AKWA IBOM STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Akwa Ibom State Ministry of Health

March 2010

Table of Contents

Table of Contents 2
List of Tables 3
List of Figures 3
Acronyms and Abbreviations 4
Acronyms and Abbreviations 4
Acknowledgement 7
Forward 8
Executive Summary 9
Vision, Mission and the Overarching Goal of the State Strategic Health Development Plan 15
Chapter 1: Background and Achievements 16
1.1 Background 16
1.2 Achievements 16
Chapter 2: Situation Analysis 18
2.1 Geography 18
2.2. Demography 19
2.3. Governance 19
2.4. Socio economic context / status 19
2.5 Health status of the population 20
2.6 Health services provision and utilization 20
2.7 Key issues and challenges 24
Chapter 3: Strategic Health Priorities 25
Chapter 4: Resource Requirements 29
4.1 Human Resources 29
4.2 Physical/Maternal Requirements 29
4.3 Financial Resource Requirement: 30
Chapter 5: Financing Plan 32
5.1 Estimated cost of the strategic orientations 32
5.2 Assessment of the available and projected funds 32
5.3 Determination of the financing gap 32
5.4 Descriptions of ways of closing the financing gap 32
Chapter 6: Implementation Framework 33
Chapter 7: Monitoring and Evaluation 35
7.1 Proposed mechanisms for monitoring and evaluation 35
Conclusion 36
Annex 1: Summary of AKSHDP leadership and governance 37
Annex 2: Population size by LGA 50
Annex 3: Details of Akwa Ibom Strategic Health Development Plan 52
Annex 4: Results/M&E Matrix for Monitoring Implementation of the Plan 84

List of Tables

Table 1: Summary of Indicators Akwa Ibom State 23

Table 2: State Essential Package of Care 26

Table 3: Projected appropriation, releases and gaps in billion Naira 31

Table 4: Projected Expenditure, Expected Annual Apprpriation and Expected Gaps (bn) 31

List of Figures

Figure 1: Map of Akwa-Ibom State 18

Acronyms and Abbreviations

AKS-SHDP	Akwa Ibom State Strategic Health Development Plan
BCC	Behaviour Change Communication
CIDA	Canadian International Development Agency
CORPs	Community Oriented Resource Persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GIS	Geographic Information System
GTZ	Gesellschaft für Technische Zusammenarbeit
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HLM	High Level Ministerial Meeting on Health Research
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health

IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement
JICA	Japan International Development Agency
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
NAFDAC	National Agency for Food Drugs Administration and Control
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDP	National Strategic Health Development Plan Framework
NSTDA	National Science and Technology Development Agency
NYSC	National Youth Service Corps
OAU	Organisation of African Unity

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

Acknowledgement

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

Forward

The performance of the health system in AKWA IBOM STATE is still away from the desired optimal level.

This has necessitated the Government of His Excellency, chief Dr GODSWIL AKPABIO to put in a lot of initiatives which at the long run will change the health status indicators of the citizenry positively. One of such steps is the preparation of this document whose implementation will lead to the realisation of this objective.

This document came out as a result of extensive consultations with all stakeholders-our royal fathers, civil society organisations, and professional bodies in the health sector.

I have no doubt this plan will help to deliver qualitative, efficient, affordable, and accessible health care services to the people.

I am highly indebted to all those who have contributed to the successful production of this document.

I want to thank his Excellency, Chief (Dr) Godswil Obot Akpabio that funded the completion of this document.

The Federal government is commended for taking the initiative and lead in the development of Strategic Health Development Plan for all the 3 levels of care in Nigeria.

The contribution of our Development Partners UNICEF, who help us kick start this process is highly appreciated.

The efforts of our technocrats towards the successful completion of this assignment

will always remain green in my heart

DR LOUISA UKPEH

HON.COMMISSIONER FOR HEALTH

AKWA IBOM STATE

Executive Summary

Vision

The 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 residents of Akwa Ibom state".

The centrality of health to national development and poverty reduction is self-evident, as improving health status and increasing life expectancy contribute to long term economic development. The legitimacy of any national health system depends on how best it serves the interest of the poorest and most vulnerable people, for which improvements in their health status gear towards the realization of poverty reduction goals. In the Nigerian context, current reviews show that the country is presently not on course to achieving the health Millennium Development Goals (MDGs) by 2015. This poses a major developmental challenge, which will impede and undermine development and economic growth.

The Government of Akwa Ibom State of Nigeria recognizes that, in order to contribute to achieving the country health targets, inclusive of the health-related MDGs, particularly for its poorest and most vulnerable population, the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded. These improvements can be achieved through the use and execution of this evidence-based Akwa Ibom State Strategic Health Development Plan **(AKS-SHDP),** as appropriately costed.

Akwa Ibom State is located within the South – Eastern axis of Nigeria and is now a part of the South South Geo-Political zone. Created on 23rd September, 1987 by the Government of President Ibrahim Babangida out of the former Cross River State Akwa Ibom state is made up of 31 Local Government Areas, further divided into 329 political wards. The state has a land mass of 8,412 sq.km, bounded to the north by Abia State, to the east by Rivers State, to the west by Cross River State, on the sandy coastal plain of the Gulf of Guinea and to the south by Atlantic Ocean which stretches from Ikot Abasi to Oron. The state has a Population of 4,333,819 million, Male: Female Ratio, 50.82: 49.18; out which 85% live in the rural areas. With Uyo as the Capital City, other urban cities are Eket, Ikot Ekpene, Abak, Ikot Abasi and Oron. The state is made up of a number of ethnic groups; Ibibio, Annang, Oron and other minor groups. With an ocean front which spans a distance of 129 km coastline which is not only the longest in the country, but is also a very rich source of a wide variety of fishes and seafood including catfish, barracuda, blue marlin, squid, sardine, croakers, shrimps, prawns, crayfish, snapper, bivalves and oysters from Ikot Abasi in the west to Oron in the east, Akwa Ibom presents a picture of captivating coastal, mangrove forest and beautiful sandy beach resorts.

The State is endowed with Mineral Resources**,** including Crude oil, natural gas, limestone, gold, salt, coal, silver nitrate, glass sand, kaolin. As one of the three largest producer of crude oil in Nigeria, Akwa Ibom State is one of the most important economic resource bases of the

Nigerian Nation. The State is host to Mobil Producing Nigeria Unlimited, a subsidiary of Exxon Mobil Corporation, Aluminium Smelter Company of Nigeria (ALSCON), Champion Breweries, Nigeria Newsprint Manufacturing Company (NNMC) among others, and is also a catchment neighbour to Nigeria's Export Processing Zones (Oil and Gas) in Ikot Abasi, Mbo and Calabar, and boast of Industrial Estates in Uyo and Ikot Ekpene.

The life expectancy at birth is 49 years while the disability adjusted life expectancy at birth is 38.3years; vaccine-preventable diseases and infectious and parasitic diseases continue to exact their toll on health and survival of Akwa Ibomites. Though there has been no state specific population based survey, but relying on the validity of the current National Demographic and Health Survey (NDHS) 2008, The Crude Birth Rate is 32/1000, while the Crude Death Rate is 12/1000. Similarly Infant Mortality Rate stands at 84/1000 live births; Under 5 mortality - 138/1000 pop; HIV Sero-Prevalence Rate – 9.7; Maternal Mortality Ratio - 545/100,000; Total Fertility Rate - 4.6. Sixty six percent of women giving birth in the last five years received Antenatal care from a qualified health professional while maternal and childhood malnutrition stand at 11% and 18% respectively.

The common causes of illnesses include; Malaria, Helminthiasis, Gastroenteritis, Respiratory tract Infection, Anaemia, Malnutrition, Hypertension, Diabetes Mellitus, Arthritis, Tuberculosis, Typhoid Fever, HIV Infection, Hepatitis, Impaired Vision, Cancer. Whereas the Common causes of death include; Malaria, Hepatitis, Diabetes, Hypertension, Road Traffic Accident, Post Partum Haemorrhage, Neoplasm/Cancers, Gastroenteritis, Ante Partum haemorrhage, Unsafe Abortion, HIV/AIDS, Infection Septicaemia, Severe Anaemia, Respiratory tract Infection, Ruptured Ectopic Pregnancy and Obstructed Labour.

The State allocation to health in 2006 stood at N3.85bn, representing 3.25% of total budget of the state, out of which only N0.98bn was actually released. Whereas in 2008, N10.25bn or 4.0% of total state budget was allocated to health with only N3.9bn actually released. Akwa Ibom State has a total of 182 medical doctors, 3 dentists, 1940 Nurses/Midwives, 31 Medical laboratory Scientists,19 Medical laboratory Technicians, 36 Pharmacists, 24 Pharmacy Technicians, 238 community Health workers, 3 Radiographers, 79 Medical record Technicians, 12 X-Ray Technicians, 3 Ophthalmic Opticians and I Ophthalmologist. These are spread across the 383 Public Health facilities in the state. The state also has 232 registered private health facilities. To enhance capacities, in 2008, the Hospitals management Board sponsored a Manpower Development/Personnel training which involved 33 Medical Doctors including 20 House officers in Teaching hospitals and 75 other health workers. Similarly, 10 Doctors, 45 Nurses & other support staff variously participated in short courses and Personnel trainings sponsored by SMOH. Overall 50 staff of the Ministry of Health have undergone computer appreciation trainings.

