to conduct manpower audit, health service utilization, HIMS, and Cost Recovery Scheme etc, annually

3.8.4.10.3 Conduct research activities to gain more insight, understanding and evaluation of Traditional healers, provide funds (N5.5m) to conduct research, annually

3.8.4.10.4 Conduct research annually to assess performance coverage (immunization coverage, sentinel surveys, etc); provide N10m for research

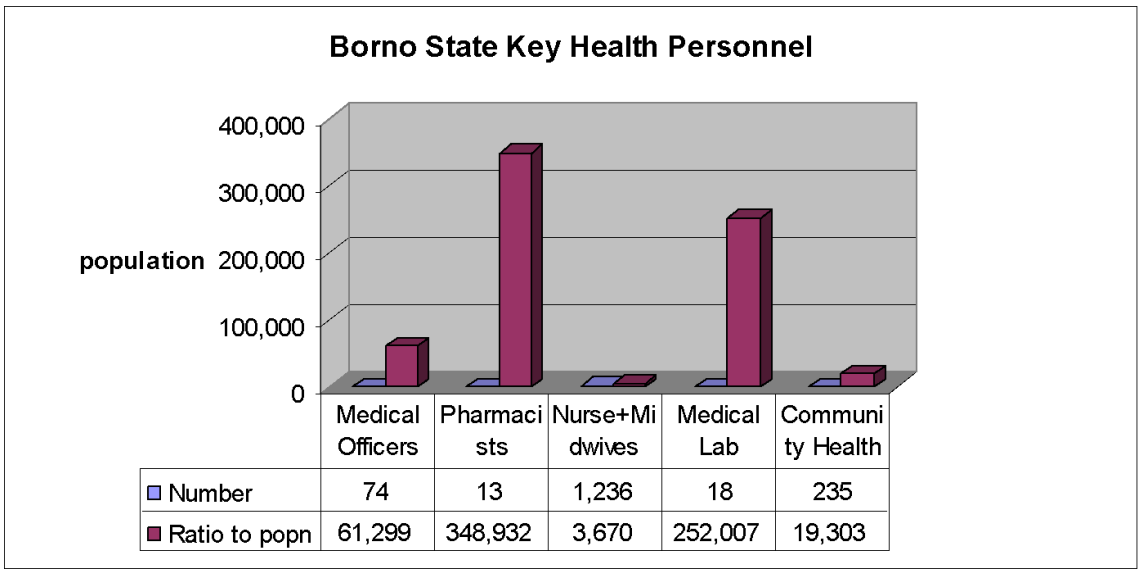
Chapter 4: Resource Requirements

The ambition of the Borno State Government to rapidly expand and increase access to healthcare to its citizens as manifested by construction and rehabilitation of many health facilities is commendable as it indicates government's interest and commitment to reverse the unacceptably low health outcomes in the state. However, deliberate and systematic plans must be in place for the desired results to be realized. Consequently, the underlying bottlenecks must be addressed squarely to maximize the outputs. The triple factors of human, physical/material and financial resources would therefore need to be addressed The resources required to implement the 6-year Borno State Strategic Health Development Plans are available presently albeit, below optimum levels and therefore need revitalization to achieve all the intended strategic goals that will eventually transform the healthcare delivery system to produce the expected positive outcomes for the state.

4.1 Human Resource

Human Resources for Health care in the state is grossly inadequate; key health personnel under the state public service include 74 doctors, 13 pharmacists, about 1236 nurses & midwives, 18 medical lab scientists and about 235 Community Health Officers. These figures are by all standards insufficient for the about 4.5m state population and forms part of the disproportionate fraction of the national outlook for human resource in health. Some of the hospital facilities do not have a doctor, pharmacist and or medical lab scientist, and many PHCs do not have midwives. Generally, the state does not have adequate and the right mix of human resources for health especially, the middle-level health personnel required to effectively provide primary healthcare services to the teeming rural population. The biggest challenge for the state is to correct this obvious imbalance, systematically and on a sustained basis. The strategic plan is to increase the workforce annually by 10% from the present level (below 25% by WHO standard) to at least 60% by 2015. A special recruitment exercise is also planned as a quick measure to fill critical gaps for key health personnel including doctors, pharmacists, midwives and community health officers and, quite significantly, an all-embracing staff re-training and re-orientation exercise targeted at all health workforce in the state is being proposed to commence by second quarter of 2010.

Figure5 Key Health personnel/Population ratios



a) The human resource for health have been strategized to grow by 10% annually beginning from 2011: the total costs for personnel and other allowances running for the period 2010-2015 have been computed (including social contributions for pension and NHIS) and estimated at about N34.64bn
b) The total costs budgeted for special recruitment exercise to fill gaps for key personnel estimated at about N2.47bn
c) Quarterly staff re-training program of re-orientation on interpersonal communication (IPC) skills, work ethics and other aspects of healthcare delivery system. More than 4800 staff are expected to be trained; 30 tutors in the 3 training institutions and about 580 Accountants, Statisticians, Budget and Planning Officers etc will be trained during the 2010-2015 strategic plan period; Biennial Skills Acquisition workshops to empower membersof communities towards ownership are all part of deliberate efforts aimed at developing the human resource base in health and is estimated to cost over N0.22bn

4.2 Physical & material Resources

The State presently has 34 Hospitals, over 450 PHC facilities and running a Drug Revolving Fund Program. Some Partial Recovery Scheme are being implemented for other consumables for surgeries, etc. Most of the health facilities will be renovated, equipped and upgraded during the 6-year strategic period. In order to sustain healthcare service delivery, increase access, ensure geographical spread and equity the following have been earmarked for the SMOH and all the 27 LGAs in the state:

a) Maintenance of existing facilities, implements, equipments and material supplies, utilities and other consumables for the six-year period is estimated to cost about N7.46bn

b) Construction & equipping of i) 9 No Gen Hospitals ii) 10 No PHCs iii) Comprehensive Health Centres iv) 15 Primary Health Centre primary healthcare 80 Dispensaries / Health Posts, vii) 25 Toilets viii) 20 Boreholes and ix 10 Cold stores and b) Renovation of i) 6 Hospitals ii) Nursing Home, Chest Clinic & Dental Hospital iii) 11 Comprehensive Health Centres iv) 20 Primary Health Centres v) 40 Health Clinics vi) 60 Dispensaries / Health Posts estimated to cost over N7.60bn.

c) Scale up MCH through construction of 26 units and renovation of 25 facilities across the state, social protection measures-MCH drugs, HIV/AIDS etc. estimated at about N2.71bn

d) Procurement of essential drugs under the DRF and strengthening of drug storage and distribution systems estimated to cost about N3.59bn.

e) Procurement and maintenance of medical equipment estimated to cost over N6.46bn

f) Procurement of 35 units Ambulances to boost referral system throughout the state estimated at N0.21bn

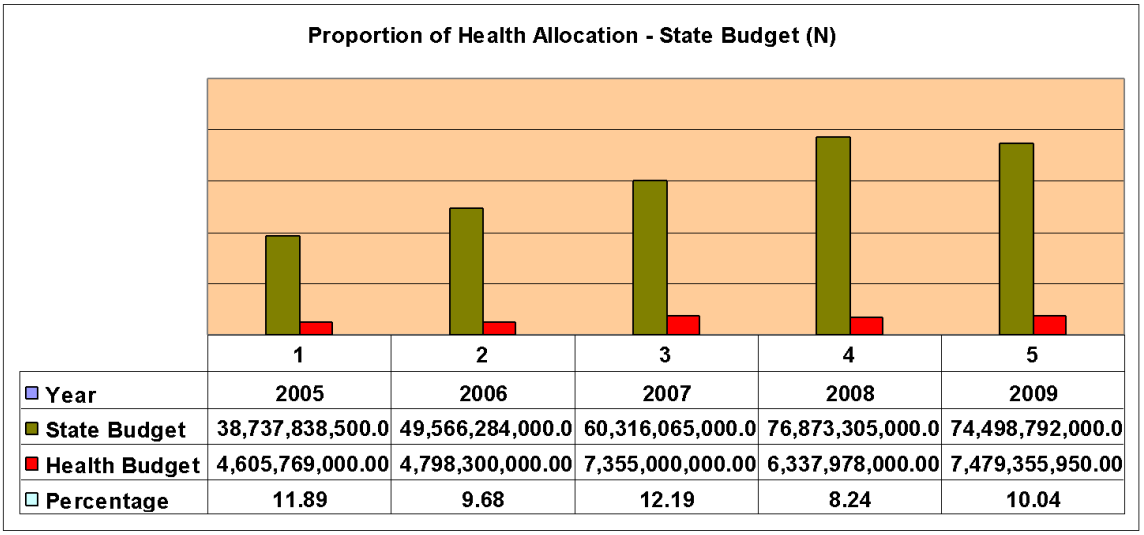
f) Procurement of logistics required for the successful implementation of the strategic plans in the state- 31 project and monitoring vehicles, 27 motor cycles for data collection and 29 computers & its accessories – all estimated to cost about N0.41bn

4.3 ***Financial Resources***

The State annual budgetary allocations have significantly increased over the last 5 years and hovers around 10%: projections for six years (for MOH & LGAs) are estimated to be around N77bn. However, the State revenue incomes are almost wholly dependent on Federal incomes and, with the instability of oil-markets; these projections cannot be dependable.

It is significant to point out that budgetary allocations are not synonymous to budgetary releases as wide gaps exist between allocated funds and released funds leading to incomplete implementation of otherwise critical programs.

Figure 6 Proportion of health allocation to total budgets (SMOH)



	1	2	3	4	5
Year	2005	2006	2007	2008	2009
State Budget	38,737,838,500.0	49,566,284,000.0	60,316,065,000.0	76,873,305,000.0	74,498,792,000.0
Health Budget	4,605,769,000.00	4,798,300,000.00	7,355,000,000.00	6,337,978,000.00	7,479,355,950.00
Percentage	11.89	9.68	12.19	8.24	10.04

Recommendations to explore other alternative sources of income such as tobacco and other consumables taxes, corporate taxes and basket funding by donor agencies.

Previously, it has been observed that much more funds were allocated for capital expenditure to finance construction of facilities relative to the maintenance and running of existing ones, leading to disrepair of many equipment and facilities. To ensure effective maintenance culture, this strategic plan provided for increase in recurrent expenditure; it is also envisaged that capitation funds would have accrued to health facilities to maintain and improve their services efficiently when the leadership finally approves the participation of the state workforce in the formal sector NHIS by 2010.

Chapter 5: Financing Plan

5.0 Introduction

The Borno Strategic Health Development Plan was premixed on the vision of the State, the SEEDS on health, the state's financial capabilities and the need to urgently address the deteriorating healthcare status in line with the National Strategic Health Development Plan.

Healthcare intervention activities that would reverse the prevailing low health outcomes as indicated by the frightening state health indices have been identified and costed, and measurable indicators with targets attached.

- The BSSHDP identified key intervention areas within each of the 8 thematic strategic goals that are very relevant, realistic and implementable in Borno State to achieve improved health services delivery

- Targets for the realization of the activities were assigned; indicators to measure performance attached to each activity, as well as the person(s) responsible to drive the successful realization of each of the identified activity.

The costing of the activities was based on prevailing market rates for services in and around Borno State using designated heads/subheads in the Excel Planning Tool kit.

