BAYELSA STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Bayelsa State Ministry of Health

March 2010

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ACRONYMS AND ABBREVIATIONS

AFP	Acute Flaccid Paralysis
AIDS	Acquired Immune Deficiency Syndrome
AMLS	Association of Medical Laboratory Scientists
ASCON	Administrative Staff college of Nigeria
BHSS	Bayelsa Health Service Scheme
BI	Bamako Initiative
BMS	Bayelsa Medicare Scheme
BSc	Bachelor of Science
CBO	Community Based Organization
CCM	Country Coordinating Mechanisms
CDC	Community Development Committee
CDP	Continuing Professional Development
CHEW	Community Health Extension Worker
CHO	Community Health Officer
CMD	Chief Medical Director
CMS	Central Medical Stores
CORPs	Community Oriented Resource Persons
CSOs	Civil Society Organizations
DHS	Demographic Health Survey
DP	Development Partners
DPF	Development Partners Forum
DPRS	Department of Planning Research and Statistics
DSN	Disease Surveillance Notification
DT	Dental Technician
EDP	Essential Drug Programme
EHO	Environmental Health Officer
EHTs	Environmental Health Tutors
ENHR	Essential National Health Research
EPR	Emergency Preparedness & Response
FCT	Federal Capital Territory
FHI	Family Health International
FMC	Federal Medical Centre
FMoH	Federal Ministry of Health
FP	Family Planning
GCE	General Certificate of Education
GIS	Geographical Information System
GLRA	German Tuberculosis and Leprosy Relief Association
H/R	Human Resources
HDCC	Health Data Consultative Committee

HIM	Health Information management
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMB	Hospitals Management Board
HMIS	Health Management Information System
HND	Higher National Diploma
HNS	National Health System
HOD	Head Of Department
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HSDP	Health System Development Project
HSG	Health System Governance
ICC	Inter-Agency Coordinating Committee
ICT	Information and Communication Technology
IDSR	Integrated Disease Surveillance and Response
IEC	Information Education Communication
IMCIs	Integrated Management Childhood Illness
IMNCH	Integrated Maternal, Newborn and Child Health
IMR	Infant Mortality Rate
IMSF	Inter-Sectoral Ministerial Forum
IPC	Interpersonal Communication
ISS	Integrated Supportive Supervision
ITN	Insecticide Treated Nets
JAMB	Joint Admission Matriculation Board
JCHEW	Junior Community Health Extension Worker
LEEMP	Local Empowerment and Environmental Management Project
LGA	Local Government Area
LHSS	Local Health Service Scheme
M&E	Monitoring and Evaluation
MA	Midwife Assistant
MCH	Maternal & Child Health
MDCN	Medical and Dental Council of Nigeria
MDGs	Millennium Development Goals
MHWUN	Medical Health Workers union of Nigeria
ML	Medical Laboratory
MLT	Medical Laboratory Assistant
MO	Medical Officer
MOH	Ministry of Health
MSc	Masters of Science
MSS	Midwives Service Scheme
N/M	Nurse/Midwife

NAFDAC	National Agency for Food Drugs Administration and Control
NANMW	National Association of Nurses and Midwives
NAOC	Nigerian Agip Oil Company
ND	National Diploma
NDDC	Niger Delta Development Commission
NDU	Niger Delta University
NDUTH	Niger Delta University Teaching Hospital
NECO	National Examination Council
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMA	Nigerian Medical Association
NMDCN	National Medical and Dental Council of Nigeria
NOA	National Orientation Agency
NPHCDA	National Primary Health Care Development Agency
NPI	National Programme On Immunization
NSHDP	National Strategic Health Development Plan
O/L	O/Level
OAU	Organization of African Unity
OPS	Organized Private Sector
PA	Pharmacy Assistant
PER	Public Expenditure Review
PHC	Primary Health Care
PHC	Primary Health Care
PhD	Doctor of Philosophy
PHN	Public Health Officer
PMTCT	Prevention of Mother to Child Transmission
PPFN	Planned Parenthood Federation of Nigeria
PPP	Public Private Partnership
PS	Permanent Secretary
PSN	Pharmaceutical Society of Nigeria
PT	Pharmacy Technician
PTF	Petroleum Trust Fund
PW	Pregnant Women
QA	Quality Assurance
RBM	Roll Back Malaria
SACA	State Action Committee on AIDS
SERVICOM	

SHA	State Health Account
SIPD	sub-National Immunization Plus Days
SMoH	State Ministry of Health
SON	Standard Organizations of Nigeria
SOP	Standard Operating Procedure
SPDC	Shell Petroleum Development Company
SSCE	Senior Secondary School Certificate Examination
SSHDP	State Strategic Health Development Plan
SSZ	South-South Geo-political Zone
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Health Attendant
TBLCP	Tuberculosis & Leprosy Control Programme
TOT	Training of the Trainers
TV	Television
UN	United Nations
UNICEF	United Nations Children's Fund
VAT	Value Added Tax
VHWs	Village Health Workers
VOC	Vote-of-Charge
VP	Vice Principal
WAHEB	West African Health Examination Board
WASC	West African Examination Council
WCA	Women of Child-Bearing Age
WDCs	Ward Development Committees
WHO	World Health Organization
WPV	Wild Polio Virus

EXECUTIVE SUMMARY

Over 40% of Nigeria's on-shore crude oil is produced in Bayelsa State. Industries are very few, and social amenities are grossly inadequate. A high level of poverty is evident which caused underdevelopment and agitation from the people, mainly the youths. The exploration and exploitation of oil involves a number of activities that impact on the host communities and their occupation

The State Health sector faces many challenges in ensuring the most efficient mechanisms for delivery of health services. Though there is no official ranking of situation in Nigeria, available information indicate that Bayelsa State Health performance is below average, this situation is made more complicated by the physical geographic terrain of the State, which make it difficult for transportation and accessibility both for health services and research for health, especially to ascertain current status of available facilities and identify areas of needs of the people.

In order to meet the challenges of achieving improved health status particularly for its poorest and most vulnerable population, the health system must be strengthened; proven cost-effective interventions must be scaled up and gains in health must be sustained and expanded. The State wish to achieve this within the context of a costed State Strategic Health Development Plan (SSHDP), aimed at providing an overarching framework for sustained health development.

Leadership and governance:
Frequent changes in leadership at all levels, corruption, lack of accountability and transparency characterize poor leadership systems and crises in governance structures in the Bayelsa State health system. Recommended interventions to address these include appropriate legislation and regulatory frameworks; States and local government consensus through national and state councils on health; effective decentralization of decision making processes; intergovernmental and 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.

Health service delivery: is characterized by inequitable distribution of resources, decaying infrastructure, 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; rehabilitation of health infrastructure, sustainable procurement system for health commodity security; rational use of drugs; strengthening referral system; attitudinal reorientation through SERVICOM; institutionalizing staff motivation and establishing quality assurance mechanisms.

Human resource for health:

There is a lack of the quality, quantity and a combination of healthcare workers with a bias distribution towards Yenagoa the State Capital and LGAs population close to the seat of the government, alongside the existence of various categories of health care providers in the state, from orthodox to traditional.

Interventions recommended include adoption and adapting of the National Human Resource Policy, supporting LGA levels to develop HRH plans and initiatives, establishing a system of Continuing Professional Development (CDP); addressing critical human resource gaps in some parts of the state; task shifting to address critical shortage and ensure periodic curriculum review by training institutions.

Financing for health:
Health financing is a major determinant of population health and wellbeing. Budgetary provision for health is still below the recommended 15% of total annual budget and Bayelsa State government will gradually increase budgetary provision for Health until it reaches 15% of the total budget. Effort will be made to consolidate and enhance private sector and development agencies contribution to the budget mix. Social insurance options will be priotised.

Health information system (HIS): The existing gaps and concerns in the State HIS include non-adherence to reporting guidelines, poor availability and utilization of standardized tools, dearth of skills for interrogation of data, non-involvement of private providers, untimely and scanty data returns, etc. Recommended interventions include modernization of the HIS; increased funding to HIS; capacity building at all levels for data collection and interpretation; availability of data collection tools at all levels; collaboration with the private sector; funding especially from LGAs; implementation of HMIS Minimum Package; institution of sanctions for defaulters; harmonization of data collecting systems with key indicators; utilization of data to inform policy formulation and programming.

Community participation and ownership:
Community participation and community ownership are keys to any sustainable health care programme. Appropriate interventions will be employed to engage and empower communities using community-based organizations and traditional structures in programme planning, implementation, monitoring, supervision and evaluation. Advocacy and behavioural change communication will be employed to create demand and ensure ownership of health services.

Partnerships for Health: If properly harnessed would provide synergized efforts for improving the performance of the health system and addressing the social determinants of health. Interventions recommended include effective Public Private Partnerships; Inter- and intra-governmental collaboration; coordination mechanisms with health development partners, including multilaterals, bilateral and the civil society; equally partnerships with professional groups, traditional care providers and the community are critical.

Research for health:

Strengthening health sector research capacity and the promotion of health system research is one major way of addressing the challenges of health system and improve human development. At the same time, the search for strategies to get research findings into policy and practice has gained momentum and the global literature has called for further exploration in the area of research to policy.

The policy processes should involve understanding not only the mechanics of decision-making and implementation, but also more complex underlying practices of policy framing. It is thus pertinent to recognize policy development as political and complex process that proceeds through a set of stages from understanding agenda-setting, to exploring possible problem resolution options, weighing up costs and benefits, decision-making, and finally implementation, possibly followed by evaluation. When analyzing health sector policy it is vital to engage key stakeholders such as the government, health providers, scientists, and the community as well as establishing the mechanism that would enhance accountability at all levels.

VISION AND MISSION STATEMENT

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 Statement

"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.

The overarching goal of the NSHDP is *to significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system.*

CHAPTER 1: BACKGROUND AND ACHIEVEMENTS

1.1 Background Information

Bayelsa State was created on the 1st of October 1996 out of the old Rivers State. The name Bayelsa is an acronym of three former Local Government Area of Brass (BA), Yenagoa (YEL) and Sagbama (SA) in the then Rivers State, which was a senatorial district in the 2nd Republic. The then Brass LGA now have Brass, Nembe and Ogbia (Bayelsa East Senatorial District), Yenagoa has Yenagoa, Kolokuma/Opokuma and Southern-Ijaw LGAs (Bayelsa Central Senatorial District) and the Bayelsa West is comprises of Ekeremor and Sagbama LGAs.

S/No.	LGA	Headquarters
1.	Brass	Twon-Brass
2.	Ekeremor	Ekeremor
3.	Kolokuma/Opokuma	Kaiama
4.	Nembe	Nembe
5.	Ogbia	Ogbia
6.	Sagbama	Sagbama
7.	Southern-Ijaw	Oporoma
8.	Yenagoa	Yenagoa.

1.1.1 Location

The state is geographically located within latitudes 04’20’33” and 05’28’39” North, longitudes 0.5’ 20’ 00’ and 06 ‘43’ 05’ East. It shares boundaries with Delta State on the North, Rivers State on the East and the Atlantic Ocean on the West and South. Bayelsa State is in the South South Geo-political zone (SSZ) of the country, in the heart of the Niger Delta Area – Bayelsa is a picturesquely rain forest, with an area of 21,110 sq.km. The state is 75% riverine with only 4 LGA Headquarters namely: Yenagoa, Kaiama, Sagbama and Ogbia accessible by road. The rest can only be reached by water transport.

1.1.2 People and Languages

The tribe is Ijaw. However, there are four (4) cultural and linguistic groups, namely: Izon (Ijaw), Nembe, Ogbia and Epie/Atissa. Urhobo and Isoko are among some minority dialects spoken.

Predominant religious are Christianity and Africa Traditional worship, with pockets of Islam and other non-christian religions.

1.1.3 Occupation and Commerce

The main occupation fishing, farming, palm oil production, lumbering, trading, palm-wine tapping, local gin making, carving and weaving. The state is a major oil and gas producing area, contributing to over 30% Nigerian oil production. Oloibiri in Ogbia LGA in Bayelsa State is where crude oil was first struck in commercial quantity as far back as 1956.