The implementation of the ward minimum health care package is just beginning in the state with the Federal Model PHC'S. Hence, the minimum personnel requirement is still an issue to be attended.

All the 31 LGA's are currently running outreaches in order to reach out to the communities in the riverine and difficult terrains.

From the bottleneck analysis, the following problem areas were identified:-

Whereas political will exist, it is not translated to adequate and timely release of funds in support of health programmes especially at the Local Government Area levels. This invariably cuts across other area as listed below. There are inequitable distributions of Health Centers in all the Political Wards of the State. There would be need to ensure that every Political Wards has a health center. Most of the health centers do not have adequate manpower to provide services. There would be need to recruit more personnel to provide services. Consequently, there is a precarious scenario of Doctor population ratio of 1:24,000 and a Nurse population ratio 1:1,500.

There is need to provide quality services by ensuring that staff are trained and re-trained in relevant areas. Balance distribution of staff especially to serve in rural areas rather than concentrate in urban centers would be need to be addressed. Most health centers do not have basic medical equipment. Lack of adequate storage facilities especially for vaccines and cold chain equipment were identified. There are no utility vehicles to support logistics of materials movement, effective monitoring and supervision.

Effort is still being made to provide each LGA with the Health Management Information System (HMIS) minimum package. This effort would be intensified in order to make the availability of the minimum package a reality in the first year of this plan. HMIS monitoring system would be strengthened through provision of vehicles, equipment and training and re-training of staff to provide the required quality health data.

Ward Development Committees would be constituted and other structures as laid down in the Ward Minimum Health Care Package. The focus is to enhance community participation and ownership of intervention and programmes in all the 31 LGAs with involvement of community members in health decisions.

The State's minimum package of care shall address care during pregnancy, during labour, at birth and Postnatal/Newborn care, Care during infancy and childhood among others. Under Care during pregnancy, the package of interventions include the following: Antenatal care package which contains the following high impact interventions Tetanus toxoid immunization, Birth and emergency planning, detection and management of complications, detection and treatment of syphilis, intermittent prophylactic treatments (IPT) for malaria, sleeping under insecticides-treated net and prevention of mother-to-child transmission of HIV (PMTCT). Under Care during labour, birth and 1-2 hours after birth, the package of intervention is skilled care at birth which contains the following high impact interventions; monitoring progress during labour, Social support (Companion) during birth, immediate newborn care (resuscitation if required, thermal care, hygienic cord care, early initiation of breastfeeding),. Another package of intervention is Emergency obstetric and newborn care which contains detection and clinical management of obstetric and newborn complications. Under Postnatal care of mother and newborn, the package of intervention is routine postnatal care of mother and newborn which contains the following high impact interventions; Exclusive breastfeeding, thermal car, hygienic cord care, extra care of LBW infants, prompt care-seeking for illness, immunization

and management of newborn illness. Under Care during infancy and childhood, the package of intervention are Community case management of diarrhea, pneumonia, and malaria ,IMCI(first-level facilities) of Algorithm-based management of diarrhea (with ORT and ZINC0, pneumonia, malaria, malnutrition and newborn illness; care for HIV-exposed and infected children, IMCI (referral level) contains management of severe newborn and child illnesses , and Community IMCI which contains community-mobilization and communications to promote: exclusive breastfeeding, complementary feeding, water, sanitation and hygiene, care-seeking for preventive interventions (e.g. vaccines), home care for illness and EPI which contains delivering of essential vaccines.

Through the review of technical resource materials, wide consultations and participatory techniques, the AKSHDP has been written around the NSHDPf eight priority areas namely: leadership and governance, service delivery, health financing, human resources for health, health information system, community participation and ownership, partnerships for health development and research for health. The plan describes in detail recommended evidence-based and cost-effective interventions required to deliver improved performance of the health system and health outcomes for all Akwa Ibomites and include Improving Strategic Planning at the State and LGA levels, strengthening regulatory functions of government, improving accountability and transparency, improving and maintaining sectoral Information base to enhance optimal performance of the health system all of which can be situated in the leadership and governance function. Further to this the plan recommends the provision of essential health care service package, strengthening of specific communicable and non communicable disease control programmes. Also efforts will be directed at ensuring that Standard Operating procedures (SOPs) and guidelines are available for delivery of services at all levels. In the same vein, improvements of the geographical equity and access to health services will be given priority attention.

Furthermore, the plan provides for ensuring the availability of drugs and equipment at all levels, establishment of a system for the maintenance of equipment at all levels, strengthening of the referral system, fostering of collaboration with the private sector, strengthening of professional regulatory bodies and institutions as well as development and institutionalization of quality assurance models. Deliberate efforts will be geared to institutionalizing Health Management and Integrated Supportive Supervision (ISS) mechanisms, the creation of effective demand for services, including improvements in financial access especially for the vulnerable groups. Recognising the need to harness and leverage all resources at the State's disposal, the plan outlines the need to develop and institutionalize the Human Resources Policy framework, reappraise the principles of health workforce requirements and recruitment as well as equitably distribute, in the right mix, of the right quality and quantity of health professionals in the state and all the LGAs.

We will establish and strengthen the Human Resources for Health Units of the state ministry of health including the Hospitals management board. The state will undertake review and adaptation of relevant training programmes for the production of adequate number of community health oriented professionals based on her established needs and priorities.

Cardinal to the forgoing is the strengthening of the health workforce capacity and output, through training based on service demand.

Other interventions prescribed by the plan include the establishment of mechanisms to strengthen and monitor performance of health workers at all levels, strengthening of communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system, development and implementation of evidence-based, costed health financing strategic plans at LGA, and State levels in line with the National Health Financing Policy.

The plan similarly provides for strengthening the systems for financial risk health protection, outlines measures to improve financing of the Health Sector and to improve coordination of donor funding mechanisms. Further still the plan outlines the need to improve health budget execution, monitoring and reporting, strengthen financial management skills.

To ensure adequate tracking and documentation of the plan implementation, the National Health Management Information System forms will be made available at all health service delivery points throughout the state.
These NHMIS data collection forms will be periodically reviewed. Efforts will be made to coordinate data collection from vertical programmes, capacity of health workers for data management will be strengthened whilst providing a legal framework for activities of the NHMIS. This will serve to guarantee improvements in coverage of data collection, ensuring supportive supervision of data collection at all levels and strengthening the use of information technology in Health Information System. The plan intends also to provide HMIS Minimum Package at the different levels (SMOH, and LGA) of data management, institutionalize HMIS management and utilization, data analysis and dissemination, strengthen data transmission and Hospital Information System, strengthen the Disease Surveillance System as well as establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs.

Other interventions outlined in the plan include provision of an enabling policy framework for community participation, provision of an enabling implementation framework and environment for community participation. The Communities will be empowered to 'own' their health services. Innovative programmes like the community Dental education programmes will be initiated to restructure and strengthen the interface between the community and the health services delivery points.

Deliberate programmes will target strengthening of host communities to manage waste and Sanitation Services in health facilities, provision of Occupational Health / Safety Services, capacity building for Stakeholders in the Community on Implementation and interpretation of health data, development and implementation of multi sectoral policies and actions that facilitates community involvement in health development.

Further to this, the plan provides for development and implementation of systematic measurement of community involvement promoting Public Private Partnerships (PPP) as well

as institutionalizing a framework for coordination of Development Partners that will ultimately facilitate inter-sectoral collaboration, engagement of professional groups, traditional health practitioners as well as communities. The state will adapt the national Health Research Policy upon its finalization into a state health research policy with appropriate health research strategies. This will focus on establishing and or strengthening mechanisms for health research throughout the state.

Deliberate efforts will be made to institutionalize processes for setting health research agenda and priorities, promoting cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors. Efforts will be intensified to mobilise adequate financial resources to support health research in the state as well as establishing ethical standards and practice codes for health research at all levels.

Identified health research institutions will be strengthened, creating a critical mass of health researchers in the state. Similarly the plan intends to develop transparent approaches for using research findings to aid evidence-based policy making, undertake research on identified critical priority areas, develop strategies for getting research findings into strategies and practices.

The plan enshrines mechanisms to ensure that funded researches produce new knowledge required to improve the health system, creating a framework for sharing research knowledge and its applications as well as establishing channels for sharing of research findings between researchers, policy makers and development practitioners.