Basis of costing the plan consisted of the following:

a) The Annual State Ministry of Health budget (N7.48Bbn baseline, 2009)
b) Each of the 27 LGAs in the State receives on the average, health allocation of about N200m - the annual projected budget for the LGAs in the state is about N5.4bn
c) The State Health plans as contained in SEEDS2 and the submitted 2010 budgets
d) Plus the MDGs 3 health intervention activities valued at about N0.75bn
e) Prevailing service charges (in Naira) – attached appendix
f) A 6 year – plan /budget was then calculated for the State as follows

- (7.48 +5.4) x 6 = **N77.28bn**

5.1 Estimated Cost of the strategic orientations

Summary of Costs for each of 8 thematic areas

1.0 Leadership and Governance for Health ========== N**1, 032,408,000**

2.0` Health Service Delivery ========== N**34, 323,119,400**

3.0 Human Resources for Health ========== N**38, 011,261,317**

4.0 Financing for Health ========== N**2, 329,514,000**

5.0 National Health Information System ========== N**245, 284,500**

6.0 Community Participation and Ownership ========== N**338, 141,800**

7.0 Partnerships for Health ========== N**81, 006,600**

8.0 Research for Health ========== N**390, 000,000**

Total========== N**76, 750,735,617**

5.1.1 ***Summary of total estimates***

Total Personnel Costs = N**37, 605,080,317**

Total Goods & Non personal services = N**26, 646,255,300**

Total Capital Projects = N**12, 499,400,000**

Total========== N76, 750,735,617

5.2 Assessment of the available and projected funds

The cost of executing the Borno State Strategic Health Development Plans amounts to **N76, 750,735,617**

The projected funds accruing to the State health sector (from MOH & LGAs budgets) is **N77, 280,000,000**

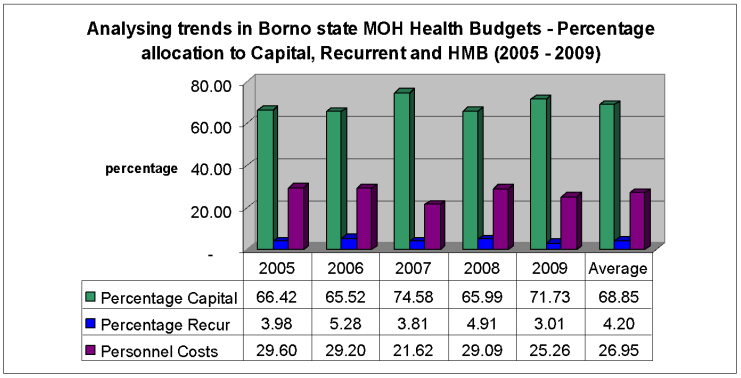
5.3 Determination of the financing gap

Considering the proposed strategic plans, optimum health outcomes are being anticipated if the identified prioritized activities are implemented using all the expected human, physical and financial resources.

However, budgetary releases do not correspond to allocation, there is the need to identify the gaps - data retrieval to establish the proportion of budgetary release versus allocation over the last 5 years has been excruciatingly slow

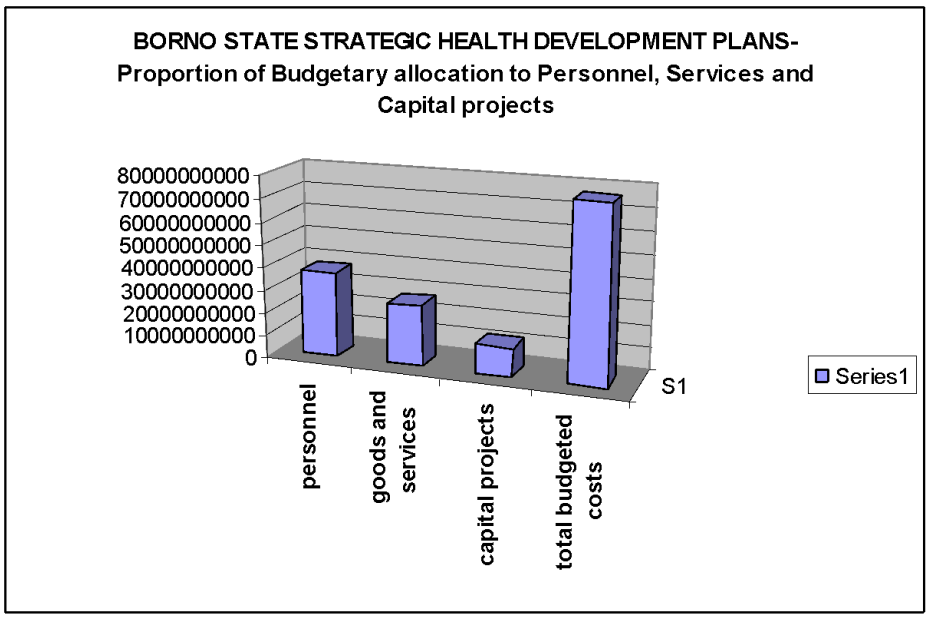
The trend observed over the last 5 years (for MOH) tends to indicate the average capital allocations is 69%, recurrent 4% and salaries & wages about 27%. This suggests massive investment in structures in deference to human resources.

Figure 6 Analysis of Proportion of health allocation to Capital, Recurrent & Personnel Costs



	2005	2006	2007	2008	2009	Average
Percentage Capital	66.42	65.52	74.58	65.99	71.73	68.85
Percentage Recur	3.98	5.28	3.81	4.91	3.01	4.20
Personnel Costs	29.60	29.20	21.62	29.09	25.26	26.95

The BSSHDP has re-prioritized funds allocations and provided about 49% to personnel – including salaries, allowances, trainings and staff development; 51% goes to recurrentand capital projects to take care of procurement of goods, services, maintenance and construction, as detailed in the Excel Tool.



5.4 Closing the financing gaps:

As budgetary releases are not complete and timely, it is anticipated that other stakeholders will contribute through basket funding to ensure adequate and timely funds are provided in order to realize the goals and targets of the strategic plans.

Chapter 6: Implementation Framework

The proposed implementation framework of Borno State Strategic Health Development Plans is depicted by the organogram (table)

The main Coordinating Unit is the State Steering Committee whose membership comprises of the Commissioners of Health (as Chairman), Finance, Local Government, the Chairman Health Committee State House of Assembly, All the 27 Council Chairmen, Permanent Secretary Ministry of Health, All Directors of the Ministry of Health, Chief Executive Hospital Management Board, Heads of Development Partners and representative NGOs, and representative of Traditional & Religious Leaders.

The State Ministry of Health supervises all health activities within the state; health delivery services are normally executed by implementation agencies and parastatals. Partner agencies support the state in specific intervention services such as immunizations, guinea worm, onchocerchiasis, HIV/AIDS, maternal & child health and malaria control programs.

Secondary healthcare is the statutory responsibility of the State Government and this function is being executed in all the 34 state hospitals under the Hospital Management Board which is the implementation agency.

Each hospital has a Hospital Management Committee made up of the Principal Medical Officer PMO, heads of the units- pharmacy, nursing, finance and members selected from the beneficiary communities, including traditional and opinion leaders, and prominent individuals.

The Ministry for Local Government and Chieftaincy Affairs supervises local government matters. However, the Local Government Councils are presumably autonomous and charged with the statutory responsibility of primary healthcare dispensation. All the about 450 primary healthcare facilities in the state are under the ambit of the LGAs. These facilities consist of Primary Health Care Centres, Health Clinics, Dispensaries, Health Posts and Maternal & Child Health Clinics.

The PHCs are also supposed to have a Management Committee made up of the Officer in-charge, heads of the units- pharmacy, nursing, and members selected from the beneficiary communities, including traditional and opinion leaders, and prominent individuals.

The Borno State Strategic Health Development Plans will strengthen and utilize the existing framework for its implementation.

The following are recommended for consideration;

i) Leadership – The Ministry of Health should take more responsibility of health matters in the state and evolve an inter-sectoral collaboration with relevant MDAs – the MLG, MOF, MOI, MOA, Dept of Budget& Planning, Partner Agencies, NGOs and Private Healthcare Providers.

ii) The MOH ensures the establishment of a State Monitoring & Advisory Team SMAT which shall supervise, monitor and drive the full implementation of the BSSHDP to fruition

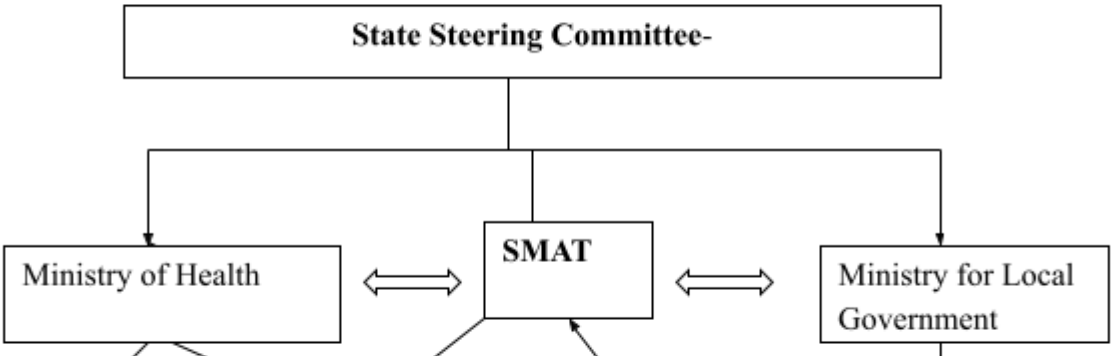
iii) The MOH ensures improved healthcare service uptake by the populace through state-wide mobilization campaigns.

iv) The MOH & MLG liaises with LGAs to revitalize / reconstitute the Hospital Management Committees at the State level and the Village, Ward and LGA Management Committees at the LGA level. Membership should be all-inclusive, democratized as much as possible to include socio-cultural, youth organizations, and be gender-sensitive.

v) The MOH & MLG liaises with LGAs to set up a Monitoring & Advisory Committee (MAC) at the LGA level to supervise, monitor and drive the full implementation of LGA-SHDP.

BORNO STRATEGIC HEALTH DEVELOPMENT PLANS –

IMPLEMENTATION FRAMEWORK



Chapter 7: Monitoring and Evaluation

7.1 Monitoring stages: The implementation of BSSHDP shall be monitored in 2 stages – specific and general monitoring.

7.1.1 Specific monitoring was provided for during the development of strategic interventions and therefore is part of particular detailed activities. For example, the dissemination and implementation of MHCP and SOPs each has a monitoring and supervision component to ensure compliance, as part of intervention activities viz, to review, cost, disseminate and implement the minimum package of care in an integrated manner and to make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels, respectively. This type of "internal" monitoring is to be carried out by the Supervisory implementing unit and or the Monitoring Unit of the Ministry of Health and the costs of monitoring provided for in that particular activity.

7.1.2 General Monitoring is also being proposed to ensure that the whole components of the strategic plans are being regularly (quarterly) monitored, supervised and evaluated to keep the strategic plans on track. A multi-sectoral 15-member State Monitoring & Advisory Team (SMAT) was proposed- with membership to include officials from MOH, HMB, MOF, Budget & Planning, MLG, NGOs, NMA, PSN, NNMA, UNIMAID, and Donor Agency at the State level & at LGA Level an 8-member Monitoring & Advisory Committee (MAC) with membership to include officials from LGA Council (Councilor Health), Departments of Health, Planning, Finance, 2 Representatives of Health Development Committee, Traditional ruler and a Partner Agency working in the LGA. In addition to field monitoring and supervision, these monitors meet regularly to review SSHDP & LGA-SHDP implementation, identify & rectify gaps in financing, through advocacy, outsourcing etc. The SMAT is also to develop health research policies and strategies for the State and LGAs

7.2 Costing the General Monitoring of the Strategic Plans:

- Two monitoring groups proposed – SMAT at State level and MAC at LGA level
- Regular field monitoring; every 3 months, 4 times in a year, 24 times during the strategic plans and a Review meeting to consider implementation progress and or bottlenecks, budget releases, advocacy, consider options, as well as take decisions on research proposals every six months, twice a year, 12 times (at least) during the strategic plans period.

The overall monitoring of the strategic plans in Borno State requires development of performance indicators for the entire health system for monitoring and evaluation, provide materials for the monitoring and actively engage in operational research and data gathering on all health issues.

i) Setting up the Secretariat for SMAT – An Office accommodation shall be sought at the Musa Uthman State Secretariat Maiduguri; an Office Secretary and 2 Clerical Officers (staff of the Ministry of Health). An Office accommodation shall also be sought from each of the 27 LGAs together with staff compliments.

ii) Procurement of computer & accessories, stationeries, consumables, telephone charges, monitoring vehicles, fuelling and maintenance as well as personnel costs. See details below.