1.1.4 Population

2009 State Population Projection from 2006 Census figure is as follows:-

LGAs	Population	<1	<5	WCA	PW
Brass	201,620	40,324	40,342	44,356	10,081
Ekeremor	294,460	58,892	58,892	64,781	14,723
Kolokuma/Opokuma	84,215	16,843	16,843	18,527	4,210
Nembe	142,655	28,531	28,531	31,384	7,133
Ogbia	196,040	39,208	39,208	43,128	9,802
Sagbama	203,905	40,781	40,781	44,859	10,195
Southern-Ijaw	348,015	69,603	69,603	76,563	17,401
Yenagoa	384,985	76,997	76,997	84,697	19,249
TOTAL	**1,855,895**	**371,179**	**371,179**	**408,295**	**92,795**

Population by Age Group

Age Groups	Both Sexes	SEX	
		Males	Females
0-4	21,613	108,853	103,760
5-9	229,357	120,454	108,903
10-14	204,696	108,756	95,940
15-19	199,148	103,701	95,447
20-24	167,662	83,074	84,588
25-29	146,861	67,228	79,633
30-34	116,574	53,493	63,081
35-39	97,218	44,788	52,430
40-44	86,377	45,165	41,212
45-49	66,377	35,509	30,868
50-54	58,216	33,414	24,802
55-59	28,530	15,935	12,595
60-64	34,103	19,716	14,387
65-69	15,453	8,531	6,922
70-74	16,682	10,733	5,949
75-79	7,512	4,390	3,122

80-84	8,452	4,843	3,609
85+	8,684	5,500	3,184
Total	**1,704,515**	**874,083**	**830,432**

Population Projections for 2015

LGAs	2009	2010	2011	2012	2013	2014	2015
Brass	201,620	207,669	213,889	220,306	226,915	233,722	240,734
Ekeremor	294,460	303,294	312,393	321,764	331,417	341,360	351,601
Kolga	84,215	86,345	89,345	92,025	94,785	97,629	100,558
Nembe	142,655	146,935	151,343	155,883	160,560	165,377	170,338
Ogbia	196,040	201,922	207,979	214,219	220,645	227,265	234,082
Sagbama	203,905	210,023	216,324	222,813	229,497	236,382	243,474
Southern-Ijaw	348,015	358,456	369,210	380,285	391,694	403,445	415,549
Yenagoa	384,985	396,535	408,432	420,684	433,304	446,304	459,693
Total	**1,855,895**	**1,911,576**	**1,968,915**	**2,027,979**	**2,088,817**	**2,151,484**	**2,216,029**

1.1.5 Health Services

There are (3) three tiers of health service Daily round Primary, Secondary and Tertiary Healthcares. There are 167 Primary Health Care facilities. PHC is the responsibility of the LG. There are 37 secondary health facilities in the State, 22 cottage hospitals, 5 clinics (Government House, HAS, FSP, CSC). The HMB runs the secondary health facilities. There are 35 Private health clinic/hospitals. FMC Yenagoa and NDUTH Okolobiri are the 2 tertiary health care facilities. Melford Okilo Memorial Hospital 500 Bed Hospital and Cottage Hospital Opolo.

Table of indicators for Bayelsa State

INDICATORS	BAYELSA
Total population	1,704,515 (830,432 females; 874,083 males)
Under 5 years (20% of Total Pop)	212 613
Adolescents (10 – 24 years)	571 506
Women of child bearing age (15-49 years)	447 259
Literacy rate	72% female; 86% men
Households with improved source of drinking water	27 %
Households with improved sanitary facilities (not shared)	6 %
Households with electricity	51 %
Employment status (currently)	54.9% female, 68.4% male

TFR	5,8
Use of FP modern method by married women 15-49	8 %
ANC	35 %
Skilled attendants at birth	22 %
Delivery in HF	18 %
Full immunization coverage	20 %
Children that have not received any immunization (zero dose)	18 %
Stunting in Under 5 children	29 %
Wasting in Under 5 children	7 %
Diarrhea in children	3,2%
ITN ownership	7 %
ITN utilization	8% children, 10% pregnant women
Malaria treatment (any anti-malarial drug)	20% children, 4% pregnant women
Comprehensive knowledge of HIV	42% female, 69% men
Knowledge of TB	83.8% female, 98.1% male

CHAPTER 2 SITUATION ANALYSIS

2.1 Socio-economic context

Bayelsa State lies in the core of the Niger Delta, the largest wetland in the world.

Over 40% of Nigeria's on-shore crude oil is produced in Bayelsa State. Industries are very few, and social amenities are grossly inadequate. A high level of poverty is evident which caused underdevelopment and agitation from the people, mainly the youths. The exploration and exploitation of oil involves a number of activities that impact on the host communities and their occupation

2.2 Health status of the population

Communicable diseases are the most common cause of death, disability and illness in the State. The ten (10) most common diseases in order of magnitude are Malaria, Diarrhea, Measles, Pneumonia, Sexually Transmitted Infections, Tuberculosis, HIV/AIDS, Hepatitis, Neonatal Tetanus and Acute Flaccid Paralysis/Poliomyelitis.

HIV/AIDS 2008 National Sentinel Survey gave Bayelsa State 7.2% prevalence (up from 3.8% in 2005. Previous prevalence rates are 4.3% (1999), 7.2% (2001) 4.0% (2003).

The health indices of the State are as follows:

- IMR 114 deaths per 1000 live birth,
- Under 5 mortality Rate 200 deaths per 1,000
- Maternal Mortality Rate 918 deaths per 100,000 live birth.

2.3 Health Services Provision and Utilization

Health services are provided in three levels of Primary, Secondary and Tertiary. Registered primary health facilities are mainly operational in the State capitals. The bulk of the health services are provided by public health facilities. Public – Private partnership in healthcare Delivery is yet to take-off in the State. Only 170 health facilities are IDs Reporting, which there are 90 AFP focal sites.

Health interventions available in controlling and preventing communicable diseases are Expanded Programme on Immunization, HIV/AIDS control programme, Tuberculosis and Leprosy control, Integrated Disease Surveillance of the 500,000 requirement of ITN to cover 80% of vulnerable group only 119,000 ITNs are distributed. Expected annual requirement of ACT for under 5 is 1,724,493 but for now only 200,000 doses are received. Also of the

1,067,430 doses of SP for IPT, we have only 128,644 doses so far administered Ten (10) medical doctors one each from the LGAs, one from FMC and one from NDUTH have been trained as TOT on malaria case management. One hundred and ninety-two (192) health workers have been trained on IPT.

Midwifery Service Scheme is to be introduced in the State as part of IMNCH to reduce infant, newborn, child and maternal mortality. The MDG free medical service for pregnant women and under-five children is operational in the State starting with one LGA in each senatorial district, namely Brass (Bayelsa East), Southern Ijaw (Bayelsa Central) and Ekeremor (Bayelsa West).

There are inadequate STL, PMTCT, HCT, ARV and OVC care and support service points in the State.

Routine immunization coverage is below the national target of 80% for 2009 (74%). Bayelsa is one of the 25 states and FCT at risk for polio (with 4 WPV). The state therefore implements sub-National immunization Plus Days (SIPDs). There is no state inter-Agency Coordinating Committee or State Task Force on Immunization, also, the absence of a State Primary Health care Development Agency hinders the provision and utilization of health services at the Primary Health Care level.

Poor utilisation of health care services is an issue especially in the villages due to poverty, ignorance and wrong perceptions. As a result of poverty, most people are unable to pay for the cost of health services which also include travel cost to the health care centres.

In 2000 there was a re-organization of Health services in the State.

1. Hospitals Management Board was strengthened and encouraged to administer the hospitals.
2. Local Health Services Scheme (LHSS) created in the department of Primary Health Care and Disease Control to monitor and supervise the Health Centers.
3. Bayelsa Health Service Scheme (BHSS) was established in the Department of Medical Services in the year 2000.
4. Bayelsa Ambulance Service Established in the Department of Medical Services in 2000.

2.4 The Key issues and challenges as articulated below:

- Difficult geographical terrain and high cost of transportation
- Centralized control of approved health budget with non-release of some approved funds

- Weak linkages between health promotion units and programmes related parastatals
- Inadequate personnel at state and LGA levels
- Conflicting priorities between development partners and SMOH
- Weak collaboration between Federal, state and local government
- Poor ownership of health intervention programmes by LGAs and communities
- Inadequate distribution of health facilities and human resource
- A lot of dilapidated health facilities and obsolete equipment
- Lack of commitment by some contractors

CHAPTER 3: STRATEGIC HEALTH PRIORITIES

3.1 The Eight Strategic Health Priorities

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

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

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

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

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

Yellow fever immunization
Meningitis immunization
Vitamin A - supplementation for U5

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

3.2 Essential health service package

To provide package of essential care, the following will be considered:

To review, cost, disseminate and implement the minimum package of care in an integrated manner.

Firstly, examine and adopt a reviewed version of the minimum health care package and then, examine and adopt a costed document of the reviewed minimum health care package. Awareness will be created about the minimum health care package and copies made available to all stakeholders. We shall provide adequate manpower, materials and funds to the health facilities and set up units at the state and LGA levels to supervise and monitor the delivery of the minimum health care package in the facilities

To strengthen specific communicable and non communicable disease control programmes:
Do a situation analysis of the Epidemiology unit and other disease control units, Review manpower needs at the disease control unit and cover shortfalls, Provide adequate funds for regular training and retraining of manpower, Equip the disease control unit with materials Provide budget lines for field activities

To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels, Obtain copies of SOPs and guidelines from the Federal level, Organise trainings on SOPs and guidelines at State and LGA levels, Distribute copies of SOPs to all health facilities and units at State and LGA levels.

CHAPTER 4: RESOURCE REQUIREMENTS

At the inception of the State in 1996, there were 7 General Hospitals, and one other at the State Capital, Yenagoa being upgraded to a specialist (now Federal Medical Centre FMC).

Total hospital bed space in the State then was 382. There were 146 primary health care facilities. As at then, we had 38 doctors in the State service among whom were 2 dental surgeons, nine doctors were in specialist training in various institutions within and outside the country, 3 pharmacists, 283 nurses and a few other professionals.

Challenges:

- Absence of Health training institutions such as School of Nursing and Midwifery.
- College of Health Technology.

4.1. Physical Resources

Facility and Manpower survey was carried out. In August 1999 by the Ministry of Health with the broad objective of providing adequate information for the improvement of the health care delivery system in the State.

The expected output of the survey is to provide the basis for relevant Human Resources Development and mobilization of other resources for rehabilitation of existing health facilities, establishment of new ones, provision of basic equipment and implementation of health programmes in general.

4.1.1 INFRASTRUCTURES

In Bayelsa State there is inadequate distribution of Health Facilities While some LGAs have multiple numbers of tertiary, secondary and primary health facilities, few has no secondary health facilities that naturally makes access to health care in those LGAs very difficult. The recommended 5km walking distance from a health facility is a far fetched dream. Although there were no documentations, the feedback from the LGAs is that most of the health facilities are in deplorable conditions.

Distribution of Health Facilities as at 1999

PHC	=	144
Private Clinics	=	8
Secondary Health Facilities	=	11

Tertiary = 1

Each LGA had a minimum of one General or Cottage Hospital except one LGA (Kolokuma/Opokuma). All the registered private clinics were found to be located in Yenagoa the State Capital, the only specialist hospital was also located in Yenagoa.

4.1.2 Equipment and Transport

There is the need to carry out a baseline survey to update the information earlier generated by the HSDP II study conducted in 2005 on the status of equipment in health centres.

The provision of equipment and adequate transportation forms an integral part in the success of the health care delivery system. Human resources cannot function in isolation without the use of equipment playing a complementary role and vice versa.

In the fulfillment of the objective of the Bayelsa State Health Schemes, Having a functional transport unit or section will go a long way in reducing variations in the health status indicators in the Bayelsa State.

A list of functional, non-function both serviceable and non-serviceable are collated and a survey to be carried out to fill up the gaps and subsequently made provision for the procurement of more equipment to enhance the even distribution of such items to the all the health facilities and personnel that requires such.

4.2 Human Resources

4.2.2.14 State Health Manpower Situation 2009

Distribution by Cadre and Gender

S/N	Health Personnel Category	Total
1.	Specialist Doctors	95
2.	Medical Practitioners	160
3.	Dental Practitioners	
4.	Dental Technologists	
5.	Dental Surgical Technicians	
6.	Dental Surgical Assistants	
7.	Health Researchers	
8.	Nurses	539
9.	Nurses Midwives	385
10.	Specialist Nurses	

11.	Pharmacy Technicians	30
12.	Pharmacists	16
13.	Environ. Health Officers	
14.	Medical Lab. Technologists /Scientists	13
15.	Medical Lab. Technicians	30
16.	Medical Lab. Assistants	
17.	Statisticians/Health Records Officer.	1
18.	Radiographers	1
19.	Community Health Officers	
20.	Community Health Extension Workers.	
21.	Physiotherapists	2
22.	Dental Therapists	2
23.	Optometrists	
24.	TBAs	
25.	Health Educators	
26.	Epidemiologists	
27.	X-ray Technicians	5
28.	Physiotherapist Assistants	
29.	Medical Record Supervisors	
30.	Store Officers	13
31.	Pharm. Assistant	1
32.	Pharm. Attendants	3
33.	Dental Technologists	3

It is to be emphasized that the middle level manpower is relatively insufficient in the State to cover all PHC facilities adequately. There were only 10 midwives and 10 nurses to cover 144 PHC centers. This picture was applicable to other cadre of health workers.