The total cost of implementing the 6 year State SHDP is N94,597,453,260.00 for the period 2010-2015.

The successful implementation of this Strategic Health Plan depends on the cooperation and commitment of all stakeholders within and outside the health sector. It is anticipated that all stakeholders will demonstrate practical commitment to the implementation of the above expressed priority interventions, which will be measurable in terms of availability and adherence to prioritized and costed annual operational plans based on this strategic plan and which will form the basis of the State and LGAs sectoral budgeting. It is assumed that the Governor and Chairmen of LGAs in the state will demonstrate the requisite leadership and commitment to this plan by prompt allocation, disbursement and utilization of available funding and resource requirements.

Other critical assumptions include the continuance of Good governance, Political stability, availability and prompt release of funds, absence and or limited political influence on programme implementation, freedom to adhere to guidelines as stated in the strategic health plan, motivated and adequate workforce, sustained collaborative public/private partnership at State and LGA levels as well as willingness of all stakeholders to participate in the planning, implementation and evaluation of this AKS-SHDP.

Akwa Ibom SMOH will ensure the establishment and strengthening of M&E mechanisms for ensure implementation of the SHDP towards meeting set targets for the state.

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

Vision

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

Mission

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

Goal

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

Chapter 1: Background and Achievements

1.1 Background

The centrality of health to national development and poverty reduction is self-evident, as improving health status and increasing life expectancy contribute to long term economic development. The legitimacy of any national health system depends on how best it serves the interest of the poorest and most vulnerable people, for which improvements in their health status gear towards the realization of poverty reduction goals. In the Nigerian context, current reviews show that the country is presently not on course to achieving the health Millennium Development Goals (MDGs) by 2015. This poses a major developmental challenge, which will impede and undermine development and economic growth.

The Government of Akwa Ibom State of Nigeria recognizes that, in order to contribute to achieving the country health targets, inclusive of the health-related MDGs, particularly for its poorest and most vulnerable population, the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded. These improvements can be achieved through the use of the evidence-based Akwa Ibom State **Strategic Health Development Plan (AKS-SHDP),** with appropriate costing.

1.2 Achievements

The State allocation to health in 2006 stood at N3.85bn, representing 3.25% of total budget of the state, out of which only N0.98bn was actually released. Whereas in 2008, N10.25bn or 4.0% of total state budget was allocated to health with only N3.9bn actually released. Akwa Ibom State has a total of 182 medical doctors, 3 dentists, 1940 Nurses/Midwives, 31 Medical laboratory Scientists,19 Medical laboratory Technicians, 36 Pharmacists, 24 Pharmacy Technicians, 238 community Health workers, 3 Radiographers, 79 Medical record Technicians, 12 X-Ray Technicians, 3 Ophthalmic Opticians and I Ophthalmologist. These are spread across the 383 Public Health facilities in the state. The state also has 232 registered private health facilities. To enhance capacities, in 2008, the Hospitals management Board sponsored a Manpower Development/Personnel training which involved 33 Medical Doctors including 20 House officers in Teaching hospitals and 75 other health workers. Similarly, 10 Doctors, 45 Nurses & other support staff variously participated in short courses and Personnel trainings sponsored by SMOH. Overall 50 staff of the Ministry of Health have undergone computer appreciation trainings.

For some time now, practical steps have been taken by the state Government to create the requisite environment that promotes and sustains the building of a private sector led economy, tailored towards global market competitiveness and taking advantage of her natural endowments, viz;

- Building world class infrastructure
- Developing a strong service sector; creating the right institutional framework;

- Investing in the development of key infrastructure comprising power (Electricity), water supply, communication, transportation mode (land, water and air) housing and urban development.

Specifically

- The Ibom Power Plant built at Ikot Abasi is designed to provide 685MW with an initial energy output of 191MW in the first phase of which 60MW (of this power) is dedicated to meet the State's current and future energy needs. Currently, over 70% of the State has been linked to the national grid, while target date for full electrification of Akwa Ibom State is December 2010.
- The Ibom Airport project has facilities for aircraft Maintenance, Repairs and Overhaul (MRO)
- The 120 exquisite / Standard rooms Five Star Hotel, with its complementary 18-hole international standard Golf course, the Marina beach and its inspiring neighborhood; the Ibaka Deep Sea Port Development
- The Science and Technology / ICT Park
- State University, a trading floor of the Nigerian Stock Exchange, building of a banking district. Currently 22 of the 24 banks in the country are doing business in the State.
- Large scale construction, rehabilitation, completion and expansion of urban and rural roads.
- The provision of portable water across the State.

The State government is implementing a wide range of reforms and has evolved targeted Medium Term Sector Strategies (MTSS) to responsibly exploit these vast resources. Akwa Ibom also offers a wide range of incentives prompt allocation of plot(s) anywhere in the State for Industrial, commercial, agricultural and residential purposes. Certificate(s) of Occupancy for such plot(s) are issued within one month of approval. The State also facilitates and assists in the collection of all permits, licenses and ensures all documentation needed by prospective investors in the State. Akwa Ibom Investment and Export Promotion Council (AKIIPOC) offer a one-stop window on business facilitation. Akwa Ibom beckons. Explore Akwa Ibom. Come and See

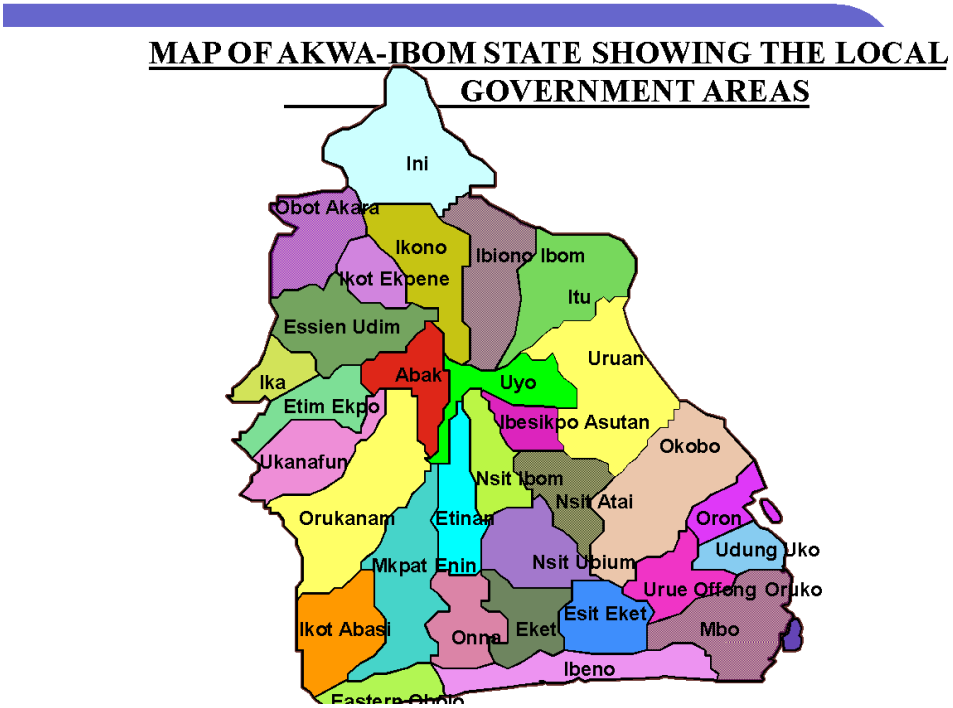
Chapter 2: Situation Analysis

2.1 Geography

Akwa Ibom State is located in the South-South geo-political zone of Nigeria. It was formerly a part of the South-Eastern state within the old Eastern Region of Nigeria. Following the 1976 state creation, it became part of Cross River State. Further restructuring of the Nigerian Federation saw the birth of Akwa Ibom as a state in the Nigerian polity; precisely on the 23rd of September 1987.

It is bounded in the north by Abia State, in the east by Rivers State, in the west by Cross River State, on the sandy coastal plain of the Gulf of Guinea and in the south by Atlantic Ocean which stretches from Ikot Abasi to Oron displaying a sprawling volume of water seemingly kissing the skyline from flank to flank.

Figure 1: Map of Akwa-Ibom State



Akwa Ibom State situates within the South – Eastern axis of Nigeria. It is a part of the South South Geo-Political zone. **'THE LAND of PROMISE'** sits astride a seemingly interminable sand bank, a pasture of dominant vegetation of green foliage trees, shrubs and a vast oil palm belt reputed to hold the highest density of cash crop in the world.