Table 2Summary of Cost of Monitoring the Borno State Strategic Health Development Plans

S/No	Description of Item	Cost in Naira (N)		Total Cost (N)
		SMAT	MAC (27 LGAs)	
1	Computer & Accessories (1 Number)	450,000.00		450,000.00
2	Computer materials / stationery	1,200,000.00	6,480,000.00	7,680,000.00
3	Other consumables	420,000.00	3,240,000.00	3,660,000.00
	sub-total	2,070,000.00	9,720,000.00	11,790,000.00
4	Telephone charges	500,000.00	2,700,000.00	3,200,000.00
	sub-total	500,000.00	2,700,000.00	3,200,000.00
5	Procure monitoring vehicle- 1 No.18-seater bus for SMAT and 1-each 4-wheel drive for LGA	11,000,000.00	162,000,000.00	173,000,000.00
6	Vehicle fuelling	1,080,000.00	11,664,000.00	12,744,000.00
7	Vehicle Maintenance	780,000.00	9,720,000.00	10,500,000.00
	sub-total	12,860,000.00	183,384,000.00	196,244,000.00

	Personnel Costs			
8	Honorarium/Sitting allowance	43,200,000.00	155,520,000.00	198,720,000.00
9	Tea break / Lunch	2,880,000.00	20,736,000.00	23,616,000.00
10	Transport allowance	7,200,000.00	36,288,000.00	43,488,000.00
	sub-total	53,280,000.00	212,544,000.00	265,824,000.00
	total ========	68,710,000.00	408,348,000.00	477,058,000.00

Costs for State Monitoring & Advisory Team estimated @ N68, 710,000.00,

Costs for 27 LGA Monitoring & Advisory Committees estimated @ N408,348,000.00.

A joint monitoring protocol involving relevant officials such as - Hon. Commissioners of Health, Finance, Local Government, Budget & Planning are meant to impact on the strategic plans through advocacy and was also incorporated in the intervention activities of the strategic plans.

Chapter 8: Conclusion

The present State administration has made some giant strides to increase accessibility to healthcare services by upgrading and rehabilitating health infrastructure, increasing the human resource for health through special recruitment of Specialist doctors from Egypt, providing free healthcare services for the weak and vulnerable members of the society and above all, increasing the annual state budget for health to about 10%.

However, most of the health indices for the state continue to be low compared to the National and even the North East zonal averages; there is high disease burden in common diseases such as malaria, diarrhoea and other communicable diseases; the maternal & child mortality rates are very high necessitating immediate and concerted actions to be able to drastically impact positively to the health outcomes - evidence-based National Strategic Health Development Plan framework provided a platform by which healthcare issues could systematically and holistically be addressed. Health intervention activities were identified, prioritized and costed by the stakeholders in the state – through an all inclusive and participatory approach.

Leadership and Governance will need to be ensured to effectively and successfully implement the plans for the next 6 years. Recommended intervention activities to address these include appropriate legislation and regulatory frameworks, strengthening the SMOH and Health Departments of LGAs to take strategic leadership on health policy & development in the State, effective decentralization of decision making processes by granting autonomy to health facilities, strengthening stewardship role of government with proper accountability and transparency and driving the State strategic health plans through adequate monitoring and supervision.

Some of the key issues identified include the need to increase utilization and uptake of healthcare through aggressive community mobilization, strengthening of implementation of communicable diseases, strengthening of coordination and collaboration with Partner Agencies and other stakeholders, and the need to revitalize programs for women and children vulnerable groups to drastically reduce Maternal and Child Mortality rates in consonance with the MDG targets. To ensure effective maintenance culture, this strategic plan provided for increase in recurrent expenditure.

The six-year costing of the BSSHDP was premixed on the 2009 State Budgetary allocation on Health. Recommended interventions to meet up with the budgets include ensuring sustainable funding to health sector through increasing government annual allocation to at least 15%, being faithful in releasing funds, improving internally generated revenues through participation of state workforce in the NHIS and improving funding through pooling funds using common basket approaches by stakeholders involved in financing health in the state (Partner Agencies). The state however, needs to improve coordination with donor partners; It must be pointed out that, with a projected population of 4.5m, about 3.0 % growth rate, 7.0 fertility rate

and over 72% poverty level, increased active presence of developing partners is certainly needed to drastically impact on the health outcomes for the state and the nation, in general.

Appendix 1. Borno State Strategic Health Development Plan Teams

S/N	NAME	ORGANIZATION	DESIGNATION
1	AlhUmoruNgurno	MOH	Permanent Secretary
2	Alh Kaka Alkali	MOH	DPRS
3	Dr R Banda	WHO	SC
4	Sir Daniel Afina	CAN	Treasurer
5	Ibrahim Shariff	MLG	DDPHC
6	Mrs. (Pharm) Rabi Tahir	NACP	Member
7	Almai Some	MOH	DDPHC
8	Bukar Modu	SHT	Principal
9	Alh. Abbas Konduga	SN	Principal
10	Musa Wazumtu	RBM	
11	Baba GanaAbiso	MOH	DPHC
12	Dr MsheliaLawiAuta	EPID-TBLP	Head
13	Dr BabaganaBako	NMA	Chairman
14	Pharm Stephen Jasini	MOH	DPS
15	HajaratuShettima	SMW	Principal
16	Moh'd N. Hannan	CISHAN	Zonal Coordinator
17	Balami A David	MOH	DN
18	Dr AbdullahiSadiq	MOH	DDC
19	Dr BalaAbubakar	FHI/Ghain	Snr Medical Advisers
20	Yakubu Ibrahim Mbaya	MWA	DPRS
21	Malum K Mirnga	Budget& Planning	D Budget
22	Pharm YabaluAbacha	PSN	Snr Pharmacist
23	Ibraheem A Garba	FHI/Ghain	CT/PMTCTO
24	Yusufu A Bemi	MOH	DAS
25	Abdullahi Muhammad	MOH	DAF
26	Dr Ibrahim A Kida	MOH	DMS
27	Bukar S Balami	LGSC	DAS
28	Dr Audu Alayende	UNFPA	Zonal Head
29	Dr I.M Ngulde	HMB	DMLS
30	Mustapha Abba Y	Budget & Panning	Sec
31	Sheikh Goni M Said	JNI	Sec
32	Alh Musa Kouto	CHDN	Chairman
33	Amina Y Shellangua	NANNMNA	Treasurer
34	Umar LummaSheuze	MOH	Sec
35	GarbaIbn Mustapha	NACH PN	Sec
36	Modu Mai Bukar	MOF	Rep Hon Com Finance
37	John F A Gadzama	Budget & Panning	D Planning
38	Gregory A U	UNCEF	Head
39	HarunaDabo	MOH	HISM Officer
40	BabaganaAjiya	MOH	DDPRS
41	M kadai	MOH	ADPRS
42	Pharm. Musa Abdullah	FMOH	CONSULTANT

Appendix 2: Detailed activities of the Strategic Health Development Plan

PRIORITY							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Cost 2010-2015**
	Strategic Objectives				Targets		
		Interventions			Indicators		
			Activities		None		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							**1,032,408,000**
	1.1	**To provide clear policy directions for health development**			All stakeholders are informed regarding health development policy directives by 2011		-
		1.1.1	Improved Strategic Planning at the State level				-
			1.1.1.1	Strengthen the SMOH to take strategic leadership on health policy & development in the State	State Steering Committee and the State Planning Team inaugurated to draft Borno State Strategic Health Development Plan by 3rd Qtr 2009	political will granted	-
			1.1.1.2	Establish inter-sectoral linkages on strategic health policy development and implementation	inter-sectoral linkages achieved through the composition of SSC & SPT members.	political will granted	-
			1.1.1.3	Develop and re-orientate the human resource capacities on strategic health plans	human capacity developed on strategic health development plans	political will granted	-
			1.1.1.4	Involve wider stakeholders in the development & implementation of strategic health plans	wider stakeholders in health including NGOs, Partner Agencies, Private Health Providers, Professional Health Unions, Civil Liberties, Traditional rulers, Religious leaders, etc.	political will granted	-
			1.1.1.5	Monitor the implementation of health plans	monitors inaugurated by 1st Qtr 2010	political will	-
	1.2	**To facilitate legislation and a regulatory framework for health development**			Health Bill signed into law by end of 2009		**51,127,994**
		1.2.1	Strengthen regulatory functions of government				**51,127,994**
			1.2.1.1	Work with the FMOH to review and update existing health laws and regulations in the country	reviewed health laws obtained by 1st Qtr 2010	Health Laws & Framework reviewed before end of 2009	-
			1.2.1.2	Work through the State Assembly to Enact laws specific to State requirements, where necessary	law makers and other policy makers engaged by 2nd Qtr 2010	political will	-
			1.2.1.3	Strengthen the Capacity of the Inspectorate Unit of the Ministry of Health- through the provision	2 vehiches procured by 3rd Qtr 2010 to	funds available	**25,075,298**

				of 2no. 4-wheel drive vehicles for effective supervision; procurement of 2No. 4-wheel drive vehicles, fuelling & maintenance	strengthen Inspectorate Unit		
			1.2.1.4	Engage & dessiminate reviewed laws to all the stakeholders (Private Practitioners) in the State; provide for 1000 copies @ N325	reviewed laws published and distributed by 3rd Qtr 2010	funds available	**572,957**
			1.2.1.5	Establish protocols for monitoring and enforcement of health laws and regulations in the State; 10days for 10people per quarter, monitoring tools, DSA, working tools	monitors inaugurated by 1st Qtr 2010	political will	**25,479,739**
		1.2.2	Framework for PPP implementation				-
			1.2.2.1	Establish PPP units at State and LGA levels to promote, oversee and monitor PPP initiatives	PPP unit established in the State by 1st Qtr of 2010	New guidelines on PPP reviewed by FMOH-by the end of 2009	-
			1.2.2.2	Strengthening of the PPP through taking stock of the private partners in the State and engage them in quarterly fora.	census of private partners in health made by 2nd Qtr 2010	funds available	-
			1.2.2.3	Sensitisation of the public on the PPP to dispel the notion of Privitasation- through media, print and electronic; Printing of leaflets & electronic media	sensitisation campaigns conducted before end of 3rd Qtr 2010	funds available	-
	1.3	**To strengthen accountability, transparency and responsiveness of the State health system**			80% of States and the Federal level have an active health sector 'watch dog' by 2013		**909,990,666**
		1.3.1	To improve accountability and transparency				-
			1.3.1.1	Undertake sensitization/advocacy campaigns aimed at empowering beneficiary communities	50% of communities sensitized by end of 2010	political will	-
			1.3.1.2	Reconstitute the Hospital Management Committees/PHCs with memberships from diverse interest groups - Rep of Health Development Committees, NGOs, Cultural / Social organisations, etc.	50% of health facilities have their management committees reconstituted by end of 2010	political will	-
			1.3.1.3	Strengthen the capacity of the various health facilities to operate- adequate funding (increase running costs proportionate to their needs- No. of Beds, services rendered etc.	improved funding of health facilities by 4th Qtr 2010	political will	-
			1.3.1.4	Decentralize decision-making process - autonomy to the facilities	autunomy granted to health facilities by 1st Qtr 2011	political will	-
			1.3.1.5	Establish an annual joint review mechanism with different stakeholders	health plans implementation reviewed with other stakeholders, annually	political will	-
		1.3.3	Improving the workforce of the State to acceptable Standards				**909,990,666**