Although a health policy exists and there are health training institutions in the State, the human resources requirement in Bayelsa State is grossly inadequate both in quality and quantity. The existing number of staff per population is far below the acceptable minimum standard, for example as at September 2009, doctor population ratio is 0.2/1000; while nurse population ratio is 0.42/1000. Health care delivery will be greatly hampered due to dearth of human resources.

CHAPTER FIVE: FINANCING PLAN

5.1 Strategy

The basic goal of the health financing domain is to ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and delivery in the State, including the LGAs.

In order to accomplish this lofty aim, several objectives are set for achievement. They include: (i) the development and implementation of Health financing strategies. ii) to ensure that people are protected from financial catastrophe. iii) to ensure adequate funding needed to meet the Health development goals. iv) to ensure efficiency and equity in the allocation and use of health sector resources.

These objectives can be achieved through several interrelated interventions and activities. Accordingly, a technical working group for Health financing will be constituted to develop and implement evidence based, costed State strategic health plan. There will be massive capacity building of officials to ensure smooth implementation of the plan. Capacities will also be developed in the area of proper recording and accounting of expenditures. All of these require a periodic production of timely and detailed financial management reports. A credible system will be put in place to increase financial transparency through the development of State health account (SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets.

To provide affordable and equitable access to quality health care delivery, sufficient budgetary allocation of financial resources will be given to Health. This will be through yearly increase in the percentage annual budgetary provision until the suggested 15% allocation to Health is achieved as advised by the special session of OAU heads of States held in Abuja in 2001.

In 2009 and 2008, a total of 7.8% and 5.4% respectively, of budgetary allocations in Bayelsa State were given to health which is about N14.5 billion and N10.3 billion respectively. Out of this about N4.9billion and N3.5billion respectively were for Recurrent expenditure (Over-head and Personnel) while N9.7 billion and N6.95 billion respectively were for capital expenditure. These figures are basically inadequate.

The challenge is how best to raise sufficient funds for health, how to pool them together to spread the financial risks of ill health, and how to ensure they are used effectively, efficiently, and equitably. Another important issue is proper recording and accounting of health expenditure. Government alone cannot provide funding for health; therefore all attempts will be made to expand collaboration with the private sector and other development and donor agencies.

5.2 Excisting schemes

Health care services in Bayelsa State are financed through a mixture of budgetary allocation from the state, federal and local governments. Another source is from private out-of –pocket expenditure from individuals and grants/aids from development agencies. Some basic contribution is coming from social insurance in the form of the Bayelsa State Medical Scheme. The National Health insurance scheme is not popular yet but those who work in federal institutions enjoy these funding for themselves and their families. Several other schemes and programmes on child and maternal health exist including special treatment programmes for Tuberculosis and Leprosy exist. The Bayelsa State Medical Scheme will be streamlined to integrate into the National health insurance scheme for better performance. Also, other social health protection models targeted at the poor and vulnerable groups will be integrated and enhanced for effectiveness and proper co-ordination. It is the focus of this plan to enhance the financial mix for more coordination and efficiency.

Bayelsa Health Service Scheme (BHSS) was replaced by Bayelsa Medicare Scheme (BMS) in the year 2008.

The Bayelsa Medicare Scheme (BMS) is positioned to pursue the execution of health and its related roles more purposefully, systematically, dynamically and efficiently. BMS is established under the premise of changing the general behavioural pattern of the people regarding Healthcare Financing BMS strongly feels that healthcare financing should be seen, accepted and treated as a collective social responsibility.

BMS believes that healthcare concerns of one man particularly in the area of financing should be the concerns of all and BMS is determined to impact on the health of all Bayelsans.

The main objectives of the Bayelsa Medicare scheme include:

1. To provide qualitative healthcare to the people
2. To administer an efficient and effective healthcare delivery system
3. To provide realistically affordable and accessible healthcare services.
4. To mobilize mass participation in appreciation of the cost-benefits
5. To show kindness in the process of provision of skilled care to the recipient.
6. To domesticate healthcare financing as a collective social responsibility.

5.3 Contributions

1. Contribution rates for State Government employees:

a. State Government pays equivalent of 3.5% of each employee's consolidated salary per-annum.

b. Each employee makes contribution of 1.75% the consolidated salary per annum of

c. State Government pays 10% of each employee's basic salary an equity contribution of 5% of the basic salary per annum.

2. Contribution rate for Local Government employees:

a. Local Government pays equivalent of 10% of each employee's basic salary per annum.

b. Each employee makes an equity contribution of 5% of the basic salary for annum.

3. Contribution rates for Political Office holders:

a. Government pays equivalent of 7.5% of each political officer's consolidated salary per annum.
b. Each political officer makes equity contribution of 7.5% of the consolidated salary per annum.

4. Contribution rate for the Tertiary Students in Bayelsa State institutions:

a) Students in all Bayelsa State Tertiary institutions in Bayelsa State shall contribute a flat rate N3,000 per annum payable with the school fees per session.

5. Contribution rates for the Organized Private Sector:

a. The employer pays equivalent of 3.5% of each employee's annual consolidated salary.
b. The employee makes equity contribution of 1.75% of the annual consolidated salary or
c. The employer pays equivalent of 10% of each employee's annual basic salary.
d. The employee makes equity contribution of 5% of the annual basic salary.

6. Contribution from urban information sector

a. N12,000.00 per individual per annum
b. N36,000.00 per family per annum (maximum family size = 6)

7. Contribution rates for the Rural Sector:

a. N6,000 per individual per annum
b. N18,000 per family per annum (maximum family size =6)

8. a. Donor agencies can donate to the programme.

b. Multinational organization (oil exploration, construction and servicing) shall pay premium for communities in areas of operation.

c. A deduction of 10% will be deducted from all contracts awarded by the Bayelsa State Government for the execution of the programme.

The Bayelsa Emergency Medical Scheme (BEMS) was introduced in line with the Bayelsa Health Service Scheme in the year 2000. It was known as Bayelsa Ambulance Service (BASS). It is still operational in order to achieve the Government's objective of providing a function and pragmatic healthcare delivery to all the citizens in Bayelsa State.

The activities of BEMS include:-

1. Highway coverage: This is the provision of 1st line treatment and evacuation of accident victims on roads and highways.
2. Home coverage: This is responding to medical emergency calls from homes.
3. Disaster Management: It co-ordinates emergency medical care in disaster situation, providing personnel and equipment, working with NGO's and voluntary aid agencies and other responders to provide medical and other support.
4. Mobile Clinic Services: This is provided when required.
5. Transport of referred cases: The BEMS provides comfortable inter-hospital care for patients referred for diagnoses or treatment.
6. Provision of training and public enlightenment in emergency response and management: The BEM organizes and conducts training workshops, seminars and talks geared towards increasing skills and general awareness of emergency response and management.

The main target of the BEMs is to achieve state-wide Medical Emergency Services coverage.

5.5 Estimated Cost of the Strategic Orientations

There are eight major strategic health priorities adopted in the State Strategic Health Development Plan (SSHDP) as follows:

i) Leadership and Governance for Health
ii) Health Services Delivery
iii) Human Resources for Health
iv) Health Financing
v) National Health Information System
vi) Community Participation and Ownership

vii) Partnership for Health
viii) Research for Health

These priority areas involve activities and interventions that require adequate financing. The Bayelsa State annual budget takes care of most of the identification of sources of funds, estimates and real expenditures required for these activities be it from Government, Donor agencies or Social insurance. The budget does not capture individual out-of-pocket expenses in health even though this is an important aspect of financing for health due to non-effective mechanism of social pooling of cost in form of social insurance and security for health.

The sources of financing for health in Bayelsa State primarily, is the Ministry of Finance, Local Government, donors, households etc. Significantly, the Ministry of Finance is the organ of government that handles all State budgetary provisions and funding by State government for the health sector. The Government is a major funder. By Government, we mean the State and Local Governments. The local government has a separate line of income from the State as it has its own allocation from the national just as the State. Households in Bayelsa State fund their own Health needs in the absence of Social Health Security. Donor Agencies like UNICEF, World Health, World Bank, European Union have funded different aspects of Health and are a good source of Health financing even though documentation about their real expenditure is very incomplete.

The details of the estimated cost of the strategic orientations based on the budgetary allocations will be discussed below.

5.6 Assessment of the available and projected fund

The budgetary allocations to health for the past three years from 2007, 2008 and 2009 are 11.9 billion. 15.9 billion and 14.1 billion respectively. These allocations represent 5%, 5.25% and 7.6% of the total annual budgets for the years under review. The indication is a gradual increase in the percentage provision for health as a total of the annual budget. This is still less than the 15% recommendation by the African leaders in a special session of OAU held in Abuja in 2001.

The total health expenditure provision per capital per annum is 0.8 for 2007, 0.7 for 2008 and 0.6 for 2009. It shows that 80% of budgetary allocation to Health in 2007 was for capital expenditure. It declined to 70% in 2008 and finally plummeted to 60% in 2009. Other budgetary trend for salary and overheads (Recurrent) and for Drugs, pharmaceuticals and medical consumables is as below:

Budget Item	***2009***	***2008***	***2007***
Salary	1,977,890,141.00	1,900,700,111.00	1,900,338,321.00
Overheads	309,953,000.00	453,420,134.00	400,362,840.00

Drugs/Pharmaceuticals and medical consumables	650,000,000.00	950, 000,000.00	750,000,000.00

Training and capacity building of health staff and personnel is also a major cost item. About 69.82 million naira was provided for capacity development of doctors and other health professionals in 2009. In 2007 and 2008, about 60million and 45million respectively was expended for training and capacity development of health staff.

External Funding

Donor agencies also contribute to health financing in Bayelsa State. They include WHO, World Bank, UNICEF, GLRA and other International and local NGOs and CSOs. In 2008 and 2007 UNICEF contributed NGN24,000,000.00 each. GLRA contributed N2, 872,800.00 for each of 2008 and 2007. The World Bank through the Health System Development Fund contributed about N425,000,000.00 in 2006 and 2007. Apart from the incomplete nature of these records, there are other agencies and NGOs that have contributed to health that are not captured in the record for health financing data.

5.7 Financing Gap

There are many inadequacies in the funding for health. The percentage allocation to Health is insufficient as it is still below 15% of total budget allocation for the State. The poor and needy deserve real assistance. Such help could come from social security and health insurance which are not popular yet in the State. The need exist for special provision for some special diseases like AIDS, TB, Leprosy etc which are currently been subsidized with assistance from foreign agencies and governments. The government needs to start preparing to take over from these agencies as they will not be here forever.

Several agencies of government do health activities but these are not captured in the annual budgets for health as health activity. It is important that these should be captured when

calculating health financial data. For instance all activities of the Environmental Sanitation Authority promote health and sanitation but their budget is treated outside Ministry of Health budgetary provisions and expenditures. Also some activities of the Ministry of Environment and are health related but are not always captured when health expenditure data is calculated.

Other donor agencies also contribute significantly to health infrastructure and development but are not captured. The following are instances:

- The European Union funded MPP3 Project in Bayelsa State implemented several health infrastructure projects including the construction of health centres from 2002 – 2006 and spent over 60million naira but it is not captured anywhere in the State Health data.
- Also, the Local Empowerment and Environmental Management Project (LEEMP) funded by the World Bank also did some health infrastructure from 2003 -2007 but are not captured.

5.8 Suggestions for bridging the gap

The issue of social security and health insurance is a very important mechanism to assist the needy and also special diseases like TB, AIDS, leprosy etc. This is a pooling together of funds from minor contributions making it really available to those in needs at cheap and accessible cost.

The establishment of the State Health Account (SHA) should be given priority. They will work in conjunction with the National Heath Account (NHA). It is there responsibility to ensure a thorough account and documentation of all expenditures and revenue in the health sector. This information is extremely useful for planning.