Trigonometrically, Akwa Ibom State lies between latitude 40 32' and 50 53' North; and Longitudes 70 25' and 80 25' East. In terms of structural make up, Akwa Ibom is triangular in shape and covers a total land area of 8,412 km^2, encompassing the Qua Iboe River Basin, the western part of the lower Cross River Basin and the Eastern part of the Imo River Basin. With an ocean front which spans a distance of 129 km coastline which is not only the longest in the

country, but it is also a very rich source of a wide variety of fishes and seafood including catfish, barracuda, blue marlin, squid, sardine, croakers, shrimps, prawns, crayfish, snapper, bivalves and oysters from Ikot Abasi in the west to Oron in the east, Akwa Ibom presents a picture of captivating coastal, mangrove forest and beautiful sandy beach resorts.

The landscape of Akwa Ibom is mostly flat. This is because the underlying geology of the state is predominantly coastal plain sediments. The coastal nature of the state makes it the natural deposit of mosaic of marine, deltaic, estuarine, lagoonal and fluvio-lacustrine material. Around Itu and Ibiono Ibom Local Area Councils, the topography of the land is undulating with some areas as high as 200 feet above sea level, while there are in some areas valleys, marshes, ravines and swamps due to influence of Atlantic Ocean, Qua Ibo, Imo and the Cross Rivers.

The location of Akwa Ibom just north of the Equator and within the humid tropics and its proximity to the sea makes the state generally humid. On the basis of its geographical location the climate of Akwa Ibom State can be described as a tropical rainy type which experiences abundant rainfall with very high temperature. This tropical climate is marked by two distinct seasons; the dry season (November – March) and the wet season (April – October). The wet season is usually interrupted by a short dry spell in August. The mean annual temperature of the state lies between 23^0C and 31^0C, while mean annual rainfall is 2,200mm in the north of the state and 3,500 mm in the south of the state and sunshine is between 1,400 to 1,500 hours per year.

Despite the seasonal variations, by the nature and location of the state along the coast which exposes it to hot maritime air mass, rainfall is expected every month of the year. Naturally, maximum humidity is recorded in July while the minimum occurs in January. Thick cloud cumulonimbus type is commonly experienced in the months of March to November. Evaporation is high with annual values that range from 1500 mm to 1800 mm.

2.2. Demography

The State is made up of 31 local government areas, with Uyo as the capital city. Its major towns include Uyo, Eket, Ikot Abasi, Oron, Etinan, Abak, and Ikot Ekpene. It has a population of **4,333,819** million based on the 2009 projections by UNICEF.

Citizens are predominantly Christian and the major languages spoken are Ibibio, Anang and Oron. Economic activities are predominantly commerce and farming with 85 percent of the population living in the rural areas.

2.3. Governance

The state has continued to enjoy stable democratically elected governments inaugurated May 29 1999, May 29 2003, and May 29, 2007 with a stated Development Vision of transforming Akwa Ibom State into a prosperous, highly educated, technologically driven and ethnically harmonious State in Nigeria with strategic policies / programmes to accomplish same.

2.4. Socio economic context / status

Akwa Ibom State is strategically located on the gulf of guinea, which has assumed immense economic and strategic importance globally. Akwa Ibom State also provides access to a number of land locked States in the South Eastern and Middle Belt Nigeria. With the on-going

development of the Ibaka Deep Sea port, the State is well placed to be a major international gateway to most parts of Nigeria.

The State is endowed with Mineral Resources**,** including Crude oil, natural gas, limestone, gold, salt, coal, silver nitrate, glass sand, kaolin. As one of the three largest producer of crude oil in Nigeria, Akwa Ibom State is one of the most important economic resource bases of the Nigerian Nation.

The State is host to Mobil Producing Nigeria Unlimited, a subsidiary of Exxon Mobil Limited, Aluminium Smelter Company of Nigeria (ALSCON), Champion Breweries, Nigeria Newsprint Manufacturing Company (NNMC) among others, and is also a catchment neighbour to Nigeria's Export Processing Zones (Oil and Gas) in Ikot Abasi, Mbo and Calabar, and boast of Industrial Estates in Uyo and Ikot Ekpene.

2.5 Health status of the population

Akwa Ibom State is contributory to the indices and therefore can be loosely said to bear a reflection of the Nigerian health status. Present indicators for Nigeria are among the worst in the world. The life expectancy at birth is 49 years while the disability adjusted life expectancy at birth is 38.3years; vaccine-preventable diseases and infectious and parasitic diseases continue to exact their toll on health and survival of Nigerians, remaining the leading causes of morbidity and mortality. Nigeria has the highest number of HIV infected persons in the African continent and the fourth highest TB burden in the world. In the face of these, non communicable diseases are increasingly becoming public health problems, especially among the affluent urban population.

Even though only 2% of the global population is in Nigeria, the country, with an estimated infant mortality rate of 75 per 1000 live births, child mortality rate of 88 per 1,000 live births, under 5 mortality rate of 157 per 1,000 live births[1] and a maternal mortality ratio of 800 per 100,000 live births, contributes a disproportionate 10% to the global burden of maternal and also infant mortality[2]. Wide regional variations exist in infant and maternal mortality across the zones. Infant and child mortality in the North West and North East zones of the country are in general twice the rate in the southern zones while the maternal mortality in the North West and North East is 6 times and 9 times respectively the rate of 165/100, 000 recorded in the South West Zone[7].

2.6 Health services provision and utilization

In Akwa Ibom State, like in the rest of the Nigeria, the health sector is broad and is comprised of public, private for-profit, nongovernmental organizations (NGOs), community-based

[1] National Population Commission (2008) *Preliminary Report of National Demographic and Health Survey* Abuja: National Population Commission

[2] Federal Ministry of Health (2008) *Integrated Maternal, Newborn and Childhealth Strategy.* Federal Ministry of Health, Abuja

organizations (CBOs), faith-based organizations (FBOs), and traditional health care providers. The composition of health providers is also very heterogeneous, and includes unregistered and registered providers ranging from traditional birth attendants and individual medicine sellers to modern hospitals. Thirty-eight percent of all registered facilities in the FMOH health facilities database are privately owned, of which about 75% are primary care and 25% are secondary care facilities (World Bank, 2005). Correspondingly, 232 out of the 615 facilities in Akwa Ibom State presently are owned by the private sector. Private facilities account for one-third of primary care facilities and could be a potentially important partner in expanding coverage of key health services

Consequently, Nigeria is said to operate a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with hardly any collaboration. Both the private and public sectors provide orthodox health care services in the country. In 2005, FMOH estimated a total of 23,640 health facilities in Nigeria of which 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary. 38% of these facilities are owned by the private sector, which provides 60% of health care in the country[3]. While 60% of the public primary health care facilities are located in the northern zones of the country, they are mainly health posts and dispensaries that provide only basic curative services. The Private Out-Of-Pocket-Expenditure (OOPE) in Nigeria accounts for over 70% of the estimated $10 per capita expenditure on health[4], limiting equitable access to quality health care.

The public health service is organized into primary, secondary and tertiary levels. While the Constitution is silent on the roles of the different levels of government in health services provision, the National Health Policy ascribes responsibilities for primary health care to local governments, secondary care to states and tertiary care to the federal level. At the same time, a number of parastatals, based at the federal level, for example, the National Primary Health Care Development Agency (NPHCDA) are currently engaged in primary health care services development and provision; the latter is evidently part of its mandate. Although national policies, formulated by the Federal Ministry of Health provide some level of standardization, each level is largely autonomous in the financing and management of services under its jurisdiction.

The health system is in a deplorable state with an overall health system performance ranking 187th out of 191 member States by the World Health Organization (WHO)[5]. Primary Health Care (PHC), which forms the bedrock of the national health system, is in a prostrate state

[3] Federal Ministry of Health (2005) *Inventory of Health Facilities in Nigeria* Abuja: Federal Ministry of Health

[4] Federal Ministry of Health (2004) *Health Sector Reform Program: Strategic Thrusts and Log Framework* Abuja: Federal Ministry of Health

[5] WHO (2000) *World Health Report 2000: Health Systems - Improving Performance*. Geneva: World Health Organisation

because of poor political will, gross under funding, and lack of capacity at the LGA level, which the main implementing body.

The health system remains overstretched by a burgeoning population; physical facilities are decaying, equipment are obsolete and there is scarcity of skilled health professionals. In addition, the roles of stakeholders are misaligned and coordination systems are weak. These are further compounded by the dearth of data which renders evidence based planning, policy formulation and health systems management weak.

The very weak health system contributes to the limited coverage with proven cost-effective interventions. For example, immunization coverage is 23%[9]; only 12% of under-fives sleep under ITNs, 20% of children in urban areas and 14% resident in rural areas with fever are appropriately treated with antimalarials at home; contraceptive prevalence rate is 15% and only 39% of women deliver under the supervision of skilled attendants[6]. It is important to note that wide regional variations exist for these indicators, with comparatively worse figures in the rural areas and in the northern part of the country.