			1.3.3.1	Rehabilitate all the three state-owned health training institutions (SON, MW& SHT)- Provide N450m for maintenance of building infrastructure, Teaching aids -N50m, other materials N30m, vehicle maintenance N10m	3 schools rehabilitated by 3rd Qtr 2010	political will	**909,990,666**
			1.3.3.2	Facilitate their Accreditation by relevant bodies	3 schools accredited by 4th Qtr 2010	political will	-
			1.3.3.3	Ensure regular staff training & re-training programme	30 staff re-trained before end of 3rd Qtr 2010	political will	-
			1.3.3.4	Map out strategies for employment of staff	criteria for employement in place by 2nd Qtr 2010	political will	-
	1.4	**To enhance the performance of the State health system**			1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011		**37,585,985**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**10,414,338**
			1.4.1.1	Establish and convene Technical Working Group (members to be drawn from public and private establishments, MOH, MOF, Budget & Planning, NGOs, Unimaid, Rep of NMA, Rep of PSN, Rep of Nurse/Midwives - to develop health research policies and strategies for the State and Its LGAs; provide for 15people, meet every 6 months, 2days, sitting allowance, refreshments, writing materials	TWG established by 1st Qtr of 2010	political will	**10,414,338**
			1.4.1.2	Establish research-based programme's review mechanism to enhance healthcare performance - provide funding for research activities	funds available for research before 4th Qtr, 2010	funds available	-
		1.4.2	Monitoring, Evaluation & Supervision				**27,171,647**
			1.4.2.1	Regular (quarterly) monitoring & supervision by the Monitoring & Supervision Unit of the Ministry to bring reports for the assessment of the SSHDP implementation at the State and LGA levels by TWG; transport & fuelling, DSA, monitoring tools, 3dyas/quarter	Quarterly supervision done & implementation chek list maintained	Political will of Government	**12,537,649**
			1.4.2.2	Create forum through advocacy, with political leaders, to ensure faithful implementation of SSHDP	at least 5 encounters made with policy makers every quarter	political will	-
			1.4.2.3	Create a forum for outsourcing assistance, where necessary	funds outsourced at least twice during the strategic plan period	interest by donors/Partners	-
			1.4.2.4	Procure monitoring vehicle - bus, maintenance, fuelling	monitoring vehicle procured by end of 3rd Qtr	availability of funds	**14,633,998**
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**34,323,119,400**
	2.1	**To ensure universal access to an**			Essential Package of Care adopted by all States by 2011		**4,799,878,927,273**

		essential package of care					
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				**10,404,221**
			2.1.1.1	Obtain from FMOH, Review and Cost the Minimum Package-provide for 60 facilities, transport, DSA	MHCP available by 1st Quarter	FMOH would have prepared the package by the beginning of 2010	**139,105**
			2.1.1.2	Print copies of Minimum Package, print 1000 copies @ N350 each	adequate MHCP document printed before end of 1st Qtr 2010	funds available	**608,586**
			2.1.1.3	Disseminate the concept through orientation workshops, 3days- provide for 3people from each of 27 LGA; DSA, transport, refreshments, workshop materials, 3 facilitators, DPHC MLG, DPHC MOH (total 90 people); LGAs to conduct LGA level trainings for all PHCs	Orientation workshops on MHCP conducted by 2nd Quarter 2010	political will	**6,477,099**
			2.1.1.4	Distribute and Implement the Package in all PHCs in the State; 3 Officers 1-to each zone for 3days, fuelling of vehicle, 3 drivers DSA	MHCP document distributed in all health facilities before the end of 3rd Quarter, 2010	funds available	**247,782**
			2.1.1.5	Establish and enforce mechanism for regular monitoring & evaluation; 5 officers, fuelling, DSA,3days/outing-every six months	facilities visited and M & E reports made every 6 months, from 4th Qtr, 2010	political will	**2,931,648**
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**4,780,971,884**
			2.1.2.1	Conduct a stakeholders review meeting with Partners on special programmes in the State including- Immunizations, RollBack Malaria, Onchocerchiaasis, Guniea worm, Schistosomiasis, TB &Leprosy and HIV / AIDS with a view to standardize implementation; provide for 15pers- from MOH, MLG, Partner Agncies; tea break & lunch, sitting allowance, 3days	Stakeholders Meeting held & minutes produced, 1st Qtr, 2010	political will	**547,728**
			2.1.2.2	Involve wider stakeholders through workshop, advocacy and IEC; Opinion and Religious leaders, NGOs - to strategise on implementation, 3days, 35 people, sitting allowance, tea break & lunch; to be followed by appropriate sensitisation and awareness campaigns, provide for sum of N10000000 for sensitisation/advocacy activities	way forward meeting of expanded stakeholders held with minutes, 1st Qtr, 2010	political will	**18,666,217**
			2.1.2.3	Provide adequate funds for capacity building / manpower training, procurement of drugs,	implementation strategies identified	political will	**2,355,333,987**

				reagents and equipment, logistics, vehicle maintenance to implement on-going programmes, as strategised	& documented, 2nd Qtr, 2010		
			2.1.2.4	Establish and implement protocols for regular joint - monitoring and evaluation; every 4 months, transport, 2 vehicle fuelling, DSA 10 pers, vehicle maintenance	joint regular monitoring team inaugurated by 2nd Qtr 2010	political will	**6,854,423**
			2.1.2.5	Emergency Response & Preparedness for epidemics- ensure adequate surveillance to control outbreaks of measles, cholera, CSM, diarrhoea, vomitting and natural disasters; train officers and even communities through workshops and IEC on emergency response procedures; provide funds for procurement of drugs and medical supplies, logistics and staff welfare	regular surveillance (monthly reports from LGAs) received at the SMOH H/qtrs beginning from 2011	political will	**2,399,569,530**
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**8,502,822**
			2.1.3.1	Obtain Reviewed SOPs and guidelines from FMOH	SOPs document available by 1st Qtr, 2010	SOPs reviewed by end of 2009	**139,105**
			2.1.3.2	Conduct TOT Orientation/workshops for health personnel; State level, 2days- 3 officers from each 27 LGAs, DPHC-MOH, DPHC-MLG, PS, (total 90pers) DSA, transportation, refreshments, 3 facilitators honorarium, workshop materials. LGAs to sponsor the LGA levels training	TOT workshops held for health officers in the 1st Qtr of 2010	funds available	**4,547,010**
			2.1.3.3	Print copies of SOPs for distribution to all PHC facilities; State to print 1000 copies @ N350 each; LGAs to print enough for their facilities	copies of SOPs printed and distributed to facilities by 2nd Qtr, 2010	funds available	**608,586**
			2.1.3.4	Commence implementation of SOPs in the State	use of SOPs in all facilities by 3rd Qtr, 2010	political will	
			2.1.3.5	Ensure compliance through adequate monitoring; every 6 months, transport, vehicle fuelling, DSA 5 pers, vehicle maintenance	use of SOPs in all facilities ensured through regular biennial monitoring beginning from 1st Qtr, 2011	funds available	**3,208,120**
		2.1.4	To incorporate in the curricula of health training institutions the concepts of MHCP, IMNCH and SOPs				-
			2.1.4.1	Re-train the teaching staff of the SON & MW and SHT on the MHCP, IMNCH & SOPs concepts	staff of SON&MW, SHT re-trained on concepts by 2nd Qtr, 2010	political will	-
			2.1.4.2	Strengthen the schools with teaching aids	teaching aids & aids provided by 3rd Qtr, 2010	political will	-
			2.1.4.3	Incorporate the concepts in the curriculum - to be examined in both theory and practicals	MHCP & SOPs concepts incorporated by 4th Qtr, 2010	political will	-
			2.1.4.4	Inuagurate State Technical Committee on Integrated Maternal, Newborn and Child Health Strategy- liaise with the FMOH to develop capacity of the STC which shall subsquently train the LGAs on concepts and implementation strategies; incorporate IMNCH programs including Preventive and Clinical Interventions in relevant activities such as Community mobilization, IEC activities, immunizations, RBM, etc	STC constituted and inaugurated before the end of 2nd Qtr, 2010	political will	-

	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		**27,176,462,079**
		2.2.1	To improve geographical equity and access to health services				**14,538,852,677**
			2.2.1.1	Mapping of Health facilities, provide lump sum professional fees of N3500000 for mapping all the state health facilities	State health facilities mapped by 1st Qtr, 2010	wide geographical area to cover	**6,085,865**
			2.2.1.2	Establish GIS for all health facilities, provide lump sum professional fees of N5000000	GIS for all health facilites available by 2nd Qtr, 2010	wide geographical area to cover	**8,694,093**
			2.2.1.3	develop criteria for sighting of new health facilities at all levels	list of new health facilities to be constructed available by 2nd Qtr, 2010	political will	-
			2.2.1.4	Construction & equipping of 10 No PHCs @ N1460000000, Renovation & Equipping of 6 No. Gen Hospitals @ 992000000, Renovation and equipping of 6 Hosp @ N898000000, Renovation & equipping of Nusing Home, Chest Clinic & Denta Hospital @ N1710200000 and provide for maintenance of 34 hospitals & other health facilities in the State, maintenance of Canoe Boats in inaccessible riverine areas (Marte & Kukawa)	New Health facilities constructed / renovated beginning from 4th Qtr, 2010	Budget constraints	**14,524,072,720**
		2.2.2	To ensure availability of drugs and equipment at all levels				**9,828,808,938**
			2.2.2.1	Review the State Essential drug list – Formulary Committee; provide for refreshments, sitting allowance for 10No., 3days	Comprehensive essential drug list available by 1st Qtr, 2010	essential drug list availble for immediate review	**417,316**
			2.2.2.2	Establish a system of procurement of drugs and distribution; Determine drug needs and engage with reputable manufacturers/distributors to supply annually; provide for advertisement in a national daily, logistics, improve storage/cooling condition of the Central Medical Stores, 6 ACs, 2 Refridgerators, procure and maintain a 4-wheel drive vehicle to improve distribution	essential drugs available at all levels by end of 3rd Qtr, 2010	availability of funds	**1,689,399,539**
			2.2.2.3	Liaise with FMOH to obtain Equipment List based on the levels of care, provide transportation & DSA to ontain list from Abuja	equipment list based on levels of care obtained from FMOH by 1st Qtr 2010	FMOH would have finalized equipment list by the end of 2009	**139,105**
			2.2.2.4	Develop/review an equipment list for different levels of health facilities - Committee of 10No, sitting allowance, refreshments, stationery	State equipment list available by end of 1st Qtr, 2010	availability of funds	**347,764**
			2.2.2.5	Procure and distribute equipment based on need, advertise in National daily, logistics	health facilities equipped by 4th Qtr, 2010	health facilities equiped	**8,138,505,213**
		2.2.3	To establish a system for the maintenance of equipment at all levels				**537,903,503**
			2.2.3.1	adopt the National Health Equipment Policy from FMOH; provide DSA & transport to acquire guidelines	NHEP guidelines obtained from FMOH by 1st Qtr 2010	guidelines ready	**139,105**
			2.2.3.2	Dissiminate and implement the NHEP guidelines			-
			2.2.3.3	Provide for budget lines for the maintenance of equipment and supervision	funds provided for equipment maintenance before 4th Qtr, 2010	funds available	**521,645,550**

			2.2.3.4	Enter into Public-Private Partnership in Maintenance of medical equipment and furniture	PPP Contract signed by 1st Qtr, 2011	funds available	
			2.2.3.5	Ensure compliance to agreement through regular monitoring, every six months; 1No monitoring vehicle, fuelling, maintenance, DSA for 4 Bio-medical Engineers	regular monitoring of PPP from 2nd Qtr, 2011	funds available	**16,118,847**
		2.2.4	To strengthen referral system				**2,270,896,961**
			2.2.4.1	Mapping out network linkages for a 2-way refferal system as per National guidelines -	national guidelines obtained and adopted, 2nd Qtr, 2010	political will	-
			2.2.4.2	Ensure the provision of adequate transportation system for referrals in the State explore the possibility of Central Ambulance Pooling System, incorporated with GSM System (CAPS) after mapping & GIS; purchase of 6 ambulances	ambulances purchased by end of 1st Qtr, 2011	political will	**83,463,288**
			2.2.4.3	Upgrade 3more hospitals to referral status - @ 1258000000	2 more set of hospitals upgraded to referral status by 4th Qtr, 2011	funds available	**2,187,433,673**
			2.2.4.4	Ensure the provision of communication to all the facilities			-
			2.2.4.5	Establish a system of monitoring referral outcomes	referral outcomes monitored by end of 4th Qtr, 2012		-
		2.2.5	To foster collaboration with the private sector				-
			2.2.5.1	Mapping out of all private healthcare providers by operational level and location in the State	private healthcare providers mapped out, 1st Qtr 2010	funds available	-
			2.2.5.2	Liaise with FMOH to Review/Develop guidelines and standards for regulation of their practice and their registration	FMOH reviewed guidelines obtained by 2nd Qtr 2010	guidelines ready	-
			2.2.5.3	Develop guidelines for Partnership with private providers, training and outsourcing of services	guidelines developed before end of 4th Qtr 2010	political will	-
			2.2.5.4	Develop Joint performance monitoring mechanism for the Private sector, every six months	commence joint performance monitoring by 2nd Qtr 2011	political will	-
			2.2.5.5	Acquire, Adopt and implement the National Policy on Traditional Medicine	obtain from FMOH national policy on traditional medicine before end of 4th Qtr 2010	national policy ready	-
	2.3	**To improve the quality of health care services**			50% of health facilities participate in a Quality Improvement programme by end of 2012		**1,300,218,922**
		2.3.1	To strengthen professional regulatory bodies and institutions				**3,361,788**
			2.3.1.1	Liase with the FMOH, adopt and implement operational guidelines of all regulatory bodies at all levels, transport to & from Abuja, DSA for 4days	acquire operational guidelines by 2nd quarter of 2010	reviewed guidelines ready	**139,105**
			2.3.1.2	Build capacity of regulatory staff to monitor compliance of providers to regulatory standards; staff to undertake 2-wks training locally; tuition, DSA, transportation, 5staff in 2batches	regulatory staff trained by 3rd Qtr 2010	funds available	**3,129,873**