The State Strategic Health plan when fully operational will also help to bridge some of these gaps.

CHAPTER SIX: IMPLEMENTATION FRAMEWORK

The Federal ministry of health, State ministry of health, Parastatals under the Federal and state ministry of Health, Local Government Health Departments, development partners and civil society organizations, communities and individuals will be involved in the implementation of the plan, just as they participate in the planning.

The State Health System is organized into tertiary, secondary and primary health care levels. The Federal Ministry of Health runs the Federal Medical Centre, Yenagoa, while the State Tertiary Health institution is the Niger Delta University Teaching Hospital, Okolobiri (temporary site). The State Hospitals management Board is addled with responsibility of managing the secondary care services. Three health human resource training institutions are the School of Nursing Tombia, College of Health Technology, Ogbia Town, and the Niger Deta University College of Health Sciences and (NDUTH.). State School of Midwifery is proposed.

Strategic Partners are:

a. UN Agencies
    i. World Health Organization (WHO) in the areas of technical assistance control, integrated disease Surveillance and Response, Polio Eradication Initiative.
    ii. United Nations children Fund (UNICEF) – in EPI, Safe Motherhood, Roll Back Malaria, HIV/AIDS and Nutrition and Early Care.
    iii. World Bank Assisted – HSDP and HIV/AIDS Control.

b. Bilateral Agencies and Non-Governmental Organizations:
    i. Africare – in malaria control
    ii. PPFN in Reproductive Health
    iii. MSF I n EPI, Epidemic Control and primary health care development.
    iv. German Tuberculosis and Leprosy Relief Association (GLRA) – in TB and Leprosy control
    v. Rotary International – Polio eradication
    vi. Red Cross – Emergency Response.
    vii. CHAN – Roll back Malaria
    viii. Yakubu Gowon Centre – Roll Back malaria
    ix. FHI/GHAN – HIV/AIDS Programme in FMC, Okoloibiri, Sagbama.

c. Private Sector:
    i. Shell Petroleum Development Company of Nigeria (SPDC) Running of some hospitals
    ii. Nigeria Agip Oil Company (NAOC) – Supports in HIV/AIDS programmes.

d. Others:
    i. Global Fund for HIV/AIDS, Tuberculosis and malaria through other recipients such as GLRA, Yakubu Gowon Centre and CHAN.
    ii. Brass LNG
    iii. Chevron
    iv. NDDC
    v. MDG – NHIS – for free treatment of pregnant women and children under 5 years of age.
    vi. NPHCDA (Federal Ministry of Health) – Developemnt of primary healthcare through construction of model health centres, equipment, drugs supply, capacity building and personnel.

The State is collaborating with the NPHCDA in implementing the Ward Health System, Ward Development Committees (WDCs) are being formed. Referrals are made from the PHC centres to the secondary health facilities, and then to the tertiary hospital, thus ensuring a continuum of care.

Engagement of private partners in the running of health facilities and services being considered as part of he State Public Private Partnership (PPP) policy.

Line Ministries (and their parastatals0 involved in implementation are Education, Gender and Social Development (Women Affairs), information and Water Resources.

To ensure sustainability and community ownership, the community will participate in the implementation. There is going to be Local Government Primary Health Care Authority for each Local Government Area in the State Primary Health Care Development Agency bill.

CHAPTER 7: MONITORING AND EVALUATION

7.1 Proposed Mechanism for Monitoring and Evaluation

This is a systematic process of collection and analysis of data to track project implementation and use of the information in project management and decision making. **Evaluation** on the other hand is a systematic process of collecting and analyzing information to assess the *effectiveness* of the programme organization in the achievement of its stated goals.

7.2 Supervision, Monitoring and Evaluation

The Department of Planning, Research and Statistics of the State Ministry of Health will be at the helm of affairs in the Monitoring framework. The structure of the DPRS provides for a M&E unit headed by a deputy director, The unit will work with the State Technical Team on the **Strategic Plan to :**

(i) Institute effective supervision of the implementation of operational plans in the state and LGA to ensure that planned activities are properly implemented;
(ii) Establish/strengthen monitoring and evaluation systems to track progress and changes, as well as correct negative practices or gaps in service availability, coverage, human resources, financing, information systems, and leadership and governance;
(iii) Examine the functionality and adequacy of monitoring and evaluation systems through the completeness, regularity and quality of reports as well as the level of use in improving the performance of local health systems;
(iv) To assist the LGAs to develop monitoring frameworks based on set targets, using coverage and other performance indicators to clarify type of data, sources, analysis and periodicity of review
(v) Data should be disaggregated by geography, gender, age and income level for targeting those in greatest need
(vi) Each level of service within the LGA health system should have a role and responsibility in monitoring and evaluation of their plans;
(vii) The LGAHMT should take the overall responsibility to guide and provide support to lower levels to undertake their monitoring and evaluation activities; and
(viii) The health facility staff and/or community health workers should provide support to communities in monitoring activities undertaken at community level.

7.3 Monitoring and Evaluation Component

The monitoring and evaluation indicators for each priority Area shall include the following:

7.3.1 Domain 1: Leadership and Governance for Health:

- the adoption by the State Executive Council of reviewed, updated and harmonized National health policy;
- the passage by the State Assembly of a State Health Act;
- the degree of deployment of ICTs in the functions and processes of the State Ministry of Health and;
- the preparation and implementation of a 5-year Strategic Plan by the SMOH (% of activities developed and implemented)

7.3.2 Domain 2: Health Service Delivery:

- proportion of primary health facilities offering the guaranteed minimum package of services in the state;
- percentage of children 12 – 23 months fully immunized;
- proportion of the population living within 5km from a health facility;
- number of basic and comprehensive essential Obstetric Care (EOC) facilities available per 500,000 population, and their geographical spread;
- incidence and prevalence of malaria;
- proportion of pregnant women attended by skilled attendants at delivery;
- proportion of Under – 5 children that are malnourished

7.3.3 Domain 3: Human Resources for Health:

- adequacy of skilled health personnel and managers as stipulated in guidelines
- adoption of the World Health Organisation standard spread of health professionals to number of patients.
- establishment of one human resource unit in the State Ministry Health and LGAs Headquarters.
- proportion of admissions into the training institutions without lowering standards.
- yearly evaluation and assessment of staff on employment to ensure that productively aligns with job description and specification

7.3.4 Domain 4: Health Financing

- availability of State Health Account;

- adequacy of skilled health personnel and managers as stipulated in guidelines;
- annual audited financial accounts of health institutions in the state;
- physical and functional state of infrastructure and equipment;
- percentage of facilities conforming to human resource guidelines;
- number of financing and service provision embraced by the private sector

7.3.5 Domain 5: National Health Information System

- Proportion of LGAs developing health plans based on HMIS
- Proportion of suspected disease outbreaks promptly
- Proportion of LGAs with electronic/voice/data communication networks (EVDCN) system
- Percentage of LGAs with HMIS/M&E plan
- Percentage of required personnel trained in the NHMIS processes
- Percentage of LGAs implementing HMIS quality assurance (QA) supervision
- Percentage of private health providers participating in the NHMIS
- Percentage of LGAs with NHMIS operational manuals

7.3.6 Domain 6: Community Participation and Ownership

- the legislature and usage of a Community Health Charter document
- the percentage (%) of consumers and communities with increased knowledge of their rights and responsibilities in healthcare;
- percentage (%) of communities involved as co-owners and co-financiers of healthcare;
- the production and approval of a guaranteed Minimum Health Package document;
- the availability and usage of community-focused communication framework

7.3.7 Domain 7: Partnerships for Health

- establishment of a sector-wide mechanism for coordinating foreign donor and NGO activities;
- legislations and guidelines for promoting traditional medicine in the state;

- integrated referral system;
- policy and guidelines on a public/private partnership in the health sector;
- output/outcome-based contractors with private health facilities for the provision of specific public health services;
- sustain consultations with development partners, agencies, other ministries and the private sector and;
- collaborative human resources development activities for health.

7.3.8 Domain 8: Research for Health

- Percentage of employees covered in the formal sector by Health insurance Scheme
- Percentage of health facilities in the LGA equipped to offer dental/oral health services
- Percentage of health facilities in the LGA equipped to offer Mental health services
- Percentage of schools in LGAs with health services
- Percentage of health facilities by states /LGAs that provide essential laboratory services
- Percentage of trained laboratory workers
- Proportion of patients sent for laboratory investigation

CHAPTER 8: CONCLUSION

The National framework is based on the principles of the four Ones: one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. It would create an avenue for ownership, resource mobilization/allocation and accountability by all stakeholders (government, development partners, civil society private sector, communities, etc).

The process of pulling together this strategic health plan has shown the urgent need for strategic interventions in the health sector in Bayelsa State considering the available indices. The State is listed as one of the 25 States in the Federation at risk for polio with the isolation of wild polio virus. The maternal mortality rate of 918 deaths per 100,000 and infant mortality rate of 114 deaths per1000 live births are higher than the national average. In view of the above, there is the need for an urgent attention to resuscitate the health sector and give it a new positive direction.

The Bayelsa Health Service Scheme (BHSS) targets the pregnant women and children under 5 years which addresses some of the health MDGs. While we commend the concept of the BHSS, however, this scheme needs to be strengthened, expanded and sustained if it is to meet its desired goal.

It is obvious that if this national framework is adopted and religiously implemented with the identified interventions, the State shall be able close the policy gaps and improve the performance of the health sector towards the delivery of quality, efficient and sustainable health care for all Bayelsans

Annex 1: Details of Bayelsa State Strategic Health Development Plan

BAYELSA STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
Priority Area						
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						**857,775,788**
	1.1	**To provide clear policy directions for health development**		**All stakeholders are informed regarding health development policy directives by 2011**		857,775,788
		1.1.1	Improved Strategic Planning at Federal and State levels	No of startegic meetings held in the state and LGAs		857,775,788
			1.1.1.1 Re-oreintation and strengthening of the human resource capacities	No of trainings on capacity dev and personnel employed	Acceptance and implementation of the new National Health Policy by key stakeholders	853,508,247
			1.1.1.2 Increase emphasis on effective implementation of agreed plans	50% of lGA stakeholders in agreement	cooperation of all stakeholders	2,845,027
			1.1.1.3 Carry out advocacy at State and LGA level in support of policy development and implementation	Advocay carried out to 50% of LGA	Availability of required inputs and resources	-
			1.1.1.4 Support State and LGAs in the development of evidence-based, costed, and prioritised strategic health plans for the sector	50% of LGAs develop costed plan	Availability of funds	-
			1.1.1.5 Undertake strategic health plans in such a way as to optimize the contribution of the wider stakeholders at each level	No. of stakeholders meeting at LGAs level	cooperation of all stakeholders	-
	1.2	**To facilitate legislation and a regulatory framework for health development**		**Health Bill signed into law by end of 2009**		-
		1.2.1	Strengthen regulatory functions of government	Strategic policies developed and passed into law		-
			1.2.1.1 Develop public/private partnership policies in line with the national policy on PPP	state PP policy developed	Adoption and implementation of relevant policy and	-

						legislative instruments	
			1.2.1.2	Offer LGAs opportunities for technical support on implementation of their strategic plans	50% 0f LGAs implements startegic plans	cooperation of all stakeholders	-
			1.2.1.3	Strengthen regulatory function of government, and monitor and deliver agreed quality standards	No of monitoring teams that vist the LGAs	Political will	-
			1.2.1.4	Collaborate with the private sector to improve their health delivery system	50% 0f private sector are impelemting SSHP	cooperation of all stakeholders	-
			1.2.1.5	Strengthen regulatory framework through legislation	SSHP made a state policy	Political will & Cooperation of all stakeholders	-
		1.2.2			SSHP made a state policy		-
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		-
		1.3.1	To improve accountability and transparency				-
			1.3.1.1	Institute stakeholders' dialogue and feedback forum in the state & LGAs for enlisting input into health sector decision making	No of stakeholders dialogue held	Adoption and implementation of relevant policy and legislative instruments	-
			1.3.1.2	Create platforms for interaction and collaboration with health sector advocacy groups	No health sector advocacy grps	cooperation of all stakeholders	-
			1.3.1.3	Empower beneficiary communities through sensitization to manage and oversee their health projects and programmes	No of sensitization meetings	Adoption and implementation of relevant policy and legislative instruments	-
			1.3.1.4	Promote emergence of independent health sector 'watch dogs'	No of watch dogs asssigned to Bayelsa State	cooperation of all stakeholders	-
			1.3.1.5	Improve access to information required for yearly joint review of the health sector	50% 0f LGA have access to information	cooperation of all stakeholders	-
	1.4	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	-