[6] National Population Commission (2008) *National Demographic and Health Survey* Abuja: National Population Commission

Table 1: Summary of Indicators Akwa Ibom State

Total population	4,333,819
Under 5 years (20% of Total Pop)	866,764
Adolescents (10 – 24 years)	1,473,499
Women of child bearing age (15-49 years)	953,440
Literacy rate	80% female; 85% men
Households with improved source of drinking water	65%
Households with improved sanitary facilities (not shared)	39%
Households with electricity	58%
Employment status (currently)	63.4% female, 65.1% male
TFR	4
Use of FP modern method by married women 15-49	18%
ANC	67%
Crude Birth Rate -	**32**/1000 pop*
Crude Death Rate -	**12**/1000 pop*
Infant Mortality Rate	**84**/1000 live births*
Under 5 mortality -	**138**/1000 pop*
HIV Sero-Prevalence Rate	**9.7%***
Maternal Mortality Rate -	**545**/100,000*
Total Fertility Rate	4.6*
Skilled attendants at birth	44%
Delivery in HF	37%
Full immunization coverage	32%
Children that have not received any immunization (zero dose)	9%
Stunting in Under 5 children	28%
Wasting in Under 5 children	14%
Diarrhea in children	4.1%
ITN ownership	14%
ITN utilization	14% children, 4% pregnant women
Malaria treatment (any anti-malarial drug)	21% children, 13% pregnant women
Comprehensive knowledge of HIV	15% female, 25% men
Knowledge of TB	81.8% female, 68.4% male

2.7 Key issues and challenges

The state does not have a health policy yet but have been thinking around this and perhaps the AKS-SHDP development affords the state the opportunity to rapidly engage relevant stakeholders in doing this.

The common causes of illnesses include; Malaria, Helminthiasis, Gastroenteritis, Respiratory tract Infection, Anaemia, Malnutrition, Cancer, Hypertension, Diabetes Mellitus, Arthritis, Tuberculosis, Typhoid Fever, HIV Infection, Hepatitis, Impaired Vision, Cancer.

Whereas the Common causes of death include; Malaria, Hepatitis, Diabetes, Hypertension, Road Traffic Accident, Post Partum Haemorrhage, Neoplasm/Cancers, Gastroenteritis, Ante Partum haemorrhage, Unsafe Abortion, HIV/AIDS, Infection Septicaemia, Severe Anaemia, Respiratory tract Infection, Ruptured Ectopic Pregnancy and Obstructed Labour

Similarly, common causes of childhood illness/death include; Malaria, Anaemia, Gastroenteritis, Respiratory tract Infection, Pneumonia, Measles, Malnutrition, HIV/AIDS – Mother to Child transmission, Helminthiasis, Domestic Accident as well as Asthma.

Chapter 3: Strategic Health Priorities

Through the review of technical resource materials, wide consultations and participatory techniques, eight priority areas of concern to improve the health system in Akwa Ibom State were identified namely:

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

For each of the priority areas, Annex I of the Akwa Ibom SHDP details the goals, strategic objectives, and recommended evidence-based, cost-effective interventions and activities required to deliver improved performance of the health system and health outcomes for **Akwa Ibomites** and indeed all Nigerians.

The essential package of care for Akwa Ibom State is detailed below.

Table 2: State Essential Package of Care

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

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

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

Chapter 4: Resource Requirements

4.1 Human Resources

Human resources are the most important of all management tools because of the centrality in the coordination of all factors required for proper management**.** Akwa Ibom State has a total of 182 medical doctors, 3 dentists, 1940 Nurses/Midwives, 31 Medical laboratory Scientists,19 Medical laboratory Technicians, 36 Pharmacists, 24 Pharmacy Technicians, 238 community Health workers, 3 Radiographers, 79 Medical record Technicians, 12 X-Ray Technicians, 3 Ophthalmic Opticians and I Ophthalmologist.

AKS Government is very much concerned with the provision of adequate manpower in the right mix in order to provide quality health care services to its citizen

Goal: To plan and implement strategies to address the human resources needs for health so as to enhance its availability as well as ensure equity and quality of health care.

Strategic objectives: To create and sustain an enabling environment for the delivery of quality health care and development in Akwa Ibom state.

Interventions: To this end, the following interventions would be employed-

i) Communication

ii) Cooperation and

iii) Collaboration between Health professional association and regulatory bodies on professional issues that can impact on health system.

4.2 Physical/Maternal Requirements

The present Akwa Ibom government has done a lot in providing physical health infrastructure. New health institutions are being constructed while old ones are being renovated. The state has a total of 43 secondary health facilities with 348 Primary health centers.

The secondary health facilities comprises of general hospitals, cottage hospitals, comprehensive health centres, Dental and Eye Clinics. Four cottage hospitals are currently being built at Ibeno, Eastern Obolo, Ukanafun and Essien Udim while one comprehensive Health Centre in Ika is being upgrade to a 40 bed Cottage Hospital. . These Local Government Areas had no secondary health facilities before which could serve as referral centres for primary health activities.

Four Local Government Area (LGAs) currently operating without a General Hospital will benefit in the next phase of construction. These LGAs include

i) Nsit Ibom,

ii) Mbo,

iii) Ibiono

iv) Obot Akara.

248 Primary Health Centres are being renovated by the Government. Presently, the policy of government is to have at least one health centre in each political ward to reduce long walking distance by clients to 5km radius. This is being done by Inter-ministerial Direct Labour co-coordinating Committee in concert with the Ministry of Health.

4.3 Financial Resource Requirement:

Enormous Financial requirement is needed for human capital and infrastructural development, provision of patented drugs and modern equipment for effective and qualitative health services to the citizenry. The state will have to increase her budgetary provision to be in line with WHO requirement of 7% budgetary allocation to Health. Already state budgetary allocation to Health is on the increase but then serious gaps still exist. How these gaps are going to be managed is very important in meeting our desired goals and objectives. However, we are hopeful that our Donor Agencies implementing and developing partners will live up to their responsibilities in ensuring that these gaps are filled.

Assessment of the Available and Projected Funds

The process involved in accessing appropriated funds is rather cumbersome. Ordinary, budget Process should allow for expenditure on heads and subheads once funds have been appropriated. Doing it the other way allows for more checks and control of implementing Ministries but it often results in the Chief Executive not being able to get approval for all the Memos. So even when government appropriated say 10 billion naira, it may end up releasing 5 – 6 billion representing 50 -60%. To over come these challenges, we need an extensive and intensive advocacy to ensure that all funds appropriated for health activities are spent to the last kobo.

In 2010, government appropriated the sum of N10.2 billion whereas the state AKSHDSP for 2010 proposed the sum of 22 billion naira. A gap of 50% therefore exists between our annual budget and the AKSHDSP and also between annual budgetary provision and annual actual releases.

The growth of the state (annual) allocation to health and projected expenditure of our strategic Health Development Plan is expected to follow the following time path within the Medium Term Expenditure Framework (MTEF). Thus:-

A) **Annual Operational Budget (2011 -2013)**

Table 3: Projected appropriation, releases and gaps in billion Naira

S/N	Year	2011	2012	2013	Total 2011 - 2013
1	Expected Annual appropriation	11.22 bn	12.34 bn	13.57 bn	**37.13 bn**
2	Expected Actual Releases	6.73 bn	7.40 bn	8.14 bn	**22.27 bn**
3	**Expected Gaps**	**4.49 bn**	**4.94 bn**	**5.43 bn**	**14.86 bn**

B) **AKSHDP Projected Expenditure, Expected Annual Appropriation And Expected Gaps (bn)**

Table 4: Projected Expenditure, Expected Annual Apprpriation and Expected Gaps (bn)

S/No	Year	2011	2012	2013	Total 2011 - 2013
1	AKSHDSP projected expenditure	24.66 bn	26.93 bn	29.62 bn	**81.21 bn**
2	Expected Actual Releases	11.22 bn	12.24 bn	13.57 bn	**37.13 bn**
3	**Expected Gaps**	**13.44 bn**	**14.59 bn**	**16.05 bn**	**44.08 bn**

In determining total financial Gaps (TFG), it is therefore expedient to add up Gaps in table A to Gaps in table B. thus:

TFG = GA + GB for each year.

For 2011, the expected financial gap is 4.49 bn + 13.44 = 17.93 billion Naira.

This value can be spread among our donor agencies, implementing and development partners, etc to be able to achieve total success in the business of Health Care Delivery in Akwa Ibom State for the year 2011.