			2.3.1.3	Create budget lines and provide necessary resources			-
			2.3.1.4	Ensure regular monitoring exercises with appropriate documentation & feedback	reports of monitoring documented		-
			2.3.1.5	Empower the regulators through the provision of necessary security			-
		2.3.2	To develop and institutionalise quality assurance models				-
			2.3.2.1	Liase with FMOH and adopt agreed Model for Quality Assurance	FMOH reviewed model obtained by 2nd Qtr 2010	model ready	-
			2.3.2.2	Use FMOH developed training modules to build capacity of public and private health providers in the State	workshops on models held by 3d Qtr 2010	political will	-
			2.3.2.3	Institutionalize and implement Quality Assurance Improvement Initiative in the State	QAII commences by 1st Qtr 2011	political will	-
			2.3.2.4	Implement SERVICOM guidelines on capacity building in all facilities of the State	capacity building workshops on SERVICOM held by end of 4th Qtr 2010	polical will	-
			2.3.2.5	Monitor Quality care implementation in the State, biennially	monitoring reports documented, from 1st Qtr 2011		-
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				-
			2.3.3.1	Liase with the FMOH to acquire developed guidelines for ISS	guidelines acquired before end of 2010	ISS guidelines ready	-
			2.3.3.2	Strengthen the capabilities of State and LGA Health Managers & Teams through team building and leadership development programmes	workshops on capacity building held by 1st Qtr 2011	political will	-
			2.3.3.3	Institutionalize a comprehensive ISS at all levels of healthcare in the State	ISS concept implemented in at least 50% of health facilities in the State by2nd Qtr 2011	political will	-
			2.3.3.4	Develop capacities of programme Managers at all levels on the ISS		political will	-
			2.3.3.5	Develop ISS Tools & Guidelines specifying modalities and frequencies of the ISS visits at all levels of facilities	guidelines for ISS developed and in use by 3rd Qtr 2011	political will	-
		2.3.4	MDGs Projects				**1,296,949,943**
			2.3.4.1	Construction of 10 PHCs			**643,362,845**
			2.3.4.2	Procurement of drugs& equipment for10 PHCs			**392,764,323**
			2.3.4.3	Procurement of ITN nets for the State			**260,822,775**
	2.4	**To increase demand for health care services**			Average demand rises to 2 visits per person per annum by end 2011		**44,861,517**
		2.4.1	To create effective demand for services				**44,861,517**
			2.4.1.1	Develop a comprehensive BCC strategy for health promotion in the state.	State BCC stategy developed in 1st Qtr 2010	Sustained political commitment	-
			2.4.1.2	Regular airing of health promotion messages and drama in the state electronic media in two major local languages and English, BRT rates-N450000 x4 x6	Regular airing commenced in 3rd Qtr 2010	Readily available resources	**18,779,240**

			2.4.1.3	Develop IEC materials on health promotion in two major local languages and English, concept development, T-shirts, Hijabs, Posters, materials, artisans fees	IEC materials in at least two local languages available in 3rd Qtr 2010	Readily available resources	**23,474,050**
			2.4.1.4	Conduct regular (biennial) health promotion campaign- personal hygiene, hand washing, proper waste disposal, de-worming, IMNCH activities, etc.; provide funds for the logistcs N250000 every 6months for 3years	At least 1 state campaigns conducted before the end of 2010	Readily available resources	**2,608,228**
			2.4.1.5	Inculcate importance of healthy living in school curriculum	Committee to review school hygiene corriculum inaugurated by 1st Qtr of 2011	political will	-
							-
			2.4.3.1		Standard Health facilities at all levels		-
			2.4.3.2		functional health facilities		-
			2.4.3.3		guidelines implemented at PHC level		-
			2.4.3.4		guidelines available/task shifting practicable		-
			2.4.3.5		Telemedicine accessible		-
	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		**1,001,698,561**
		2.5.1	To improve financial access especially for the vulnerable groups				**1,001,698,561**
			2.5.1.1	Liase with FMOH to develop models for financial protection for the vulnerable groups-pregnant women, children, orphans and aged; DSA, transport to obtain document,	developed models obtained from FMOH before end of 1st Qtr 2010	models ready	**139,105**
			2.5.1.2	Adopt agreed models for implementation in the State	model reviewed and adopted by 2nd Qtr 2010	political will	-
			2.5.1.3	State to upgrade 6 more health facilities to scale-up MCH @ 576000000	2 more MCH facilities ready by 2nd Qtr of 2011	funds available	**1,001,559,456**
			2.5.1.4	State Government to ensure that all civil servants are registered on the NHIS	all state civil srvants registered with NHIS by 3rd Qtr 2010	political will	-
			2.5.1.5	State Government to facilitate community cooperatives for community health financing through the NHIS non-formal sector, as soon as comes on board	cooperative societies formed in preparation for NHIS before end of 2011	political ill	-
HUMAN RESOURCES FOR HEALTH							
3. To plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care							**38,011,261,317**
	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		**139,036**

		3.1.1	To develop and institutionalize the Human Resources Policy framework				**139,036**
			3.1.1.1	adopt the National Policies on HRH on Training & recruitment of health personnel; obtain reviewed document, DSA, transport	HRH plans adopted by 1st Qtr 2010	national policy ready	**139,036**
			3.1.1.2	Review and adopt the National Policy guidelines on task shifting	task shifting practicable before end of 2010	national policy ready	-
			3.1.1.3	Establish health professional forum to meet on regular basis to discuss HRH problems	forum established by 1st Qtr 2011	political will and commitment of health professionals	-
	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		-
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				-
			3.2.1.1	Develop, introduce and utilize staffing norms based on work load, service availability and health sector priorities	staffing noms developed and implemented by 3rd Qtr 2010	political will	-
			3.2.1.2	Establish coordinating mechanisms for consistency in HRH planning and budgeting by MOH, Finance, Education, Civil Service Commission and other stakeholders	at least 2 coordinating meetings held with stakeholders in attendance before end of 2010	political will	-
			3.2.1.3	Strengthen the capacities of State and LGAs to access and implement Federal Government circulars, guidelines and policies related to HRH	an officer detailed by SMOH as liason officer with FMOH to collect circulars & guidelines by 1st Qtr 2010	political will	-
			3.2.1.4	Review the entry criteria into training institutions for health providers to conform with State needs and peculiarities	criteria reviewed by 3rd Qtr 2010	political will	-
	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		**2,057,727**
		3.3.1	To establish and strengthen the HRH Units				**2,057,727**
			3.3.1.1	Establish HRH Unit under the planning Research & Statistics at the State MOH, to be followed later in each of the 27 LGAs	state has a functional HRH unit by 2nd quarter of 2010, LGAs by 4th Qtr 2010	political will	**886,352**
			3.3.1.2	Organize a training programme for the staff of HRH units (4staff, training locally), 2 weeks, transport, DSA, tuition fees	staff trained by 3rd Qtr 2010	availability of funds	**1,171,375**
	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		**121,750,708**

		3.4.1	To review and adopt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities				**139,036**
			3.4.1.1	State to obtain FMOH reviewed guidelines on training programme for community-oriented health professionals	reviewed guidelines obtained from FMOH by 1st Qtr 2010	guidelines ready	**139,036**
			3.4.1.2	Reviewed training programmes will be adopted in all of the three institutions in the State-SON,SMW &SHT	guidelines reviewed and adopted by 2nd Qtr 2010		-
			3.4.1.3	Empower the three schools through relevant accreditation to be able to train the critical mass of middle level work force required ie. Midwives, Community health officers and community health extension workers CHEW to be deployed to PHC facilities	trainees- MWs, CHEWs enrolled by the 3rd Qtr of 2010	political will	-
			3.4.1.4	Ensure compliance of training institutions through adequate monitoring and evaluation			-
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**121,611,673**
			3.4.2.1	Inadequate facilities in all of the three training institutions to be upgraded	facilities rehabilitated by 2nd Qtr 2010	political will	-
			3.4.2.2	Capacity building and continuing professional development of staff will be enhanced -5 tutors each from the 3 schools for 2 weeks training outside Maiduguri, 2times(total of 30 staff to be re-trained); tuition fees, DSA, transport,	30 staff re-trained before end of 3rd Qtr 2010	availability of funds	**10,427,671**
			3.4.2.3	Post Graduate training programmes (local & international) for medical personnel will be pursued to achieve professionalism in critical areas, budget line exists	3 Number personnel to be sponsored every year beginning from 2010	availability of funds	**67,779,863**
			3.4.2.4	Quarterly staff re-training programme: re-orientation through workshops of health workforce on attitudinal change including training and retraining in interpersonal communication (IPC) skills and work ethics-will be conducted for the promotion of client satisfaction and improvement of quality care; (2-days workshop at State capital, 40(10 senior, 20 middle and 10 junior) staff/session, 3 facilitators, simple w/bag, transport, tea break & lunch, honorarium for facilitators, DSA for participants	positive feedback from clients on services rendered	availability of funds	**43,404,139**
		To improve organizational and performance-based management systems for human resources for health			50% of States have implemented performance management systems by end 2012		**37,887,314,614**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**37,887,314,614**
			3.5.1.1	Only 25% of the required health work force available currently in the State by WHO standard. Embark on systematic training of staff to obtain an annual 10% increase of staff strength beginning from 2011	state to attain 60% of its staff requirements by 2015	politial will	**37,018,037,874**
			3.5.1.2	State to embark on special recruitment exercise to correct the imbalance in some critical areas-doctors 10, pharmacists 12, midwives 30 and CHOs 10 for immediate redeployment	50% of personnel employed and redeployed by 2nd Qtr 2010	availability of funds	**869,276,740**
			3.5.1.3	Ensure that each LGA employs at least one medical Doctor	1 medical Doctor each, employed by	political will	-

					the LGA before end of 2011		
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				-
			3.5.2.1	Establishment of active monitoring and evaluation procedure for a continuous assessment and monitoring of HRH with a view to reporting on the pattern of changes to assist in further planning	staff M&E inaugurated by 1st Qtr 2011	political will	-
			3.5.2.2	State to institute mechanisms of retaining its workforce through other incentive packages including special allowances for rural postings	staff attrition rate reduced by half	political will	-
		To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda			50% of States have regular HRH stakeholder forums by end 2011		-
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				-
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**2,329,514,000**
	4.1	**To develop and implement health financing strategies at State and Local levels consistent with the National Health Financing Policy**			50% of States have a documented Health Financing Strategy by end 2012		**11,723,505**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA and State levels in line with the National Health Financing Policy				**11,723,505**
			4.1.1.1	State to constitute a 15-member Technical Woking Group - with membership to include officials from MOH, HMB, MOF, Budget & Planning, MLG, NGOs, NMA, PSN, NNMA, Unimaid, and Donor Agencies. Meet regularly to review SHDP implementation, identify & rectify gaps in financing, through advocacy, outsourcing etc.	TWG inaugurated by 1st Qtr 2010	political will	-
			4.1.1.2	TWG to meet regularly and consider reports of Monitoring Unit of MOH, assess BSSHDPs performance, embark on advocacy for faithfull budget implementation, possible outsourcing of assistance and other issues. Establish and Maintain a Secretariat for the Monitoring; computer, office materials & supplies,	meetings held with minutes produced, at least biennially	availability of funds	**11,723,505**
	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		**2,164,087,745**
		4.2.1	To strengthen systems for financial risk health protection				**2,164,087,745**
			4.2.1.1	State to review and commence participation of its workforce in the NHIS programme .	NHIS formal sector takes off by 2nd quarter of 2010	political will	-
			4.2.1.2	State to encourage NHIS to explore the possibility of implementing the non-formal sector NHIS in due course	Non-formal NHIS commences before end of 2011	political will	-
			4.2.1.3	State to scale up implementation of social protection measures against financial risks associated with ill health, pauper patients, MCH drugs,drug revolving, HIV/AIDS, etc.	50% increase in coverage of MCH drugs and ARVs before end of 2011	availability of funds	**2,164,087,745**
			4.2.1.4	explore collaboration with Partners and donors for subsidised care services	No. of Partners collaborating with	interest by Partners	-