		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				-
			1.4.1.1	Deepen and expand the analytical work at both State and LGA levels	50% of LGAs involvement	Availability of funds	-
			1.4.1.2	Outsource areas for further analytical work to Universities, private sector research firms and research institutes		cooperation of all stakeholders	-
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**65,425,307,665**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		65,425,307,665
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		(i)Essential Package of Care adopted by all LGAs by end 2011, (ii) Essential Package of Care adopted by 60% of health facilities by end 2011		65,425,307,665
			2.1.1.1	Examine and adopt a reviewed version of the minimum health care package		**support of relevant agencies, including international, Federal and state agencies, to the PHC system**	38,137,365,272
			2.1.1.2	Examine and adopt a costed document of the reviewed minimum health care package		**support of relevant agencies, including international, Federal and state agencies, to the PHC system**	24,657,779,265
			2.1.1.3	create awareness about the minimum health care package and make copies available to all stakeholders		**Political will & Cooperation of all stakeholders**	2,630,163,122
			2.1.1.4	provide adequate manpower, materials and funds to the health facilities and set up units at the state and LGA levels to supervise and monitor the delivery of the minimum health care package at the facilities		**LGAs would give necessary political and financial support to PHC system**	-
			2.1.1.5				-
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		(i) Timeliness and completeness of IDSR reports >80%. (ii) > 80% Timeliness of response to control		-

					outbreaks by end 2011		
			2.1.2.1	Do a situation analysis of the Epidemiology unit and other disease control units		**Effectiveness of selected interventions**	-
			2.1.2.2	Review manpower needs at the disease control unit and cover shortfalls			-
			2.1.2.3	Provide adequate funds for regular training and retraining of manpower		**Availabiliity of required resources**	-
			2.1.2.4	Equip the disease control unit with materials			-
			2.1.2.5	Provide budget lines for field activities		**Political will**	-
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels		SOPs and Guidelines available in every health facility (100%) by end 2011		-
			2.1.3.1	Obtain copies of SOPs and guidelines from the Federal level		**Governments commitment and political will to ensure availability of materials and implentation of programme and project**	-
			2.1.3.2	Organise trainings on SOPs and guidelines at State and LGA levels		**Availability of funds**	-
			2.1.3.3	Distribute copies of SOPs to all health facilities and units at State and LGA levels			-
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		-
		2.2.1	To improve geographical equity and access to health services		50% of the population is within 30mins walk or canoe pulling or 5km of a health service by end 2011		-
			2.2.1.1	Map the distribution of health faclities and services and identify gaps		**Governments commitment and political will**	-
			2.2.1.2	Establishing GIS for all health facilities in the State		**Availability of funds**	-
			2.2.1.3	Construct health facilities within five km or 30 minutes walking or canoe pulling distance of every community		**Political will**	-
			2.2.1.4	Refurbish and upgrade all substandard health facilities		**Political will**	-

		2.2.2	To ensure availability of drugs and equipment at all levels		Functional drug revolving fund scheme to be in place in 50% health facilities by end 2011, 50% of health facilities to have 100% equipment in equipment list by end 2011		-
			2.2.2.1	Take an inventory of drugs and equipment in all health facilities and identify shortfalls		**Political will to ensure availability of materials and implentation of programme and project**	-
			2.2.2.2	Establish a revolving drug scheme in all health facilities with reference to the essential drug list		**commitment by all stakeholders**	-
			2.2.2.3	Establish an equipment list for all health facilities in line with the essential package. and procure and distribute to all health facilities according to need.		**Political commitment at all levels**	-
			2.2.2.4	Procure and distribute equipment to all health facilities based on need and level of care.		**Financial and other resources would be available on timely basis and well utilised**	-
		2.2.3	To establish a system for the maintenance of equipment at all levels		100% of equipment to be functional in 50% of health facilities by end 2011		-
			2.2.3.1	Disseminate and implement the National Health Equipment Policy in all health facilities.		**Political commitment at all levels**	-
			2.2.3.2	Create budget lines for the for the maintenance of equipment and furniture in every health facility in the State.		**Financial and other resources would be available on timely basis and well utilised**	-
			2.2.3.3	Establish medical equipment and hospital furniture maintenance workshops across the State		Availability of funds	-
			2.2.3.4	Identify and engage Partners in the private sector for maintenance of medical equipment and hospital furniture.		Political will & Cooperation of all stakeholders	-
		2.2.4	To strengthen referral system		50% of cases refered in time to appropriate health facilities by end 2011		-
			2.2.4.1	Identify network linkages for two-way referral system.		**LGAs would give necessary political and financial support to PHC system**	-

			2.2.4.2	Obtain and implement guidelines for referral of all cases such as emergency obstetric care, complicated malaria, road traffic accidents, etc;		**commitment by all stakeholders**	-
			2.2.4.3	Hold advocacy meetings with care providers and other stakeholders at the community level and agree on shared responsibilities		**Cooperation of all stakeholders &Commitment**	-
			2.2.4.4	Provide communication and ambulance vehicles to facilities and make other arrangements with community and transporters to move patients.		**Facilities would be provided with relevant human and financial resources**	-
			2.2.4.5	Set up reporting system for referrals			-
		2.2.5	To foster collaboration with the private sector		50% health facilities in the State collaborating with State to deliver health services.		-
			2.2.5.1	Map all categories of private health care providers by operational level and location		**Political will**	-
			2.2.5.2	Develop guidelines and standards for regulation of their practice and their registration.		**commitment by all stakeholders**	-
			2.2.5.3	Develop guidelines for partnership, training and outsourcing of services for private health care providers.		**commitment by all stakeholders**	-
			2.2.5.4	Develop and utilise checklists to monitor performance of private and public health facilities.		**commitment by all stakeholders**	-
			2.2.5.5	Adapt and implement the national policy on traditional medicine at all levels		**commitment by all stakeholders**	-
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		-
		2.3.1	To strengthen professional regulatory bodies and institutions		50% professional regulatory bodies accomodated in State with funds provided		-
			2.3.1.1	Review, and update operational guidelines of all regulatory bodies at State and LGA levels		Government's commitment and political will	-
			2.3.1.2	Implement operational guidelines of all regulatory bodies at State and LGA levels		commitment by all stakeholders	-
			2.3.1.3	Build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines.		commitment by all stakeholders	-
			2.3.1.4	Create Budget lines and necessary resources for the regulatory unit.		Political will	-

			2.3.1.5	Implement regular monitoring exercises with appropriate documentation and strengten feedback		Availability of funds	-
		2.3.2	To develop and institutionalise quality assurance models		State and 50% LGAs having effective quality assurance units		-
			2.3.2.1	Review and strengthen quality assurance unit		Political will	-
			2.3.2.2	Develop quality assurance training modules to build capacity of both public and private health care providers		Attitude of staff would be positive and responsive to client's needs	-
			2.3.2.3	Conduct training of trainers (TOT) and cascade to other health workers in the State and LGAs		Availability of funds	-
			2.3.2.4	Implement quality assurance and improvement initiatives at State and LGA levels		commitment by all stakeholders	-
			2.3.2.5	Develop SERVICOM guidelines, to build institutional capacity and train staff for its implementation at State and LGA levels		people will would use provided facilities and service	-
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		State and 50% LGAs have data on Integrated Supportive supervision		-
			2.3.3.1	Conduct trainings on team building and leadership development programmes		Government's commitment and political will	-
			2.3.3.2	Draw up schedule for comprehensive ISS at State and LGA levels		Availability of funds	-
			2.3.3.3	Conduct trainings to develop capacities of programme managers at all State and LGA levels on the ISS mechanism		Commitment	-
			2.3.3.4	Develop ISS tools and guidelines specifying modalities and frequencies of the ISS visits at State and LGA levels		Commitment	-
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		-
		2.4.1	To create effective demand for services		Average demand rises to 2 visits per person per annum by end 2011		-
			2.4.1.1	Provide budget lines for health promotion through Behavioural Change Communication at State and LGA levels		Government's commitment and political will	-
			2.4.1.2	Put in place a programme monitoring and evaluation system. Assign and train four officers for the monitoring and evaluation unit.		Availability of funds & commitment	-
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and**		-

					quantified by end 2010 2. Vulnerable people access services free by end 2015		
		2.5.1	To improve financial access especially for the vulnerable groups				-
			2.5.1.1	Set up pre payment schemes		Government's commitment and political will	-
			2.5.1.2	Scale up existing financial protection schemes.		Commitment	-
			2.5.1.3	Set up exemption schemes vouchers, and health cards.		Commitment	-
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							**35,532,083,208**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		-
		3.1.1	To develop and institutionalize the Human Resources Policy framework				-
			3.1.1.1	Domesticate national human resource policy	Increase in the different number of health professionals from what we have.	Delay in release of funds for field survey.	-
			3.1.1.2	Develop strategic plan to guide human resource development		Change of govt. may affect state health policy.	-
			3.1.1.3	Updating of and or recruitment and training of health personnel.		Lack of funds.	-
			3.1.1.4	Develop a policy framework to guide existence of private and public practitioners at all levels of health service delivery	Adoption of the World Health Organisation standard spread of health professionals to number of patients.	Lack of trust on both sides.	-
			3.1.1.5	Establish a fora for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks		Poor co-ordination and management of outcomes of meetings.	-
	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 and stream line career pathways for all groups of health professionals.		Lack of capacity to develop strategies for a frame work for career pathways.	-
			3.2.1.2	Develop, introduce and utilize staffing norms based on workload.		Lack of team spirit.	-
			3.2.1.3	Establish and co-ordinate mechenism for consistency in human resource of health planning and budgeting.	Keying into and adopting the National Human Resource for Health Policy.	Administrative interferance	-
			3.2.1.4	Review the entry criteria and admission quota in the training institutions.	Increase in the percentage of admissions in the training institutions without lowering standards.	Disagreement on strategy to adopt.	-
			3.2.1.5	Strengthen State and LGA capacities to access and implement federal government circulars, guidelines and policies related to HRH		Inability to articulate technical issues in govt circulars.	-
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		-
		3.3.1	Establish and strengthen the HRH Units				-
			3.3.1.1	Create human resources units .	Establishing one human resource unit in the state ministry of health and encourage same in headquarter of each local government area.	Absence of a robust training plan.	-
			3.3.1.2	Strengthen human resource units.	Equiping and placing a desk-officer in each unit.	Lack of funds.	-

			3.3.1.3	Establish training programmes for health planning and management.	Preparation of harmonised training plan in line with the State Health Policies and Priorities.	Wrong choice of personnel for training.	-
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		-
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities				-
			3.4.1.1	Reviewing of training programmes in line with State health priorities		Misplaced priorities.	-
			3.4.1.2	Establish or expand training for community health workers and other cadres of supportive personnel		Lack of funds.	-
			3.4.1.3	Promote the national Midwives Service Scheme and the Community Midwifery Programme	10% Increase in output of Midwives in the next two years, subsequently 20% to the service both Community Midwifery programme and Midwives Service Scheme.	Lack of political will and funding.	-
			3.4.1.4	Review admission criteria for relevant disciplines in disadvantaged L.G.A.	10% deliberate increase of admission quota for disadvantaged local government areas.	Disagreement on the strategy to adopt.	-
			3.4.1.5	Strengthen adequate production of qualified health professionals through appropriate accreditation and regulatory bodies		Difficulty in getting institutions accredited	-
		3.4.2	Strengthen health workforce training capacity and output based on service demand				-
			3.4.2.1	Strengthen training institutions for the production of healthcare provider.	Securing accreditation by meeting required standards.	Paucity of educational materials.	-