Chapter 5: Financing Plan

5.1 Estimated cost of the strategic orientations

It is estimated that AKSSHDP would cost a total of ₦94, 597,453,260.00 for the next 6 years comprising of

1. Leadership and governance, N945,974,533
2. Service delivery, N57,281,091,564
3. Human resources for health, N27,938,608,591
4. Health financing, N3,228,918,642
5. Health information system, N1,418,961,799
6. Community participation and ownership, N945,974,533
7. Partnerships for health development and N945,974,533
8. Research for health. N1,891,949,065

The State allocation to health in 2006 stood at N3.85bn, representing 3.25% total budget, out of which only N0.98bn was actually released. Whereas in 2008, N10.25bn or 4.0% of total state budget was allocated to health with only N3.9bn actually released. Consequently, revised state budgets for 2006 and 2008 stood at N118.7bn and N265.2bn respectively**.**

5.2 Assessment of the available and projected funds

From AKSG annual budgetary provision and funding support from Development Partners.

5.3 Determination of the financing gap

The financing gap would be met with Partners funding

5.4 Descriptions of ways of closing the financing gap

MDG's and Partners funds.

Chapter 6: Implementation Framework

The successful implementation of this Strategic Health Plan depends on the cooperation and commitment of all stakeholders within and outside the health sector. It is anticipated that all stakeholders will demonstrate practical commitment to the implementation of the above expressed priority interventions, which will be measurable in terms of availability and adherence to prioritized and costed annual operational plans which will incrementally attain the desired ends and based on this strategic plan as well as form the basis of the State and LGAs sectoral budgeting. It is assumed that the Governor and Chairmen of LGAs in the state will demonstrate the requisite leadership and commitment to this plan by prompt allocation, disbursement and utilization of available funding and resource requirements.

Other critical assumptions include the continuance of Good governance, Political stability, availability and prompt release of funds, absence and or limited political influence on programme implementation, freedom to adhere to guidelines as stated in the strategic health plan, motivated and adequate workforce, sustained collaborative public/private partnership at State and LGA levels as well as willingness of all stakeholders to participate in the planning, implementation and evaluation of this AKS-SHDP.

Existing structures include the state Ministry of Health, saddled with the responsibility of stewardship of all the health services in the state. There is also Hospitals Management Board that takes charge of the general hospitals and reports to the main ministry.
There is also an intended state Primary Health Care Development Agency whose mandate will centre around providing technical support for primary health care services across the state

The private sector despite its critical role as major players in providing health care to the people in the state, is yet to be maximally utilised, particularly because they are concentrated in the urban areas where just 30% of the populace lives. Better coordination and streamlining of their operations can guarantee their being actively engaged in regulatory functions, capacity building, M&E, supportive supervision and community mobilization. Development partners are important in providing technical support and funding as well as logistic support in healthcare delivery.

Similarly the traditional institutions whose leaders can be reached and engaged as sustainable and strategic partners in a bid to upscale the cost-effective health interventions as well as in leveraging of funds from the community for health financing.

The interventions that are directed at individuals and households require them to accept and utilize the services. The understanding of the benefits of health services by the heads of households and individuals is cardinal to their health-seeking behaviour. The overall low literacy level of individuals especially women has made it difficult to engage them on some key Reproductive Health interventions that can improve Maternal Mortality Reduction and the health of women and children as a whole. The decision making powers of the heads of

households can impact negatively or positively on the health of the members of the household. So also can the socioeconomic status of individuals and House Holds affect their ability to access health services.

Professional associations and regulatory bodies are stakeholders in ensuring the implementation of policies, guidelines and Standard Operating Procedures, meting out appropriate sanctions to erring members. They can also be of important in providing technical assistance to health workers when new guidelines and SOPs are introduced.

Structures, Institutions, strategic partners, civil society, individuals, households and other actors should be identified as well as their roles and their inter relations

Chapter 7: Monitoring and Evaluation

7.1 Proposed mechanisms for monitoring and evaluation

Implementation of the State strategic plan will be monitored at State and Local Government level. Effort is still being made to provide each LGA with the Health Management Information System (HMIS) minimum package. This effort would be intensified in order to make the availability of the minimum package a reality in the first year of this plan. HMIS monitoring system would be strengthened through provision of vehicles, equipment and training and re-training of staff to provide the required quality health data.

The steering committee of the state strategic development plan for health will have the overall oversight responsibility for monitoring implementation of the plan.

The committee will set up a monitoring and evaluation technical working group that will work with the Health management Information Systems (HMIS) Unit of the State Ministry of Health to develop a monitoring and evaluation framework in line with the M and E Strategic Plan.

Integrated Supportive Supervision (ISS) activities in the state occur monthly and at least each health facility is visited by the ISS teams several times in a year depending on logistics availability. ISS is also one of the important points of collaboration between public and private practitioners, Non Governmental Organizations and the community. All these people can play major roles in monitoring and evaluation.

A monitoring report will be compiled and presented at the annual stakeholders meetings and at the State and National Councils on Health (NCH). At the state level, monitoring reports will be shared with all stakeholders with copies of half yearly reports submitted to the National monitoring and evaluation observatory at the federal level. There is also plans to hoist a website where half yearly progress reports of the state ministry of health will be posted.

Conclusion

This AKS-SHDP has the potential to transform the health system of the state and improve the dismal health indices in maternal and child health. The effective monitoring of the plan and its efficient implementation will be a major determinant of its success in achieving the set objectives.

Annex 1: Summary of AKSHDP leadership and governance

Objective	Strategies	Indicators
1. To provide clear policy directions for health development	1.1 Improved Strategic Planning at State levels	All stakeholders are informed regarding health development policy directives by 2011
	1.2: Enhance the performance of the health care system	Increased number of health care personnel in state and LG health facilities.
2.0.To facilitate legislation and a regulatory framework for health development	2.1:Strengthen regulatory functions of government	Health Bill signed into law by end of 2009
3.0: To strengthen accountability, transp arency and responsiveness of the national health system	3.1: To improve accountability and transparency .	80% of States and the Federal level have an active health sector 'watch dog' by 2013
4.0. To enhance the performance of the national health system	4.1. Improving and maintaining Sectoral Information base to enhance performance	1. Oyo State (and their LGAs) updating SHDP annually. 2. Oyo State (and LGAs) has a costed SHDP by end 2011

HEALTH SERVICE DELIVERY

Objective	Strategies	Indicators
1. To ensure universal access	1.1: To review, cost, disseminate and implement the minimum	Minimum package of care available and disseminated

to an essential package of care	package of care in an integrated manner	
	1.2: To strengthen specific communicable and non communicable disease control programmes	Communicable and non communicable disease control programmes strengthened
	1.3: To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels	1.0 Standard SOPs and guidelines available
2.0. To increase access to health care services	2.1: To improve geographical equity and access to health services	1.0 Access to health services improved
	2.2: To ensure availability of drugs and equipment at all levels	1.0 Essential drugs are available at all times
	2.3: To establish a system for the maintenance of equipment at all levels	1.0 Equipments are well maintained in the state and LGAs
	2.4 To strengthen referral system	1.0 Reduction in morbidity and mortality rates
	2.5 To foster collaboration with the private sector	1.0 Existence of a good collaboration with the private sector
3.0 To improve the quality of health care services	3.1:To strengthen professional regulatory bodies and institutions	1.0 80% of States and the Federal level have an active health sector 'watch dog' by 2013
	3.2 To develop and institutionalise quality assurance models	1.0 Quality assurance models are available

	3.3 To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms.	1.0 Health Management and Integrated Supportive Supervision (ISS) mechanisms are institutionalised
4.0. To increase demand for health care services	4.1To improve financial access especially for the vulnerable groups	Oyo State (and their LGAs) updating SHDP annually 2. Oyo State (and LGAs) has a costed SHDP by end 2011
5.0 To provide financial access especially for the vulnerable groups	To improve 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

HUMAN RESOURCES FOR HEALTH

Objective	**Strategies**	**Indicators**
1. To formulate comprehensive policies and plans for HRH for health development	1.1: To develop and institutionalize the Human Resources Policy framework	Human resource policy framework developed
	1.2: Reappraisal of the principles of Health work-force.	1.0 Principles of health work-force reappraised
	1.3: Establishment and strengthening of human resources health unit	1.0 Human resource health unit established

	1.4: Equitable distribution, right mix and retention of the right quality and quantity of health human resources	1.0 Health human resources are available and equally distributed
2.0. To provide a framework for objective analysis, implementation and monitoring of HRH performance	2.1: To reappraise the principles of health workforce requirements and recruitment at all levels	1.0 Principles of health workforce requirements reappraised
3.0 Strengthen the institutional framework for human resources management practices in the health sector	*3.1:* To establish and strengthen the HRH Units	Established HRH units available at the state and LGA level
4.0. 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	4.1. To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities	Reviewed and Adapted document for training programmes available at the state

	4.2 To strengthen health workforce training capacity and output based on service demand.	1.0 Training programmes are result oriented
5.0To improve organizational and performance-based management systems for human resources for health	5.1To achieve equitable distribution, right mix of the right quality and quantity of human resources for health	1.0 Oyo State has implemented performance management systems by end 2012
	5.2 To establish mechanisms to strengthen and monitor performance of health workers at all levels	1.0 Mechanisms for monitoring performance of health workers are available by end of 2012
6.0 To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda	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	Oyo State has regular HRH stakeholder forums by end 2011