					State for subsidized healthcare		
	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		**119,621,396**
		4.3.1	To improve financing of the Health Sector				**119,621,396**
			4.3.1.1	Encourage Policy Makers, to increase the State budgetary allocation to at least 15% by the year 2015- (a minimum annual 1% incraese), and to ensure faithful releases of health -budgets through sustained advocacy, refreshments, transport, sitting allowance	Advocacy encounters and impact, recorded annually, from 2010	availability of funds	**1,497,315**
			4.3.1.2	Liase with the FMOH to assist States and LGAs benefit from alternative new sources of financing, such as VAT, Tobacco tax, donations charities from Corporations, etc.	Officer detailed gives quarterly reports of outcome of encounters with FMOH	new sources of funds available	**374,329**
			4.3.1.3	Explore External sources of financing healthcare such as providing counter part funding, with World Bank, ADB, bi- and multi-lateral institutions	at least 1 external funding agency came to the state before the end of 2011	external financiers available	**117,398,820**
			4.3.1.4	Explore other sources of financing healthcare through Internal Intervention Agency such as MDG & other donor partners, advocacy, transport	MDG co-finance vital aspects of state health plans	Intervention Agencies positive response	**350,933**
			4.3.1.5	Encourage Public-Private Partnership and Ownership of health institutions through advocacy	more health facilities set up in the state, especially in remote areas	Private health providers interest to invest	-
		4.3.2	To improve coordination of donor funding mechanisms				-
			4.3.2.1	State will adopt donor - government coordination mechanisms / guidelines from FMOH	regular meetings held with Donors	political will	-
			4.3.2.2	State will avoid duplications and maximise donor funds utilisation		political will	-
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012		**34,082,623**
		4.4.1	To improve Health Budget execution, monitoring and reporting				**6,007,975**
			4.4.1.1	The State ensures funds releases are as per budgetary allocation to execute identified health plans	Budgets released as and when due	political will	-

			4.4.1.2	TWG shall monitor implementation and ensure proper recording and accounting expenditures are maintained, every 4 months - 15 No, DSA, transport, refreshments, writing materials	meetings held with minutes produced	political will	**3,853,245**
			4.4.1.3	State to establish Joint - Monitoring of health budget execution; budget execution strengthened at the State and LGA levels through quarterly joint field monitoring by officials of MOH,MOF, Budget & Planning & MLG- transport & fuelling, DSA for 5 officers	M & E activities documented every quarter, beginning from 2nd Qtr 2010	funds available	**2,154,729**
			4.4.1.4	Credible mechanisms will be put in place to increase financial transparency such as State Health Accounts (SHAs) and Public Expenditure Reviews (PERs) will be encouraged-		political will	-
		4.4.2	To strengthen financial management skills				**28,074,648**
			4.4.2.1	Capacity of 20 Officers- Accountants, Statisticians, Planning & Budget Officers will be strengthened annually to ensure proper accountability, transparency in tracking of health expenditures, DSA, tuition fees, transport	20 staff trained annually	funds available	**28,074,648**
NATIONAL HEALTH INFORMATION SYSTEM							
NATIONAL HEALTH INFORMATION SYSTEM							**245,284,500**
	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		**225,050,737**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				**173,331,551**
			5.1.1.1	Obtain standardized NHIMS data tools from FMOH	tools obtained fom FMOH by 1st Qtr 2010	tools available	**185,923**
			5.1.1.2	Create buget lines for the provision of data tools	budgets made available	funds available	-
			5.1.1.3	Print adequate Data tools to last for 6-months; Form 001-003, Registers, cards etc, to be printed every six months, provide for the cost of printing	data tools printed annually	funds available	**167,330,880**
			5.1.1.4	Distribute NHIMS tools/forms to health facilities 3 Officers 1-to each zone for 3days, fuelling of vehicle 3 drivers, twice annually	NMIS forms available in each facility by 2nd Qtr 2010	funds available	**2,677,294**
			5.1.1.5	Monitor utilization of the forms by the facilities (Visit health facilities every 4 months, 3 officers-3days 1person/zone), DSA, transport fuel	quarterly monitoring undertaken with documented reports from 3rd Qtr 2010	funds available	**3,137,454**
		5.1.2	To periodically review of NHMIS data collection forms				**13,163,363**
			5.1.2.1	Monitor & Establish regular feedback mechanism from the field on the appropriateness of the NHIMS forms - feedback meeting every 4 months- data producers 27(M &E), for 1 day- transport, teabreak/lunch, DSA	Hold state meetings to review completed forms, minutes produced, each year	forms available	**10,416,347**
			5.1.2.2	Participate in the National Annual periodic review of the NHMIS forms by the FMOH and other stakeholders, Com - trip by air, DPRS, HIMS trip to Abuja by road, DSA for 2days	National annual review meetings held, minutes produced	funds available	**2,747,015**

		5.1.3	To coordinate data collection from vertical programmes				-
			5.1.3.1	State to obtain guidelines from FMOH on revitalisation of Health Data Consultative Committee	guidelines obtained by 1st Qtr 2010	guidelines ready	-
			5.1.3.2	Establish State Consultative Committee for collaboration with other Agencies on data collection	SCC established 2nd Qtr 2010	political will	-
			5.1.3.3	Adopt and implement the integration/harmonization of HIS with M & E System in all facilities to ensure coherence	HIS integrated with M & E system by 3rd Qtr 2010	political will	-
		5.1.4	To build capacity of health workers for data management				**33,954,224**
			5.1.4.1	Develop training materials on data collection, analysis and utilization	training materials developed by 1st Qtr 2010	funds available	-
			5.1.4.2	Data collection mechanism at State and LGA levels will be strengthened through orientation workshop for data collectors at the State capital, 2 days, 27 LGAs- 2 each, 2 facilitators, DSA, transportation, venue, training materials, tea break/lunch- every year	workshop to improve data collectors capacity held by 2nd Qtr 2010	funds available	**13,163,363**
			5.1.4.3	Train and re-train health service providers (managers) importance of HIMS tools on programmes / policy formulation; 33 PMOs, i/c PHCs, 160 in 3 baches; 1 day, DSA, transportation, teabreak/lunch, training materials, venue, 2 facilitators	workshop to re-train ihealth managers on importance of HIMS tools held by 4th Qtr 2010, to be continued annually	funds available	**20,790,862**
		5.1.5	To provide a legal framework for activities of the NHMIS programme				-
			5.1.5.1	Adopt National Health Bill at the State and LGA levels	National Bill adopted in the State 1st Qtr 2010	National Bill passed by NA before end of 2009	-
			5.1.5.2	Mechanisms for drafting State bye-laws to be enacted through the State Assembly, where necessary	law makers engaged by 2nd Qtr 2010	political will	-
			5.1.5.3	Sustained advocacy at the State and LGA levels for policy makers and other leaders on the importance and usefulness of health data	policy makers engaged, documented positive outcome	political will	-
		5.1.6	To improve coverage of data collection				-
			5.1.6.1	Strategise to improve data collection in all public and Private health facilities in the State	completed data tools returns from public & private by end of 2010	political will	-
			5.1.6.2	Improve the collection of community-based data	completed community-based data tools returns by end of 2010	political will	-
			5.1.6.3	Support the National Population Commission to strengthen vital statistics register of birth and death in all the LGAs of the State- provide technical support	technical support rendered to NPC	political will	-
		5.1.7	To ensure supportive supervision of data collection at all levels				**4,601,599**
			5.1.7.1	Provide appropriate logistics to officials to supervise data collection at lower levels- provide for proper maintenance of 1 No. vehicle (N5000/2-months) Headquarter & 6 No. motor cycles at the zonal offices(N2500/2-months)	vehicles & m/cycles serviced every 2 months from 2nd Qtr, 2010	funds available	**4,601,599**
	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	Strengthen the use of information technology in Health Information System (HIS)	ICT enstalled before end of 2010 in the State	funds available	-
			5.2.1.2	FMOH to assist the State with Software on data collection		software available	-
			5.2.1.3	Pursue Public-Private Partnership in the management of data warehouse	PPP incorporated in management of data by 4th Qtr 2010	funds available	-
			5.2.1.4	Promote use of e-health - electronic Management Intelligence Information System, websites, Patient information system, etc.		political will	-
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				-
			5.2.2.1	Acquire and Adopt FMOH -guidelines on NHMIS Minimum Package	guidelines obtained by 1st Qtr 2010	guidelines ready	-
			5.2.2.2	Advocacy for State and LGAs to provide basic infrastructure for data storage, analysis and transmission - computers, power supply and internet-	advocacy encounters and impact, recorded, from 2nd Qtr 2010	political will	-
			5.2.2.3	Deploy provided hardwares obtained to facilities in the State and LGAs	acquired facilities installed by end of 3rd Qtr 2010	funds available	-
			5.2.2.4	Train Technical staff at all levels on data software	workshops for technical staff held before end of 2010	funds available	-
	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		**185,923**
		5.3.1	To strengthen the Hospital Information System				**371,846**
			5.3.1.1	Liaise with FMOH to Develop guidelines on technical specifications for the establishment and strengthening of patient Information System	guidelines obtained by 2nd Qtr 2010	guidelines ready	**185,923**
			5.3.1.2	Liaise with FMOH to Develop guidelines on technical specifications for the establishment of disease mapping in the State and LGAs	guidelines obtained by 2nd Qtr 2010	guidelines ready	**185,923**
			5.3.1.3				
			5.3.1.4				
			5.3.1.5				
		5.3.2	To strengthen the Disease Surveillance System				-
			5.3.2.1	Ensure regular reporting of notifiable diseases by all the State and LGA health facilities	monthly disease surveilleince reports received monthly	funds available	-
			5.3.2.2	Initiate and strengthen community-based surveillance to improve Disease Surveillance System	monthly community-based disease surveilleince reports received quarterly from 4th Qtr 2010	funds available	-
	5.4	**To monitor and evaluate the NHMIS**			NHMIS evaluated annually		**37,776,108**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**11,426,143**