			3.4.2.2	Upgrade teaching and learning materials and infrastructures.	Provision of teaching and learning materials and infrastructures.	Lack of funds.	-
			3.4.2.3	Strengthen Accreditation systems for training institutions to ensure professional standards of health personnel	Availability of funds	Lack of funds.	-
			3.4.2.4	Establish quality assurance and education review units in all training institutions.	Creation of an inspectoriate division to ensure standard		-
			3.4.2.5	Promote human capital capacity building and continuing professional development (CPD) and coordinate with professional regulatory bodies		cooperation of all stakeholders	-
	3.5	**To improve organizational and performance-based management systems for human resources for health**					-
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				-
			3.5.1.1	Create data base of human resources of health.		Lack of viable data.	-
			3.5.1.2	Develop and provide job descriptions and specifications for all categories of health workers.	Yearly evaluation and assessment of staff on employment to ensure that productively aligns with job description and specification	Commitment	-
			3.5.1.3	Redeploy staff equitably between rural and urban areas in relation to needs and staff mix.		cooperation of all stakeholders	-
			3.5.1.4	Ensure mandatory rotation of health workers to unserved rural areas in the State.	Two yearly compulsory rural postings for all newly qualified professionals.		-
			3.5.1.5	Establish safety standards in workplaces.	Annual routine medical examination for all health workers	commitment	-
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				-
			3.5.2.1	Training and retraining of health workforce on attitudinal change and interpersonal communication skill and work ethics.	No. of trainings held	availability of funds	-
			3.5.2.2	Institute system of recognition, reward and sanctions			-
			3.5.2.3	Establish mechanisms to monitor health worker performance, including use of client feedback (exit interviews)	No of monitoring teams that visit state and LGAs	availability of resources	-

	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		-
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				-
			3.6.1.1	To establish effective dialogue and complaints channels between management and staff of public and private sectors		Lack of monitoring mechanism.	-
			3.6.1.2	To constitute a service monitoring team of workers and professionals to ensure co-orperation.			-
			3.6.1.3	To involve workers and professional groups in management teams	Quaterly interactive sessions with clients to assess health workers performance.	cooperation of all stakeholders	-
			3.6.1.4	To design and monitor services to enhance cooperation amongst all actors			-
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							**9,629,155,927**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		**9,629,155,927**
		4.1.1	Strategic Health Financing Plans				**9,629,155,927**
			4.1.1.1	Set up a technical working group for Health financing in Bayelsa State	TWG inaugurated & meetings held	The costed Health plan may be defeated by inflation and incorrect data	**9,629,155,927**
			4.1.1.2	Build capacity for the development and implementation of the Strategic Health Plan			-
			4.1.1.3	Develop evidence based, costed State Strategic Health Plan	Strategic health plan developed and costed	Commitment	-
			4.1.1.4	Implement the strategic Health Plan	No. of activities carried out	Availability of resources	-
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		-
		4.2.1	To strengthen systems for financial risk health protection				-
			4.2.1.1	To request and receive technical support to explore existing and innovative social health protection approaches			-

			4.2.1.2	To explore existing and innovative social health protection approaches - social health insurance, other prepaid schemes, community based health insurance schemes etc	Report of Survey of existing health schemes available.	Commitment	-
			4.2.1.3	To request and receive technical support to rapidly scale up successful health approaches to achieve wider population coverage.		cooperation of all stakeholders	-
			4.2.1.4	To scale up successful Health approaches to achieve wider population coverage	increased coverage health insurance scheme	cooperation of all stakeholders	-
			4.2.1.5	Review and suggest amendment of current NHIS laws to strengthen its regulatory authority	NHIS Laws reviewed & published	Political Will & Commitment	-
	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**		-
		4.3.1	To improve financing of the Health Sector				-
			4.3.1.1	To put in place mechanisms for the state to increase the allocation of public resources to the health sector (apportion 15% of total budget on health)	15% of annual budget is allocated to health	Approval & funding by Government	-
			4.3.1.2	To request and receive support to test and implement strategies for attracting alternative financial flows to the health sector and to share lessons learnt			-
			4.3.1.3	To establish alternative financial flow like pre-payment schemes, and health insurance schemes, grants from the Federal Government, proportion of Value Added Tax (VAT), “sin tax” from alcohol and cigarette and donations from corporations and charities			-
			4.3.1.4	To establish special funds for chronic and emerging diseases (e.g. mental health, cancers, diabetics etc.)	Availability of Health schemes dedicated to chronic and emerging diseases.	availability of funds	-
			4.3.1.5	To establish financing safety nets to protect the interests of the poor and vulnerable groups			-
		4.3.2	To improve coordination of donor funding mechanisms				-
			4.3.2.1	Conduct a detailed assessment of coordination structures and functions which exist in the State.		Cooperation of all stakeholders	-
			4.3.2.2	Establish appropriate models for more effective coordination in the State.			-
			4.3.2.3	Establish mechanisms for coordinating donor resources with that of government for health	Availability of common basket	cooperation of all stakeholders	-

				development in the form of common basket funding	funding for health		
			4.3.2.4	Promote the implementation of Paris declaration on aid effectiveness with a follow up of the Accra agenda			-
	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**		-
		4.4.1	To improve Health Budget execution, monitoring and reporting				-
			4.4.1.1	Receive technical assistance in developing costed, annual operational plans in the State and LGA		cooperation of all stakeholders	-
			4.4.1.2	Develop costed annual operational budget plans in the state	Existence of a costed operational budget plan	Commitment	-
			4.4.1.3	Build additional capacity to ensure that proper internal recording and accounting of expenditures are maintained			-
			4.4.1.4	Produce timely and detailed financial management reports periodically	Existence of periodic financial Management reports	Availability of resources	-
			4.4.1.5	Put credible mechanisms in place to increase financial transparency through the development of State Health Accounts (SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets	Existence of SHAs and PERs	Political Will & Commitment	-
		4.4.2	To strengthen financial management skills				-
			4.4.2.1	Conduct hands-on training and competency transfer to enable the State and LGAs manage their financial management systems	70% of coverage of health insurance scheme	Availability of resources	-
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care							**1,090,805,745**

	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**		-
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				-
			5.1.1.1	States and LGAs to make forms available by providing adequate budget and ensuring that funds are released for printing of the data collection forms	Amount released by state and LGAs for printing of data collection forms	**Availability of Funds**	-
			5.1.1.2	Distribute forms to appropriate facilities to ensure their utilisation	Number of forms distributed to facilities	**Availability of Funds**	-
			5.1.1.3	Produce six (6) months stock of forms	Six (6) months stock of forms produced	**Availability of Funds**	-
		5.1.2	To periodically review of NHMIS data collection forms				-
			5.1.2.1	Periodically review NHMIS data collection forms in consultation with all stakeholders	Number of reviews on the NHMIS forms with consultants	**Availability of Funds**	-
			5.1.2.2	States and LGAs health managers to create mechanisms to ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools and establish mechanisms for annual review	Feedback mechanisms created for annual review	commitment by all stakeholders	-
		5.1.3	To coordinate data collection from vertical programmes				-
			5.1.3.1	Revitalise the Health Data Consultative Committee at State level in collaboration with partners and other government agencies to streamline and strengthen data collection systems	**Number of HDCC meetings held in the state and minutes**	**commitment by all stakeholders**	-
			5.1.3.2				-
			5.1.3.3	Establish and strengthen linkages and harmonized data collection mechanism at State and LGA levels	**Data collection mechanism harmonized in both the state and LGA levels**	**commitment by all stakeholders**	-
		5.1.4	To build capacity of health workers for data management				-
			5.1.4.1	Conduct comprehensive training and re-training of service providers on data collection tools, analysis	Number/type of trainings	Availability of Funds	-

				and utilisation of data for action in health programming and policy formulation	conducted for service providers		
			5.1.4.2	Establish adequate monitoring systems at State and LGA levels to ensure data quality	Monitoring tool developed	Availability of Funds	-
			5.1.4.3	Undertake recruitment of health information personnel to support the system	Number of health information personnel recruited	Availability of Funds	-
		5.1.5	To provide a legal framework for activities of the NHMIS programme				-
			5.1.5.1	Enforce mechanism to sanction private care providers that fail to submit health data to the relevant health authorities in order to make data collection and utilisation mandatory	Number of private care providers sanctioned	**commitment by all stakeholders**	-
			5.1.5.2	Put additional legal framework for activities of the NHMIS programme in place at State and LGA levels	Additional legal framework for NHMIS activities put in place	**Political will& Commitment**	-
			5.1.5.3	Embark on a systemic advocacy to policy makers to make them understand the value and usefulness of data and promulgate an enabling law and bye laws to make it mandatory	Number of advocacy visits to policy makers to promulgate enabling laws and bye laws on data	**Political will& Commitment**	-
			5.1.5.4	The SMoH will spearhead advocacy both to the top government functionaries as well as State Assembly	Advocacy tours to State Assembly by speared by the SMoH	**Political will& Commitment**	-
			5.1.5.5	Strengthen the vital registration system in the state	ICT equipment provided	**Political will& Commitment**	-
		5.1.6	To improve coverage of data collection				-
			5.1.6.1	Improve state data collection process and coverage	60% of LGAs make returns to the state	cooperation of all stakeholders	-
			5.1.6.2	Encourage LGAs to develop innovative strategies to collect data from all public and private health facilities and improve the collection of community based data	Data collected from both the public and private health facilities improved	cooperation of all stakeholders	-
			5.1.6.3	Support the National Population Commission to strengthen vital statistics of birth and death registration both by the federal and state government	Support to NPC strengthened	commitment	-
			5.1.6.4	Setup adequate data collection tools and follow up on defaulting facilities	Data collection tools setup and followup on defaulting facilities ensured	Political Will & Commitment	-

		5.1.7	To ensure supportive supervision of data collection at all levels				-
			5.1.7.1	Ensure provision for adequate logistics for officials to supervise data collection at lower levels	Logistics provided for officials supervising data collection	Availability of funds & political will	-
	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	Promote decentralized software-based systems for data collection and analysis	Software-based data collection system decentralized	Availability of funds & commitment	-
			5.2.1.2	Establish public-private partnerships in the management of data warehouses	Public-Private partnership on data management warehouse established	cooperation of all stakeholders	-
			5.2.1.3	Establish mechanisms to enhance the wide use of e-health data, such as through electronic Management Intelligence Information System, websites, Patient information system, etc	e-health data mechanisms established	cooperation of all stakeholders	-
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				-
			5.2.2.1	Make adequate and timely availability of the NHMIS Minimum Package at state and LGA levels for data management	NHMIS minimum package made available in the state & LGAs	Availability of funds & commitment	-
			5.2.2.2	Provide basic infrastructure for data storage, analysis and transmission systems (computers, power supply, and internet)	Basic infrastructure for data storage provided	Availability of funds & commitment	-
			5.2.2.3	Ensure appropriate use of computer hardware systems and deploy acquisition systems for database software at all levels	Database sofware deployed to computer hardware systems	Availability of funds	-
			5.2.2.4	Build capacity of relevant staff on the database	Number/type of trainings conducted for database staff	Availability of funds & commitment	-
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010** **2. NHMIS**		-

					annually reviewed and new versions released		
		5.3.1	To strengthen the Hospital Information System				-
			5.3.1.1	SMoH to establish and strengthen patient information systems as well as systems for mapping disease	e-health data mechanisms established	Availbility of funds	-
		5.3.2	To strengthen the Disease Surveillance System				-
			5.3.2.1	The State and LGAs to ensure that regular reporting of notifiable diseases by all health facilities is carried out	Regular reporting of notifiable diseases ensured by health facilities in the state and LGAs	cooperation of all stakeholders	-
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		-
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				-
			5.4.1.1	To facilitate timely availability of logistics materials (vehicles or motorcycles) will be provided and use of NHMIS field monitoring instruments at all levels	Vehicles, Motocycles, etc provided for NHMIS field monitoring.	Availability of funds	-
			5.4.1.2	HIS Quality Assurance (QA) manual (Handbook) at each level of health care delivery	Name/number of facilities using the HIS Quality Assurance handbook	political will	-
			5.4.1.3	Institute quarterly HIS review meetings at LGA level, bi-annual review meetings at State level .	Number of HIS review meetings held at both the state and LGA level	Availability of funds	-
		5.4.2	To strengthen data transmission				-
			5.4.2.1	To build Institutional and human capacities for timely and complete transmission of data in line with relevant guidelines	Number/name of institutional and human capacities built	political will	-
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available**		-

					results regularly		
		5.5.1	To institutionalize data analysis and dissemination at all levels				-
			5.5.1.1	Strengthen institutional and human capacities for appropriate data analysis and dissemination of information and data to inform decision making and programming	Health institutions and human capacities strengthened	commitment by all stakeholders	-
			5.5.1.2	Institute production of periodic health data bulletin and annual reports by Departments of Planning Research and Statistic at the States level.	Number of health bulletins and annual reports produced	Availability of funds	-
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**367,510,668**
	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**		100,378,275
		6.1.1	To provide an enabling policy framework for community participation		A reviewed policy guideline of community participation on community development policy is made available to 50% communities in all the LGAs of the State by end 2012.		32,741,295
			6.1.1.1	Adoption of the revised community participation section of the National Health policy		commitment by all stakeholders	16,370,648
			6.1.1.2	Adoption of finalissed community participation development policy		the multiplicty of National health policy documents could make it cumbersome to produce	16,370,648
		6.1.2	To provide an enabling implementation framework and environment for community participation		1. updated and well-developed guidelines for the establishment of community development in health are adpoted and distributed to 60% of communities in		67,636,979