FINANCING FOR HEALTH

Objective	**Strategies**	**Indicators**
1. To develop and implement health	1.1: To develop and implement	Oyo State has a documented Health Financing Strategy by end 2012

financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy	evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy	
	1.2: To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy	
2.0. To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services	2.1: To strengthen systems for financial risk health protection	NHIS protects all Nigerians by end 2015
3.0 To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner .	*3.1:* To improve financing of the Health Sector	Allocated State and LGA health funding increased by an average of 5% pa every year until 2015
	3.2: To improve coordination of donor funding mechanisms	Documents on all funded activities on health in Oyo State is available

4.0. To ensure efficiency and equity in the allocation and use of health sector resources at all levels	4.1: To improve Health Budget execution, monitoring and reporting	1. Oyo State and LGAs have transparent budgeting and financial management systems in place by end of 2015 2. Oyo State and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012
	4.2 To strengthen financial management skills	Professionals are employed

NATIONAL HEALTH INFORMATION SYSTEM

Objective	**Strategies**	**Indicators**
1.0 **To improve data collection and transmission**	1.1: To ensure that NHMIS forms are available at all health service delivery points at all levels	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010
	1.2: To periodically review of NHMIS data collection forms	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010
	1.3: To coordinate data collection from vertical programmes	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010
	1.4: To build capacity of health workers for data management	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010
	1.5:	1. All LGAs making routine NHMIS returns to State level by end 2010

	To provide a legal framework for activities of the NHMIS programme	2. Oyo State making routine NHMIS returns to Federal level by end 2010
	1.6: To improve coverage of data collection	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010
	1.7: To ensure supportive supervision of data collection at all levels	1. All LGAs making routine NHMIS returns to State level by end 2010 2. Oyo State making routine NHMIS returns to Federal level by end 2010
2.0. To provide infrastructural support and ICT of health databases and staff training	2.1: To strengthen the use of information technology in HIS	Information capacity training(ICT) infrastructure and staff capable of using HMIS in 50% of States by 2012
	2.2:To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management	HMIS minimum package available at the LGAs
3.0 To strengthen sub-systems in the Health Information System .	*3.1:* To strengthen the Hospital Information System	1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released
	3.2:To strengthen the Disease Surveillance System	1.0 Active disease surveillance present in the state

4.0. To monitor and evaluate the State HMIS	4.1:To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs	1.0 State HMIS evaluated annually
5.0 To strengthen analysis of data and dissemination of health information	5.1 To institutionalize data analysis and dissemination at all levels	1. Oyo State has a Unit capable of analysing health information by end 2010 2. Oyo State disseminates available results regularly

COMMUNITY PARTICIPATION AND OWNERSHIP

Objective	**Strategies**	**Indicators**
1.**To strengthen community participation in health development**	1.1 To provide an enabling policy framework for community participation	Policy framework reviewed by end of 2010
	1.2: To provide an enabling implementation framework and environment for community participation	1.0 Enabling implementation framework and environment for community participation provided by end of 2011
	1.3 To carry out advocacy and community sensitization of community members to the need of community participation in health development	1.0 Number of advocacy visits and sensitization held and reported by end of 2010

2.0. **To empower communities with skills for positive health actions**	2.1: To build capacity within communities to 'own' their health services.	1.0 Number of Ward Development Committee trained and their contributions to daily running of Health facilities by end of 2012
	2.2 To hold monthly data sharing and health education on emerging issues with community members	1.0 Minutes of data sharing meetings held
	2.3 To Identify and map out key community stakeholder for community participation in Health care delivery.	1.0 Number of stakeholders identified by end of 2010
	2.4 To carry out Quarterly community dialogue.	1.0 Number o f Quarterly community dialogue meetings held with minutes.
3.0 **To strengthen the community - health services linkages** .	*3.1:* To restructure and strengthen the interface between the community and the health service delivery points	1.0 Number of Health facilities restructured and strengthened per ward by the year 2011..
	3.2:To identify, review and improve existing linkages between health delivery structure and the community	1.0 Number of linkages identified

PARTNERSHIPS FOR HEALTH

Objective	**Strategies**	**Indicators**
1. **To ensure that collaborative mechanisms are put in place for involving all partners in the development and**	1.1: To promote Public Private Partnerships (PPP)	MOUs on PPP

sustenance of the health sector	1.2: To institutionalize a framework for coordination of Development Partners	No of Meetings
	1.3 To engage professional groups	Singed MOUs
	1.4 To engage with communities	Singed MOUs
	1.5 To engage with traditional health practitioners	Singed MOUs

RESEARCH FOR HEALTH

Objective	**Strategies**	**Indicators**
1. **To strengthen the stewardship role of governments at all levels for research and knowledge management systems**	1.1: To develop health research policies at State and LGA levels	**1.** ENHR Committee established by end 2009 to guide health research priorities 2. SMOH publishes an Essential Health Research agenda annually from 2010
	1.2: To establish and or strengthen mechanisms for health research at all levels	Mechanisms for health research established
	1.3:To institutionalize processes for setting health research agenda and priorities	Health research agenda and priorities intitutionalised

	1.4:To promote cooperation and collaboration between Oyo state Ministry of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors	Obvious Collaboration between stakeholders
	1.5:To mobilise adequate financial resources to support health research at all levels	Funds available for health research at State and LGA levels
	1.6:To establish ethical standards and practise codes for health research at all levels	Ethical standards and practice codes available at State and LGA
2.0. **To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**	2.1: To strengthen identified health research institutions at all levels	health research institutions strengthened
	2.2: To create a critical mass of health researchers at all levels	Availability of health researchers at all levels
	2.3: To develop transparent approaches for using research findings to aid evidence-based policy making at all levels	Policy making is evidenced based and transparent
	2.4: To undertake research on identified critical priority areas	Research undertaken in critical priority areas

3.0 **To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)** .	*3.1:* To develop strategies for getting research findings into strategies and practices	GRIPS Unit established
	3.2: To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system	Research undertaken in critical priority areas
4.0. **To develop, implement and institutionalize health research communication strategies at all levels**	4.1: To create a framework for sharing research knowledge and its applications	A state health research communication strategy is in place by end 2012
	4.2 To establish channels for sharing of research findings between researchers, policy makers and development practitioners	A state health research communication strategy is in place by end 2012
	To utilize health research findings to develop interventions	A state health research communication strategy is in place by end 2012

Annex 2: Population size by LGA

LGA	Total Population
Abak	153,765
Eastern Obolo	66,931
Eket	190,763
Esit Eket	70,422
Essien Udim	212,996
Etim Ekpo	116,540
Etinan	187,145
Ibeno	83,333
Ibesikpo Asutan	151,566
Ibiono Ibom	209,648
Ika	80,635
Ikono	145,821
Ikot Abasi	145,952
Ikot Ekpene	158,173
Ini	109,662
Itu	140,436
Mbo	114,986
Mkpat Enin	196,820
Nsit Atai	82,465
Nsit Ibom	120,070
Nsit Ubium	141,760
Obot Akara	163,926
Okobo	115,036
Onna	136,390

Oron	**96,689**
Oruk Anam	**190,870**
Udung Uko	**58,899**
Ukanafun	**140,436**
Uruan	**130,782**
Urue Offong/Oruko	**78,667**
Uyo	**342,235**
State Total	**4,333,819**

Akwa Ibom State projected population distribution 2009:NPC population census 2006

Annex 3: Details of Akwa Ibom Strategic Health Development Plan

AKWA IBOM 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							**945,974,533**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**81,259,906**
		1.1.1	Improved Strategic Planning at Federal, State and LGA levels		State and LGA health plan developed		**81,259,906**
			1.1.1.1	Development and dissemination of state health policy, standards and protocols across primary and secondary health interventions at the State and LGAs Levels with emphasis on attaining MDGs		Political instability and change of government	1,596,945
			1.1.1.2	Develop evidence-based,costed, prioritised health plans, including managerial capacity building for health management teams at state & LGAs		Lack of financial backing	61,366,710
			1.1.1.3	Optimise the contribution of the wider stakeholders at each level with regular review and planning meetings at state & LGAs level		Lack of sensitization and awareness	6,483,526
			1.1.1.4	Effective implementation of agreed plan through wide dissemination and advocacy at the state & LGA levels, eg IMNCH strategy briefs		Lack of agreement between participatory groups	11,812,725
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		**17,480,533**
		1.2.1	Strengthen regulatory functions of government		State and LGA health plan developed		**17,480,533**
			1.2.1.1	Develop public /private partnership policies and plans in line with the National policy on PPP		Lack of awareness of the policy	3,798,179
			1.2.1.2	Develop standard operating procedures with agreed quality standards to guide service delivery, ensure compliance and aid supportive supervision		Bereaucratic bottleneck	6,915,905
			1.2.1.3	Foster public service collaboration with the private sector to improve the health delivery system, through joint continuous professional development and generation of public health information and intelligence		Lack of commitment to enforce responsibilities by key stakeholders	4,888,916
			1.2.1.4	Review , update, and enforce Public Health legislation to close policy gaps and ensure enactment of relevant acts and laws through the state assembly.		Breach of agreement	1,371,684