			5.4.1.1	Encourage LGAs to provide logistics - vehicles/motor cycles and costs of maintenance for SHMIS	more vehicles & m/cycles provided by LGAs before end of 4th Qtr, 2010	political will	-
			5.4.1.2	Promote use of NHMIS Quality Assurance - Print and Distribute HIS (QA) Manual, provide for printing of 100 copies @ N325	QA mannual available in health facilities by 1st Qtr 2011	funds available	**75,531**
			5.4.1.3	Ensure Quarterly Review meeting at the LGA level and Bi-annual Review of the HIS at the State level; provide for State level meeting - 2 pers each from LGAs and 3 state officers(total 37); transport, DSA, tea & lunh break, 2 days	Quarterly Review & Bi-annual Review meetings held at LGA & State levels, respectively with documented reports from 2nd Qtr 2010	political will	**11,350,611**
		5.4.2	To strengthen data transmission				-
			5.4.2.1	Obtain, Promote guidelines and monitor on regular basis to ensure monthly transmission of SHMIS data	obtain guidelines from FMOH by 1st Qtr 2010	guidelines ready	-
	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		**8,436,265**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**8,436,265**
			5.5.1.1	Establish training programmes on data analysis and dissemination for SHMIS Officers	data staff trained on data analysis by 2nd Qtr 2010	funds available	-
			5.5.1.2	Develop guidelines on data analysis and dissemination	guidelines on data analysis obtained by 1st Qtr 2010	guidelines ready	-
			5.5.1.3	Promote use of data to inform decision making	No. of decisions based on data	political will	-
			5.5.1.4	Produce periodic Health Data Bulletin and Annual Reports - health Data Consultative Committee to produce bulletin, 8pers, sitting allowance for 5 days, teabreak/lunch, printing 1000 copies @ N325 each, once a year	Data Bulletin produced annually, from 4th Qtr 2010	funds available	**8,436,265**
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**338,141,800**
	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		**201,156,296**
		6.1.1	To provide an enabling policy framework for community participation				**115,862,151**
			6.1.1.1	Obtain and adopt the FMOH Policy framework on Community Participation- to suit State peculiarity, transport to abuja, DSA for 4days	community participation framework obtained by 1st Qtr 2010	document available	**320,293**
			6.1.1.2	Building Capacity of local consultants on community mobilization- State-wide 3-days Orientation workshop for 27 Local Govt consultants/resource persons; 3 Facilitators (Community mobilization, IEC & IPC experts), other stakeholders, Opinion Leaders- Muslim	27 LGA Consultants trained to facilitate mobilization of 311 wards in the state by 1st Qtr 2010	political will	**8,007,336**

				and Christian leaders, NGOs 2, MLG 2, MOI 1 & MOH Officials 3 (total 40 people); teabrake/lunch, DSA, venue, workshop materials,			
			6.1.1.3	Create an enabling environment for community participation in health development through proper implementation of mobilization activities in all 311 wards; 27 LGA Consultants + 2 local resource persons in each LGA -undertake sensitisation/advocacy of each ward for 2days supervised by 3 State facilitators- 1 in each senatorial zone, provide for DSA 84, transport, ward refreshments-3000/sitting	at least 70% of the communities mobilized by end of 3rd Qtr 2010	political will	**47,107,159**
			6.1.1.4	Develop of & Implement IEC materials in local languages - Radio & Tv jingles, dramas, banners & posters at State and LGA levels-Develop concept, test-run, implement, professional fees, Radio & TV dramas, rates/slots, for 3 quarters, artists,	Radio jingles aired in local stations by 2nd Qtr 2010	funds available	**49,044,934**
			6.1.1.5	Reconstitute through election/selection leadership of the various community development unions at the wards and LGA levels - to be supervised by Local Consultants in 2 days, local artisans, posters	leaders of wards and LGAs elected/selected by end of 3rd Qtr 2010	political will	**11,382,428**
		6.1.2	To provide an enabling implementation framework and environment for community participation				-
			6.1.2.1	Guidelines for establishing community development unions would be reviewed and made flexible to reflect situation on ground	guidelines obtained by 1st Qtr 2010	guidelines ready	-
			6.1.2.2	Adequate sensitisation/advocacy campaigns on ownership would be carried out at the community levels, carrying them along - 311 wards, 2days/ward/ 3facilitators	advocacy visits undertaken by 2nd Qtr 2010	political will	-
			6.1.2.3	Participatory approaches to involve wider members of the community put in place	more people involved in community health development issues	political will	-
			6.1.2.4	Establish inter-sectoral linkages	other relevant MDAs working with MOH on SSHDP	Political will	-
		6.1.3	Strengthen Community Ownership and Participation				**85,294,145**
			6.1.3.1	Undertake advocacy visit to community gate-keepers and the entire community to increase awareness and understanding in using health facilities, 2days, 3persons /LGA, DSA, transport, refreshments-provide N10000/each LGA	No. of advocacy visits made and reports documented	funds available	**8,864,121**
			6.1.3.2	Review the policy framework for community participation and integrate with other activities such as religious, cultural, administrative and management system of the community; 10 No., sitting allowance, refreshments, 2days	50% of health development committees integrated with other existing socio-cultural organizations	funds available	**560,514**
			6.1.3.3	Identify and reconstitute the existing development committees at the state and LG Areas giving greater participation and control to the members of the community in order to give them sense of ownership	development committees reconstituted by 3rd Qtr 2010	political will	-
			6.1.3.4	Inaugurate the Health Development Committees at well attended ceremony at the LGA Secretariat chaired by LGA Chairmen; artisans, posters, T-shirts & women Hijabs @ N1000,	inauguration ceremony held in at least 70% of LGAs	Political will	**75,869,511**

				500 No./LGA, (public address system, chairs, benches, canopies, posters, banners, refreshments- provide lump sum N300000/LGA)	before end of 3rd Qtr 2010		
	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		**14,873,627**
		6.2.1	To build capacity within communities to 'own' their health services				**14,873,627**
			6.2.1.1	Develop and upgrade existing participatory tools for mobilising communities in planning and management	participatory tools developed by 1st Qtr 2010	political will	-
			6.2.1.2	Identify and map out key community stakeholders functions and their health capacity-needs	capacity-needs identified by 2nd Qtr 2010	political will	-
			6.2.1.3	Biennial Skills Acquisition workshops to Re-orient the community development committees and community-based health care providers on their roles, responsibilities and empower them with Health Knowledge, capacity in management and basic health data interpretation; 3days TOT workshops- State level- 3participants from each of 27 LGAs, 1pers each from MOH, MLG & MOI, 1repr. of traditional ruler, 2religious leaders, 3facilitators, workshop materials, refreshments (90), DSA, transport, Honorarium to facilitators. LGA Level training to be conducted every six-months with 3 participants from each ward, 1-repr. of traditional ruler, 2-repr. of religious leaders, 3facilitators, refreshments, DSA - LGA Level trainings to be funded by the LGA Council	State level TOT skills acquisition workshops held by 3rd Qtr 2010	funds available	**14,873,627**
			6.2.1.4	Establish dialogue between communities and government structures at all levels- in program planning, implementation and monitoring, through IEC and other suitable medium of communication for maximum impact	communities engaged through different for a before end of 4th Qtr 2010	political will	-
			6.2.1.5	Provide funding for community activities	funds available	political will	-
	6.3	**To strengthen the community - health services linkages**			50% of public health facilities in all States have active Committees that include community representatives by end 2011		-
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				-
			6.3.1.1	Review the existing health delivery structure and assess their level of linkages with the community in the State and LGAs	health delivery linkages established at the State and LGA levels by 3rd Qtr 2010	political will	-
			6.3.1.2	Develop guidelines for strengthening the community-health services linkage	guidelines for strengthening linkages developed before end of 2010	political will	-
			6.3.1.3	identify and restructure health delivery structure in order to promote community participation in health development at all levels	50% increase in community participation in	political will	-

					health development attained by1st Qtr 2011 at State and LGA levels		
			6.3.1.4	Provide enabling envioronment for exchange of experiences & ideas between community development committees	communities interact to discuss health development issues by 2nd Qtr 2011	interest by communities	-
	6.4	**To increase State capacity for integrated multisectoral health promotion**			50% of States have active intersectoral committees with other Ministries and private sector by end 2011		**38,034,847**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**38,034,847**
			6.4.1.1	Increase community's awareness towards health development through community participation	more communities aware of health development issues by 3rd Qtr 2010	interest by communities	-
			6.4.1.2	Develop health promotion guidelines on community involvement and strengthen the health promotion components in the community	community health promotion components implemented before end of 2010	interest by communities	
			6.4.1.3	Empower communities with health knowledge, skill and behavioral communication- through IEC-dramas, radio & tv jingles, posters	50% communities knowledgeable about common health problems by 3rd Qtr of 2011	interest by communities	**38,034,847**
			6.4.1.4	Facilitate action plans aimed at development of health promotion capacities at community levels linking health with other sectors	community health multi-sectoral linkages established before end of 2011	interest by communities	-
	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		**84,077,030**
		6.5.1	To develop and implement systematic measurement of community involvement				**84,077,030**
			6.5.1.1	Conduct Research to Measure the impact of approaches, methods and initiatives of the communities after a specified time (6-months)	one research on community participation conducted by 4th Qtr of 2010	funds available	**84,077,030**
			6.5.1.2	Document and share the findings - disseminate lessons learnt and best practices to other communities	best practices/experiences shared through review meeting at the beginning of 2011, and subsequently, annually	political will	-
			6.5.1.3	Develop continuous monitoring and evaluation of the programme for sustainability	M & E activities documented every quarter, beginning from 3rd Qtr 2010	political will	-
PARTNERSHIPS FOR HEALTH							

7. To enhance harmonized implementation of essential health services in line with national health policy goals							**81,006,600**
	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		**81,006,600**
		7.1.1	To promote Public Private Partnerships (PPP)				**7,582,126**
			7.1.1.1	Create a PPP Unit at SMoH to deal directly with all Private Partners - to be headed by Deputy Director, 1 middle management staff and 3 junior staff, one time activity- Staff available, assign mandate	PPP Unit established in the State by 1st Qtr of 2010	political will	-
			7.1.1.2	Enumerate all Private Partners operating in the health sector in the State by category. To be updated once every year (in the first quarter) - to include all private health facilities(registered or not), NGOs providing health services, Partner Agencies in health, hospitals/clinics, pharmacies, patent medicine stores, nursing homes-(to liase with Inspectorate unit), 9 (4-seniors), 2 middle and 3 junior, 5days, DSA, transport	Register of private partners available in the State, by 1st Qtr, 2010	funds available	**4,189,276**
			7.1.1.3	Workshop for policy makers on the role of partner Agencies.Total to be sensitized, all law makers plus 10 support staff. 1 Day meeting in the House of Assembly - special workshop bags N1000, projector, facilitator, refreshments for 40people- another one in 2011 after elections	50% Law makers coversant with role of partner Agencies , 2nd Qtr, 2010	Law makers interest in the exercise	**882,141**
			7.1.1.4	Joint budgeting between State MoH and Partner Agenciess. To be done once a year in the 3rd Qtr of 2010	50% patners partake in drawing of annual State budget	political will	
			7.1.1.5	Workshop to put in place mechanism to encourage the private sector set up health facilities in rural and under-served areas. 35 people targeted for two days at a hotel, venue, advert in NTA & BRT	Number of Health facilities set up in rural setting -5/quarter	prioritization of investments by private practioners	**2,510,709**
		7.1.2	To institutionalize a framework for coordination of Development Partners				**8,846,408**
			7.1.2.1	Workshop on the development of the framework for the harmonization and alignment of development partner's support- all partners operating in the State-WHO, UNICEF, UNFPA, FHI/GHAIN, WB,ADB…, MOH, MOF, MLG, Budget, 38pers, 2 facilitators, bag, venue, training materials, DSA 2 days	workshop held and resolutions adopted 2nd Qtr, 2010	political will	**2,096,424**
			7.1.2.2	Conducting Development Partners Forum comprising of only health development partners, quarterly involving 15 people, teabrake/lunch, sitting allowance	Quarterly meetings held and Reports available		**44,999,899**
			7.1.2.3	Conduct Health Partners Coordinating Committee (HPCC) meeting biennially to discuss programmes implementation and resource coordination through basket funding; refreshments, sitting allowance	Basket funding mechanism established and quotas allocated to	Health partner priorities	**2,249,995**