					all the LGAs of the state by 2011. 2. 65% of Intersectoral stakeholder's committees involving community representatives are established at state, LGAs and ward levels by 2012		
			6.1.2.1	Adopt and adapt existing guidelines for establishing community development		localising guildelines in the State could result to distortions of the existing national guildlines	24,405,593
			6.1.2.2	Adopt and utilise participatory tools and approaches to enhance community involvement in planning, management, monitoring and evaluation of health interventions		this will involve the consultation of many communities to know their existing participatory tools and approaches that are in use. Therefore, more resources would likely be involved.	22,135,515
			6.1.2.3	Establish inter-sectoral stakeholder committees involving community representatives at all levels so as to enhance collaboration		the selection of community representaives could be miss construed for opportunity for employment and therefore more sensitisation and education would be required at the community level	21,095,872
	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**		101,041,884
		6.2.1	To build capacity within communities to 'own' their health services		50% of communities with community development committes and community-		101,041,884

					based health providers in the State are participating in community level health care delivery services by 2013		
			6.2.1.1	Empower communities with health knowledge and capacity in management, implementation, as well as basic interpretation of health data		This will require the training of the communities in the various wards in all the LGAs, with an enlarged TOTs	19,435,981
			6.2.1.2	Define key roles and functions of community stakeholders and structures		cooperation of all stakeholders	26,028,019
			6.2.1.3	Develop, upgrade or modify existing participatory tools for mobilising communities in planning and management		Communities will be involved in the planning and development and upgrading of this document. Therefore, the random selection of communities could posse a lot of difficulties	19,435,981
			6.2.1.4	Orientate community development committees and community-based health care providers will be re-orientated on their roles and mobilize and allocate responsibilities and resources for funding for community level activities		the dearth of community-based health care providers in the communities would require the setting up of such committees before a successful orientaion	19,609,429
			6.2.1.5	Involved Communities at all levels in program planning, implementation and monitoring of health activities		continious training of community members is very necessary to actually involving thje m in program plaaing and implementation	16,532,474
	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**		64,058,935
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		**60% communities in the state are**		64,058,935

					participating in healthcare delivery services in the state by 2013		
			6.3.1.1	Assess the level of linkages of the existing health delivery structures within the community		community leaders would feel threatened that their positions could be conpromised with new developments thereby would refuse any colaboraation towards review and assessment of existing linkages	15,803,995
			6.3.1.2	Provide technical guidance and support to community stakeholders for the development of guidelines for strengthening the community-health services linkage		commitment by all stakeholders	15,918,471
			6.3.1.3	Restructure health delivery structures to ensure adequate promotion of community participation in health development			16,168,235
			6.3.1.4	Promote facilitation of exchange of experiences between community development committees		Cooperation of stakeholers	16,168,235
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		73,712,144
		6.4.1	Develop and implement multisectoral policies and actions that facilitate community involvement in health development		60% of communities in the state are involved in health care development activities by end of 2012		73,712,144
			6.4.1.1	Undertake Advocacy to community gatekeepers to increase their awareness on community participation and health promotion		cooperation of all stakeholders	32,117,579
			6.4.1.2	Develop and implement community health development programmes		Political Will & Commitment	13,864,855
			6.4.1.3	Formulate action plans to facilitate the development of health promotion capacities at community levels		cooperation of all stakeholders	13,864,855
			6.4.1.4	Giive support to various levels to link health with other sectors using the health promotion guidelines		Availability of resources	13,864,855
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include**		28,319,430

				evidence-based community involvement guidelines by end 2010		
		6.5.1	To develop and implement systematic measurement of community involvement	55% 0f communities in the state are able to give assessment of the health care delivery services in the community by 2012		28,319,430
			6.5.1.1 Use locally adapted models to establish simple mechanisms to support communities to measure impact and document lessons learnt		cooperation of all stakeholders	15,568,974
			6.5.1.2 Disseminate the best practices from specific community-level approaches, methods and initiatives and the findings from such efforts to enhance knowledge sharing amongst stakeholders		Commitment & Availability of funds	12,750,456
PARTNERSHIPS FOR HEALTH						
7. To enhance harmonized implementation of essential health services in line with national health policy goals						**634,406,695**
	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**		-
		7.1.1	To promote Public Private Partnerships (PPP)	1. SMOH has an active ICC with Donor Partners that meets at least quarterly by end 2011. 2. SMOH has an active PPP forum that meets quarterly by end 2011. 3. All LGAs simillar active		-

					committees by end 2012		
			7.1.1.1	Update state PPP policy for the state with a view to leveraging technical and financial resources alongside improved management approaches for improved delivery of health care services.		cooperation of all stakeholders	-
			7.1.1.2	Develop Strategies for implementing PPP initiatives in line with this state policy.		cooperation of all stakeholders	-
			7.1.1.3	Establish PPP units at all levels to promote, oversee and monitor PPP initiatives.		cooperation of all stakeholders	-
			7.1.1.4	Undertake mechanisms for engaging the private sector – such as contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism and provision incentives (e.g health commodities, or technical support at no cost).		Political will & Commitment	-
			7.1.1.5	Explore other options that encourage the private sector set up health facilities in rural and under-served areas.		cooperation of all stakeholders	-
		7.1.2	To institutionalize a framework for coordination of Development Partners		Development partners contributions harmonised and in line with country health programmes. Functional DPF and HPCC at State level by end 2010.		-
			7.1.2.1	Institutionalize a framework for the harmonization and alignment of development partner's support at all levels.		cooperation of all stakeholders	-
			7.1.2.2	Establish Development Partners Forum comprising only health development partners at Federal and State levels as single entry points for engaging with partners.		Cooperation of all stakeholders	-
			7.1.2.3	Strengthen the Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners.		Political will & Commitment	-
			7.1.2.4	Establish similar mechanisms at state level.			-
			7.1.2.5	Establish mechanisms for resource coordination through common basket funding models such as Joint funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support.		cooperation of all stakeholders	-
		7.1.3	To facilitate inter-sectoral collaboration		Functional Intre-Sectoral Ministerial Forum in the State by end 2010.		-
			7.1.3.1	Encourage other social and economic sectors, other than health, have to take specific actions within their spheres of influence that would		cooperation of all stakeholders	-

				synergize the key health specific actions that could in turn bring about health gains for the entire population.			
			7.1.3.2	Establish an inter-sectoral ministerial forum at all levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes.	Inter-sectoral forum established	cooperation of all stakeholders	-
		7.1.4	To engage professional groups		Functional joint professional and State ministerial standards committee and number of meetings held with minutes		-
			7.1.4.1	Promote effective partnership with professional groups through jointly setting standards of training by health institutions, subsequent practice and professional competency assessments.		cooperation of all stakeholders	-
			7.1.4.2	Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes.		cooperation of all stakeholders	-
			7.1.4.3	Promote effective communication to facilitate relationships between professional groups and Ministries of Health		cooperation of all stakeholders	-
			7.1.4.4	Strengthen collaboration between government and professional groups to advocate for increased coverage of essential interventions, particularly increased funding			-
			7.1.4.5	Convene public lectures through a coordinated approach by professional associations to enhance the provision of skilled care by health professionals	No. of Public Lectures	adoption of mechanism for cooperation	-
		7.1.5	To engage with communities		Functional village health committees. Indicators on health system performance in place. Number of health campaigns per LGA		-
			7.1.5.1	Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels		political will and leadership role by SMOH	-
			7.1.5.2	Include rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services in information packages for community consumption.			-
			7.1.5.3	Develop indicators on health system performance at States, LGAs and facilities to improve transparency and accountability of the government to its citizens.		commitment by all stakeholders	-

			7.1.5.4	Institute mechanisms for competition between States, LGAs and facilities for satisfactory performance in delivery of community support programmes for health.			-
			7.1.5.5	Establish and empower Health Service Charters at all levels, with Civil Society Organisations, traditional and religious institutions to promote the concept of citizen's rights and entitlement to quality, accessible basic health services.		cooperation of all stakeholders	-
		7.1.6	To engage with traditional health practitioners		Functional joint traditional and ministerial health committee. Number of training sessions conducted for traditional health practitioners per year.		-
			7.1.6.1	Seek to have better understanding of traditional health practices and support research activities to gain more insight and evaluate them.			-
			7.1.6.2	Organise traditional medicine practitioners into bodies/organisations that are easy to regulate and actually regulate their practice.		cooperation of all stakeholders	-
			7.1.6.3	Adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful.			-
			7.1.6.4	Train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system.		availabilty of funds	-
			7.1.6.5	Seek the cooperation of traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene, immunisation and family planning where applicable.			-
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							**964,592,485**
	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**		126,376,437

		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		Health research offficers forum inagurated and holding meetings every quarter		-
			8.1.1.1	Develop health research strategies at all levels			-
			8.1.1.2	Convene Technical Working Groups to develop health research policies and strategies at all levels.		A functional TWG	-
			8.1.1.3	Establish a Health research steering committee at state level to shepherd research activities at state and LGA levels		Political Will & Commitment	-
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		Functional research division		-
			8.1.2.1	Strengthen the capacities of health research divisions and units at all levels to coordinate and encourage research efforts.		availabilty of funds & commitment of staff	-
			8.1.2.2	Link researchers and creating communities of practice		cooperation of all stakeholders	-
			8.1.2.3	Strengthen Departments of Planning Research and Statistics (DPRS) at all levels.		Political Will	-
			8.1.2.4	Creat active research units in FMOH, SMOH and LGA to undertake operations research and other research-related activities.			-
			8.1.2.5	Ensure the coordinated implementation of the Essential National Health Research (ENHR) guidelines.			-
		8.1.3	To institutionalize processes for setting health research agenda and priorities				28,562,160
			8.1.3.1	Establish and or strengthen functional institutional structures for research.	No. Of institutions established and working	political will	17,920,397
			8.1.3.2	Expand the health research agenda to include broad and multidimensional determinants of health and ensure cross-linkages with areas beyond traditional boundaries and categories.	No. Of institutions established and working	cooperation of all stakeholders	6,144,555
			8.1.3.3	Develop guidelines for collaborative health research agenda at all levels.	11 man committee inaugurated with TOR and minutes of meetings	cooperation of all stakeholders	4,497,208
		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				49,347,083
			8.1.4.1	Establish strong links between the users of research such as policy makers and the producers of research such as universities and health institutions	No. Of consultative meetings held with minutes book	cooperation of all stakeholders	6,990,226
			8.1.4.2	Establish a forum of health research officers at the SMOH and LGAs.	Health research offficers forum	commitment by all stakeholders	8,011,874

					inagurated and holding meetings every quarter		
			8.1.4.3	Convene annual multi-stakeholders forum to identify research priorities and harmonize research efforts.	Annual multi-stakeholders meeting held and research priorities identified .	Availability of resources	17,387,575
			8.1.4.4	Develop collaborative research proposals and their implementation between governments , public and private health research organisations at all levels.	Consultative stakeholders meeting held	Availability of resources	16,957,408
		8.1.5	To mobilise adequate financial resources to support health research at all levels				44,004,204
			8.1.5.1	Allocate at least 2% of health budget for health research at all levels.	Budget allocated to health research and amount released	Approval & funding by Government	8,109,639
			8.1.5.2	Deploy funds for health research in a targeted manner while expanding beneficiaries of funding to researchers from both public and non-public health research organizations and individuals.	Amount of funds allocated to Health researchers from public/non-public orgs.	Political Will & Availability of funds	17,074,726
			8.1.5.3	Explore opportunities for accessing funds from bilateral and multilateral organizations, research funding agencies and through north-south and south-south collaboration.	Stakeholders meeting held with research funding agencies in attendance.	cooperation of all stakeholders	9,361,036
			8.1.5.4	Establish a credible and transparent independent state research funding agency to attract additional fund.			9,458,802
		8.1.6	To establish ethical standards and practise codes for health research at all levels				4,462,990
			8.1.6.1	Establish a health research ethical mechanisms, guidelines and ethical review committee at state level.	Ethical and guideline review committee established and functional	cooperation of all stakeholders	3,338,688
			8.1.6.2	Strengthen similar mechanisms in tertiary health and education institutions.	Ethical and guideline review committee established in health institutions	cooperation of all stakeholders	488,827
			8.1.6.3	Establish monitoring and evaluation system to regulate research and use of research findings at all levels.	Monitoring and evaluation system strengthened to regulate research findings.	Political Will	635,475
	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**		392,087,136