					government and partners		
		7.1.3	To facilitate inter-sectoral collaboration				**6,749,985**
			7.1.3.1	Conduct inter-sectoral ministerial forum comprising Officials from different ministries such as Health, Finance, Water, Agric etc. with a purpose to share common goals and experience; teabrake/lunch, sitting allowance, 30 people1 day - thrice per year, sitting allowance, refreshments	Intersectorial ministerial forum meetings every 4 months and minutes available	political will	**6,749,985**
		7.1.4	To engage professional groups				**18,694,600**
			7.1.4.1	Conduct yearly meetings with Professional groups through which joint setting standards of training by health institutions, subsequent practice and professional competency assessments will be finalized. To involve 25 people for 3 days, transport, sitting allowance, refreshments	protocols for quality assurance developed	political will	**6,294,628**
			7.1.4.2	Conduct yearly review meetings with professional groups on planning, implementation, monitoring and evaluation of health plans and programmes involving 20 people for 2 days	Review meetings held and Report available	POlitical will	**3,535,706**
			7.1.4.3	Produce biennial joint publications/magazine to enhance relationships between professional groups and State MOH -1000 copies @ 325	Two magazines per year produced and circulated	funds available	**6,964,270**
			7.1.4.4	Promote linkages with academic institutions to undertake research, education and monitoring through existing networks. Yearly meeting involving 16 people, MOH, HMB, UniMaid, UMTH, SON&MW,SHT	Yearly meetings with academic institutions held	funds available	**1,542,854**
			7.1.4.5	Pay advocacy visit to State House of Assembly to lobby for enacting of regulation and legislation to allow for competency-based practice by all types of health professionals according to the principles of "continuum of care" 40 people involved, transport, advocacy refresments	legislation on competency based practice for all cadres of health profession	political will	**357,142**
		7.1.5	To engage with communities				**32,172,784**
			7.1.5.1	Introduce weekly Radio programme on health matters- personal hygiene, preventive, curative and emergencies and role of health community development associations;To be facilitated by the Health Education Unit of the MOH; for about 6 months	weekly production available and aired on State wide radio and television station	funds available	**3,642,849**
			7.1.5.2	Print posters targeting community consumption including rights of beneficiaries, means of accessing care at health facility and minimum standards of quality health services; lump sum N500000	number of public places with posters on community sensitization	funds available	**892,855**
			7.1.5.3	Workshop on development of indicators on health system performance at State, LGA and facility levels to improve transparency and accountability. Involving - (2 each from 27 LGA, SMOH, MLG, MOF, MOI, 1 NGO, Religious Leaders, 1 NMA, 1 PSN, I NNM, 2 facilitators, for 3 days (70pers), in a local hotel, DSA, transport, tea break & lunch, w/materials, venue, banners	SOPs and indicators available	funds available	**5,271,417**
			7.1.5.4	Cascaded training on Quality health care delivery and mechanism for rewarding best performance at State, LGA and health facility	Best performing LGAs/HFs awards given yearly	funds available	**19,744,241**

				levels; State level TOT, 2days, 27LGAs, 34 Hospitals, MLG, MOH, MOI, 3 facilitators, (67)			
			7.1.5.5	Training of Volunteer Community Health Workers to manage priority health conditions through appropriate self-mediated mechanisms 40 community volunteers every six months, trained for 3 days, transport, tea break & lunch, workshop materials, 2 facilitators	1 neighbourhood health committee per health facility with a least 1 community health worker/volunteer	funds available	**2,621,423**
		7.1.6	To engage with traditional health practitioners				**6,960,698**
			7.1.6.1	Register traditional medicine practitioners into bodies / organisations that are easy to regulate and actually regulate their practice. 2 weeks exercise involving 6 clerks and 1 supervisor, DSA, transport	80% of traditional medicine practioners bodies registered by 2011	political will	**1,174,997**
			7.1.6.2	Conduct research activities to gain more insight, understanding and evaluation of Traditional healers,	Annual research papers available, and results disseminated in a publication	funds available	-
			7.1.6.3	Adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful	80% of Good traditional pactices adopted into health care system by 2012	THP cooperation	-
			7.1.6.4	Advocacy for legislation to ban traditional practitioners from advertising themselves and making false claims in public media	Legislation banning THP from advertising put in place by 2013	cooperation of State Assembly members	-
			7.1.6.5	Annual retreat of traditional practitioners aimed at promoting health programmes in such priority areas like nutrition, environmental sanitation, personal hygiene, immunization and family planning; 15 representatives of THP,TWG-5, PS,Hon. Com, Directors, HMB,Partner Agencies(total 45people) venue, refreshments/lunch, sitting allowance, 2facilitators, 2days	Number of THPs promoting other health programes	THP cooperation	**5,785,701**
RESEARCH FOR HEALTH							
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							**390,000,000**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010		-
		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels				-
			8.1.1.1	Adopt the NHRP	NHRP adopted by 1st Qtr 2010	NHRP available	-
			8.1.1.2	Develop State Health Research Strategies	strategies for Health Research developed by 2nd Qtr 2010	federal guidelines in place	-
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				-
			8.1.2.1	Strengthen capacities of Department of Planning Research & Statistics in the MOH and LGAs to coordinate research activities	DPRS mandated to outsource researches by 2nd Qtr 2010	funds available	-

			8.1.2.2	Provide Technical assistance to develop and strengthen the capacity of Health Research Unit of the DPRS to undertake operations research and other research-related activities	operational researches to be conducted annually	funds available	-
		8.1.3	To institutionalize processes for setting health research agenda and priorities				-
			8.1.3.1	Establish / strengthen functional institutional structures to implement the Essential National Health Research programme	TWG mandated to offer advice on research ares	funds available	-
			8.1.3.2	To broaden the research agenda to include broad and multi-dimensional determinants of health	TWG mandated to offer advice on research ares	funds available	-
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors				-
			8.1.4.1	Develop and disseminate guidelines for a collaborative research agenda	guidelines for colaborative research developed before end of 2010	funds available	-
			8.1.4.2	Establish a forum of Health Research Officers at MOH and LGAs	forum established by 1st Qtr 2011	political will	-
			8.1.4.3	Convene a multi-stakeholders forum to identify research priorities for harmonization of research efforts	multi-sector research priorities established by 2012	political will	-
			8.1.4.4	Support development of collaborative research proposals and their implementation	at least 2 collaborative research undertaken before 2015	political will	-
		8.1.5	To mobilise adequate financial resources to support health research at all levels				-
			8.1.5.1	Encourage the State & LGAs to allocate about 2% of their health budget to research	undertake sustained advocacy campaign for research to State policy makers and, atleast 50% LGAs (at least 5 encounteres / quarter)	political will	-
			8.1.5.2	Reach out to Partner Agencies and other organizations for funding in health research	at least 1 research jointly sponsored annually	Partner Agencies interested	-
		8.1.6	To establish ethical standards and practise codes for health research at all levels				-
			8.1.6.1	State to adopt National guidelines on research	national guideline adopted	guidelines ready	-
			8.1.6.2	Develop and promote guidelines on ethical standards for research in health	ethical guidelines developed by 3rd Qtr 2010	national guidelines reviewed and available	-
			8.1.6.3	Establish Ethical Review Committee and in tandem with what obtains in higher institutions	ethical committee established by 2nd Qtr 2010	political will	-
			8.1.6.4	Establish mechanisms to monitor, evaluate and regulate research and the use of research findings	TWG mandated to monitor & document researches	political will	-
	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		**390,000,000**
		8.2.1	To strengthen identified health research institutions at all levels				-

			8.2.1.1	Cooperate with FMOH to strengthen research institutes and other research-based organizations for better health outcomes	attend meetings and offer technical and other support advice	political will	-
		8.2.2	To create a critical mass of health researchers at all levels				-
			8.2.2.1	State will Encourage and support its indigenes acquire higher degrees in healthcare through scholarships	No. of sponsored indigenes, annually	funds available	-
			8.2.2.2	Provide research grants to prospective researchers, especially PhDs in healthcare	No. of PhDs given grants by the State from 2010	funds available	-
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				-
			8.2.3.1	State will encourage use of research findings to achieve evidence-based policy formulation	New policies influenced by research findings fom 2011	political will	-
		8.2.4	To undertake research on identified critical priority areas				**390,000,000**
			8.2.4.1	provide funding to undertake periodic operational research	at least 2 operational researches conducted every year by end of 2010	funds available	-
			8.2.4.2	State to provide funds to conduct manpower audit, health service utilization, HIMS, and Cost Recovery Scheme etc, annually	manpower audit, utilization surveys conducted annually	funds available	**230,921,051**
			8.2.4.3	Conduct research activities to gain more insight, understanding and evaluation of Traditional healers, provide for N5.5m to conduct research, annually	research on tradional medicine conducted annually	funds available	**56,447,368**
			8.2.4.4	Conduct research annually to assess performance (immunization coverage, sentinel surveys, etc); provide N10m for research	coverage and sentinel surveys annually conducted	funds available	**102,631,578**
Total							**76,750,735,617**

Appendix 3: Results/M&E Matrix for the Borno SSHDP

BORNO 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	30	55	90%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	TBD	25	50	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	0	20	40	65
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	TBD	30	55	80
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	40%	65%
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	20	35	70
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	35	45	70
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	30	55	75
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	30	45	65
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	20	45	65%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	35	50	70%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	30	45	75
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	35	55	80%

4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	20	50	70%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	20	40%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	30	45	85%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	20	45	60%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	20	40	65%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	20	40	60
	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	15	25	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	20	35	65%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	30	50	70%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	30	55	70%
	25. Contraceptive prevalence rate	NDHS	6.50%	10%	15%	20%
	26. % increase in number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	2%	5%	10%	15%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	2%	5%	10%	15%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10%	20%	30%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	40%	50%	75%

	30. % of women age 15-19 who have begun child rearing	NDHS/MICS	48%	40%	30%	20%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	32.80%	40%	50%	75%
	32. Proportion of births attended by skilled health personnel	HMIS	11.80%	20%	30%	40%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	10%	25%	40%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	2%	5%	10%	15%
	35. Case fatality rate among women with obstretic complications in EmOC facilities per complication	HMIS	50%	40%	30%	25%
	36. Perinatal mortality rate**	HMIS	37/1000LBs	30/1000LBs	25/1000LBs	20/1000 LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	30	45	65
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	2%	5%	10%	25%
	39. % of newborn with infection receiving treatment	MICS	No Baseline	10%	25%	40%
	40. % of children exclusively breastfed 0-6 months	NDHS/MICS	3.10%	10%	25%	40%
	41. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	1.50%	10%	25%	40%
	42. % children <5 years stunted (height for age <2 SD)	NDHSMICS	49.20%	45%	35%	30%
	43. % of under-five that slept under LLINs the previous night	NDHS/MICS	1.10%	25%	40%	60%
	44. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	3.90%	10%	25%	50%
	45. % malaria successfully treated using the approved protocol and ACT;	MICS	TBD	40	55	65
	46. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	TBD	30	40	60
	47. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	TBD	30	55	70
	48. HIV prevalence rate among adults 15 years and above	NDHS		15	30	70
	49. HIV prevalence in pregnant women	NARHS		20	35	70
	50. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS		10	15	25

	51.Condom use at last high risk sex	NDHS/MICS				
	52. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	13.80%	25%	50%	60%
	53. Prevalence of tuberculosis	NARHS	5%	4%	3%	1%
Output 6. Improved quality of Health care services	54. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	25%	40%	60%
	55. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	25%	40%	60%
	56. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20%	50%	75%
	57. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10%	25%	50%
	58. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	25%	40%	60%
	59. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	10%	25%	40%
	60. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10%	30%	50%
Output 7. Increased demand for health services	61. Proportion of the population utilizing essential services package	MICS	TBD	25%	50%	75%
	62. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25%	50%	75%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	63. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20%	40%	60%
	64. Retention rate of HRH	HR survey Report	TBD	20	25	40
	65. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10%	30%	50%
	66. Distribution of HRH by geographical location	MICS	TBD	20	40	55
	67. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10%	25%	50%
	68. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	15%	25%	50%

	69. % of staff satisfied with the performance based management system	HR survey Report	TBD	10%	25%	50%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	70. % LGAs making availabile consistent flow of HRH information	NHMIS	5%	25%	40%	60%
	71. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	72. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	73. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	74. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	75. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	76. HRH database mechanism in place at LGA level	HRH Database	TBD	50 - 75%	75 - 100%	100%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH **NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels**						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	77. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10%	25%	50%
	78. Decreased proportion of informal payments within the public health care system within each LGA	MICS	75%	60%	50%	40%
	79. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	25%	40%	60%

	80. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	25%	40%	60%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	81. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40%	60%	100%
	82.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	83. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	84. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	85. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	40	50%
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	86. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	20%	30%	45%	60%
	87. % of LGAs receiving feedback on NHMIS from SMOH		20%	30%	45%	60%
	88. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	30%	60%	80%
	89. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	25%	40%	60%
	90.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	91. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	92. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	93. % of LGA plans using the HMIS data	NHMIS Report	TBD	40%	75%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	94. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	25%	50%	75%

	95. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	96. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	97. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	98. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	99. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%
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	100. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	101. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	25%	50%	75%
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	102. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	103. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	104. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	105. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%
	106. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	40%	75%	100%
Output 17: Health research communication strategies developed and implemented	107. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	75%	100%