				research agencies by end 2010		
		8.2.1	To strengthen identified health research institutions at all levels			80,949,746
			8.2.1.1 Strengthen identified health research institutions identified by inventory of all public and private institutions and organizations undertaking health research at all levels.	Inventory conducted and all private and public institutions identified ,coded and documented	cooperation of all stakeholders	30,796,099
			8.2.1.2 Conduct periodic capacity assessment of health research organizations and institutions.	No.of times periodic assessment conducted	Availability of funds	20,726,264
			8.2.1.3 Develop and implement measures to address identified research capacity gaps and weaknesses at state and LGA levels and development partners in conjunction with health research organizations/institutions	Annual meeting held with minutes to address research gaps.	Political will	13,432,965
			8.2.1.4 Ensure the development and implementation of resource mobilization strategies targeting the private sector, foundations and individuals for health research.	Resource mobilization team formed and functional	cooperation of all stakeholders	15,994,418
		8.2.2	To create a critical mass of health researchers at all levels			100,576,149
			8.2.2.1 Create critical mass of researchers in conjunction with training institutions.	No.of times capacity building training conducted.	cooperation of all stakeholders	67,555,887
			8.2.2.2 Develop appropriate training interventions for research, based on the identified needs at all level.	No.of training interventions for research developed and implemented.	Availability of funds & commitment	18,697,632
			8.2.2.3 Regularly provide competitive research grants for prospective researchers while motivating increased PhD training in health in tertiary institutions through award of PhD studentship scholarships.	No.of times research grants and award of PhD scholarships were provided	Availability of funds & political will	14,322,630
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels			63,547,506
			8.2.3.1 Evolve mechanisms for translating research findings into policies to achieve evidence-based policy formulation.	Seminars/workshops for translating research findings into policies developed and utilized.	cooperation of all stakeholders	19,479,755
			8.2.3.2 Establish close liaison and linkages between research users (e.g. policy makers, development partners) and researchers.	No.of times meetings held between policy makers,	political will	23,463,695

					partners and researchers.		
			8.2.3.3	Involve a wide range of actors including research producers in policy-making consultations.	No.of consultative meetings held with minutes book.	political will	20,604,057
		8.2.4	To undertake research on identified critical priority areas				147,013,734
			8.2.4.1	Undertake systematical researches on a number of topical areas such as estimating the burden of different diseases biennially.	Bsaeline study to estimate the different disease burdens biennially conducted.	availability of funds	59,446,248
			8.2.4.2	Undertake biennial Human Resources for Health studies; studies on health system governance (HSG) and studies on health delivery systems.	No.of studies on H R for health,HSG and health delivery systems conducted.	Availability of funds	31,596,798
			8.2.4.3	Undertake studies on financial risk protection, equity, efficiency and value of different health financing mechanisms biennially, etc by policy makers and other key stakeholders.	No.of policy makers/ stakeholders that studied financial risk protection etc.	availability of funds	55,970,688
			8.2.4.4	Conduct baseline studies on the availability& distribution of medical equipment		Build capacity of relevant staff on operations research	-
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		71,881,028
		8.3.1	To develop strategies for getting research findings into strategies and practices				-
			8.3.1.1	Establish getting research into strategies (GRISP) units at all levels and instituting bi-annual Health Research-Policy forums at all levels.	No.of GRISP units established and fuctional	cooperation of all stakeholders	-
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				71,881,028
			8.3.2.1	To identify required health research gaps at all levels as well as undertaking operations research by government Health Ministry, Departments and Agencies at all levels.	Assessment visit conducted and health research gaps identified.	availability of funds	37,330,738
			8.3.2.2	To contract public and non-public research organizations/institutes to collaborate with government in the conduct of operations research	No.of public/private research	cooperation of all stakeholders	34,550,290

				thereby addressing gaps in research capacity in government institutions.	organizations/institutes identified to conduct operations research.		
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		374,247,884
		8.4.1	To create a framework for sharing research knowledge and its applications				216,576,745
			8.4.1.1	To communicate the research outputs to large audiences for them to be meaningful.	Dissemination/awareness workshop for major stakeholders conducted	cooperation of all stakeholders	15,970,955
			8.4.1.2	To publish the research findings in academic journals, involve the development of a framework for sharing research knowledge at all levels.	No.of research findings published in academic journals		15,359,921
			8.4.1.3	To conven Annual health conferences, seminars and workshops at State & LGA levels on key thematic areas (financing, human resources, MDGs, health research, etc).	Annual health conferences, seminars and workshops conducted	availability of funds	13,662,714
			8.4.1.4	To pursue opportunities for international collaboration on national research agenda, both in terms of ensuring research findings from Nigeria are published and presented in other countries and that Nigerians receive research updates from other countries.	MOUs on sharing research findings between nigeria and other nations established	cooperation of all stakeholders	99,456,735
			8.4.1.5	To ensure participation in international conferences on health and mainstream best practices at State and LGAs.	No.of officers that participate in international conferences on health.	Availability of resources	72,126,420
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				157,671,139
			8.4.2.1	To develop the capacity of researchers to effectively produce policy briefs targeted at informing policy-makers, as well as the broad scientific and non-scientific audiences by Governments and donors.	Capacity training on the production of policy briefs for researchers conducted	availability of funds	25,419,002
			8.4.2.2	To conduct inventory of national journals according to areas of focus and select national journals to be supported on the basis of their ability to address issues related to Essential National Health Research (ENHR) principles.	Inventory of national journals according to areas of focus conducted.		37,888,978

			8.4.2.3	To support the publication of high quality national journals, following a review of editorial boards by Governments and donors.	No.of high quality journals published with governments and Donors support.	Availability of funds	19,034,922
			8.4.2.4	To establish appropriate linkages between editors of national journals and reputable publishers (especially online, free web-based access publishers) and international collaborators, to improve the quality of national journals.	Consultative meeting of stakeholders(publishers,development partners etc) held	availability of funds	39,839,398
			8.4.2.5	To vigorously pursue wide dissemination of selected national journals to all stakeholders at state and LGA levels.	Review meetings on national journals on health research conducted.	availability of funds	35,488,838
Total Cost							**114,501,638,180**

Annex 2: Results/M&E Matrix for Bayelsa SHDP

BAYELSA 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	50	75	100%
	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	25	50	75
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	TBD			
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	TBD	25%	50%	75%
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	50	75	100
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	50	75	100
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	50	75	100
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	25	50	75%
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	50	75	100%
	12. Number of LGA Health Watch Reports published	Health Watch Report	0	50	75	100

	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	50	75	100%
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	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	25	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	3	2	4	6
	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	20%	22%	25%	30%
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	18%	25%	50%	75%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%

	25. Contraceptive prevalence rate	NDHS	0.2 - 49.6%	5 - 60%	10 - 70%	20 - 80%
	26. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	0.2 - 27.5%	2 - 30%	5 - 50%	10 - 75%
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	2 - 30%	5 - 50%	10 - 75%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10 - 45%	20 - 75%	100%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20 - 40%	30 - 60%	40 - 75%
	30. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy)	NDHS/MICS	2.9 - 65.0%	2.0 - 40%	1.0 - 30%	0.5 - 20%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	35%	40%	55%	70%
	32. Proportion of births attended by skilled health personnel	HMIS	22%	30%	45%	60%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	10 - 40%	25 - 50%	40 - 75%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	0.1 - 5.6%	1.0 - 10%	5.0 - 20%	10 - 30 %
	35. Case fertility rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	10 - 60%	7 - 40%	5 - 25%
	36. Perinatal mortality rate**	HMIS	37 - 53/1000LBs	25 - 45/1000LBs	15 - 30/1000LBs	10 - 20/1000 LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	??	??	??
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	0.5 - 22.4%	10 - 40%	25 - 60%	50 - 75%
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline			??
	40. Number of interventions performed to repair an obstetric fistula	HMIS	No Baseline			??

	41. Proportion of women screened for cervical cancer	HMIS	5%	10%	25%	35%
	42. % of newborn with infection receiving treatment	MICS	No Baseline	10 -25%	25 -50%	50 - 75%
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	0 - 57.4%	10 - 65%	20 - 75%	40 - 80%
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	20.00%	35%	50%	65%
	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	29.00%	20%	15%	10%
	46. % of under-five that slept under LLINs the previous night	NDHS/MICS	8.00%	15%	22%	40%
	47. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	20%	30%	45%	50%
	48. % malaria successfully treated using the approved protocol and ACT;	MICS	15%	25%	30%	40%
	49. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	5%	10%	20%	35%
	50. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	4%	8%	12%	20%
	51. HIV prevalence rate among adults 15 years and above	NDHS	4.70%	3%	2.50%	2%
	52. HIV prevalence in pregnant women	NARHS	7.20%	5%	3.40%	2.50%
	53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	20%	30%	40%	50%
	54.Condom use at last high risk sex	NDHS/MICS				
	55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	42-69%	60%	65%	72%
	56. Prevalence of tuberculosis	NARHS	1.5 - 6.9%*	1.0 - 4.0	0.5 - 3%	0.1 - 2*
	57.Death rates associated with tuberculosis	NMIS	3%	2.50%	2%	1.50%
	58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	84%	25%	30%	45%

Output 6. Improved quality of Health care services	59. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	10%	20%	30%	50%
	60. % of facilities with capacity to deliver quality health care	Facility Survey Report	15%	20%	35%	50%
	61. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	5%	10%	20%	45%
	62. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	2%	10%	15%	30%
	63. % of health facilities with all essential drugs available at all times	Facility Survey Report	2%	10%	20%	35%
	64. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	5%	10%	20%	50%
	65. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10 - 45%	30 - 75%	50 - 90%
Output 7. Increased demand for health services	66. Proportion of the population utilizing essential services package	MICS	20%	30%	35%	40%
	67. % of the population adequately informed of the 5 most beneficial health practices	MICS	20%	35%	40%	50%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	68. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20 - 40%	30 - 60%	50 - 75%
	69. Retention rate of HRH	HR survey Report	TBD	???	???	???
	70. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10 - 30%	30 - 50%	50 - 75%
	71. Stock (and density) of HRH	HR survey Report	1 CHW:4000	1 CHW:4000 pop;	1 CHW:3000	1 CHW:2000 pop;

			pop; 1 Nurse or MW:8000 pop; 1 Dr & Dentist:8000 pop; 1 Pharmacist: 20,000 pop;	1 Nurse or MW:8000 pop; 1 Dr & Dentist:8000 pop; 1 Pharmacist: 20,000 pop;	pop; 1 Nurse or MW:6000 pop; 1 Dr & Dentist:7000 pop; 1 Pharmacist: 15,000 pop;	1 Nurse or MW:4000 pop; 1 Dr & Dentist:5000 pop; 1 Pharmacist: 10,000 pop;
	72. Distribution of HRH by geographical location	MICS	TBD	???	???	???
	73. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10 - 20%	25 - 50%	50 - 75%
	74. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	25 - 30%	30 - 50%	50 - 80%
	75. % of staff satisfied with the performance based management system	HR survey Report	TBD	10 - 25%	25 - 50%	50 - 75%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	76. % LGAs making availabile consistent flow of HRH information	NHMIS	0 - 100%	25 - 100%	50 - 100%	100%
	77. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	78. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	79. 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
	80. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	81. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	82. 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**						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	83. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10 -25%	25 - 50%	50 - 75%
	84. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	50 - 90%	30 - 75%	10 - 50%
	85. % 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%	40 - 60%	60 80%
	86. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	25 - 40%	40 - 60%	60 - 80%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	87. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	40 - 60%	60 - 80%	100%
	88.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	70%	60%	50%	40%
	89. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	90. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	25%	40%	60%
	91. % 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,	92. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	0 - 34%	25 - 50%	50 - 75%	75 - 100%

Monitoring and Evaluation						
	93. % of LGAs receiving feedback on NHMIS from SMOH		TBD	25 -50%	50 - 75%	75 - 100%
	94. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	30 - 60%	60 - 80%	80 -100%
	95. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	25 - 40%	40 - 60%	60 - 80%
	96.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	97. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	98. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	99. % 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	100. 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%
	101. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	102. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	103. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	104. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	105. % 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'	106. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%

Collaboration and Coordination						
	107. % 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	108. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	109. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	110. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
	111. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	40%	75%	100%
	112. % 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	113. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	75%	100%