			1.2.1.5	Streamline roles and responsibilities of Regulatory Institutions in the state to align with the national health bill		Lack of commitment to enforce responsibilities by key stakeholders	505,849
	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**		**841,304,738**
		1.3.1	To improve accountability and transparency		60- 70% of activities implemented by 2013		**841,304,738**
			1.3.1.1	Create structures to ensure decentralized decision making process at the state and LGAs.	Decision making bodies set up in State and LGAS		943,078
			1.3.1.2	Instiitute Stakeholders' dialogue and collaborative feedback mechanism to encourage interaction with health advocacy groups and promote emergence of independent health sector 'watch-dogs'			13,347,517
			1.3.1.3	Empower beneficiary communities through sensitization to own, manage and oversee their health programmes			555,743,972
			1.3.1.4	Ensure capacity building for improved financial management, establishing structures to monitor and enforce fiscal discipline, transparency, accountability and consistency in funds management for ALL programmes and services.	60 - 70% of active Independent 'watch dog' in place		257,474,288
			1.3.1.5	Improve access to information on health system performance,making such review reports available in the public domain (INTERNET & AKS WEBSITE) and on demand by stakeholders			13,795,883
	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**	**5,929,356**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				**5,929,356**
			1.4.1.1	Deepen and expand the analytical work required to understand health sector performance in the state, to drive improvements and reforms through annual conferences on leadership functions for health			4,808,440
			1.4.1.2	Outsource prioritised areas of future analytical work to Universities , private researchers, State owned research units and national research institutes			1,120,915
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**57,281,091,564**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**25,434,224,796**

		2.1.1	PROVISION OF ESSENTIAL HEALTH CARE SERVICE PACKAGE				**1,903,055,532**
			2.1.1.1	Review, cost, disseminate and implement the minimum package of care in all areas of health care delivery in an integrated manner, including MNCH strategy			44,396,273
			2.1.1.2	Promote awareness of Reproductive Health issues, build capacity of young persons, health workers, and other relevant groups in delivery of quality RH information, counseling and clinical services.	**Number of copies of reviewed SOPs/Guidelines distributed,to the delivery points.**		788,290,536
			2.1.1.3	Strengthen the PHC centres and Communities to perfom Growth Monitoring and Promotion for infants and children from birth to 5 years in the context of IMNCH.	**Availability of copies of checklist used during monitoring**		459,061,706
			2.1.1.4	Delivery of sustainable, comprehensive, quality prevention of HIV/AIDS/TBL/STIs care and support services, guided and monitored by National protocols for all health service providers	**Types and number of equipment supplied**		503,007,659
			2.1.1.5	Strengthen Integrated monitoring, evaluation and supervision of programmes	**Ratio of personnel per service unit**		108,299,358
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				**23,447,780,559**
			2.1.2.1	Build capacity, improve immunization coverage and supportive funding of quality immunization services.			15,832,166,725
				Develop and sustain activities that promote, protect and support exclussive breastfeeding and adequate complementary feeding practices, and micronutrient supplementation.			2,292,924,480
			2.1.2.3	Build capacity, improve TB/HIV/STIs collaboration activities especially in rural areas in line with national guidelines.			2,765,930,218
			2.1.2.4	Expansion of DOTS centres, procurement of drugs/equipment, training, collaboration, monitoring and evaluation of Tubreculosis and Leprosy Control services			2,096,849,769
			2.1.2.5	Provision of free treatment to HV/AIDS infected patients, establishing new treatment centres, sensitization, advocacy, training health care providers and procurement of Test kits, ARDs etc			459,909,367
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				**83,388,705**
			2.1.3.1	Adoption, dissemination, distribution and implementation of all SOPs and guidelines.			83,388,705
			2.1.3.2	Free Health Care for under 5 Children, pregnant Women and the elderly in AKS			-
			2.1.3.3	Roll out and scale up of the Integrated Maternal, New Born and Child Health strategy			-
			2.1.3.4	Improvement in Schools Health services and control of sickel cell Anemia			-
			2.1.3.5	Provide Artemisinin Based Combination Therapies, Insecticide Treated Bednets and other materials to young children, pregnant women and the public to control malaria			-

	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**		**15,760,846,602**
		2.2.1	To improve geographical equity and access to health services				**7,914,009,241**
			2.2.1.1	Mapping of existing health facilities - to know where they are sited, functionality, type, accessibility with a view to properly siting new ones, determine where increased funding is needed as well as renovation and refurbishing needs etc.	**No of health facilities available(functional and non-functional}**		85,793,944
			2.2.1.2	Establishment of Youth Friendly centres(YFCs) in all the LGAs.	**No. of HF refurbished/upgraded.**		4,943,297,238
			2.2.1.3	Ensure implementation of outreach sevices to communities in line with national guidelines	**No. of outreach services held/ month**		498,817,032
			2.2.1.4	Advocate for dedicated budget line for maintenance of roads to improve access to health facilities.	**No. of access roads created and maintained.**		133,400,736
			2.2.1.5	Advocacy/Sensitization of political,traditional, religious leaders/retraining for health workers to address issues of stigma and discrimination in health facilities/communities			2,252,700,291
		2.2.2	To ensure availability of drugs and equipment at all levels				**1,730,638,790**
			2.2.2.1	Support local production of essential drugs and other IMNCH commodities	**Available list reviewed.**		132,447,116
			2.2.2.2	Review and strengthen the state and LGAs unified drug revolving fund (DRF).	**No. of meetings held/no . Of participants in attendance.**		120,675,217
			2.2.2.3	Procurement of drugs/equipment in line with essential package of care	**Quantity/types of drugs and equipment procured.**		529,788,466
			2.2.2.4	Train key staff in logistics management of drugs, vaccines, RH supplies, ITN, medical equipment etc	**Available requisition /supply documents.**		513,216,683
			2.2.2.5	Ensure regular supply of Essential drugs using BI principles at health facilities and community levels based on Essential Drug List.			434,511,308
		2.2.3	To establish a system for the maintenance of equipment at all levels				**2,866,155,600**
			2.2.3.1	Adapt the national health equipment policy to develop, disseminate and distribute a state health equipment policy	Available policy document in use.		55,627,789
			2.2.3.2	Establish medical equipment and hospital furniture maintenance workshop in the state and create budget lines for the maintenance of equipment and furniture at all facilities	Available estimate document presented.		264,894,233
			2.2.3.3	Expand PHC facilities /services in under served areas including revitalization of non functioning facilities.	Medical equipment and hospital furniture maintenance workshops built and equiped.		2,463,516,366

			2.2.3.4	Build capacity for installation and maintainance of medical equipment.			82,117,212
			2.2.3.5				-
		2.2.4	To strengthen referral system				**2,861,747,760**
			2.2.4.1	Mapping of existing network linkages for two-way referral systems in line with the national standards.	**Available report of mapping exercise carried out.**		11,167,941
			2.2.4.2	Sensitization/awareness creation activities for State and LGA stakeholders for mobilization of local mechanisms for referral system (women groups,NURTW,okada riders,opinion leaders,religious leaders,boat riders and youth groups.)	**Number of people/groups sensitized.**		1,852,034,519
			2.2.4.3	Resuscitate and strengthen a two-way referral system through logistics support such as radio communication and transport to each local government.	**Availability of the written report.**		998,545,300
			2.2.4.4	DOTs expansion, procurement, training, collaboration, monitoring and evaluation for Tuberculosis and Leprosy control			-
			2.2.4.5	Provide vaccines and equipment for National Programme on Immunization (NP) programmes to conduct 6 rounds of NIDs in the state annually.			-
		2.2.5	To foster collaboration with the private sector				**388,295,211**
			2.2.5.1	Mapping of private sector health facilities(to determine their location, operational levels and manpower status.	**Available report of mapping exercise carried out.**		10,320,279
			2.2.5.2	Review of existing Guidelines and SOPs for regulation of their practice and registration, partnership, training and outsourcing of services; development of same where they are non-existent	**Available policy document in use.**		159,360,371
			2.2.5.3	Adoption, dissemination and distribution of existing guidelines for partnership training and out sourcing of services.	**No. of copies of guidelines distributed.**		14,834,077
			2.2.5.4	Facilitate implementation of joint performance monitoring mechanism with the private sector .	**Availability of developed monitoring checklist.**		79,796,739
			2.2.5.5	Engage and motivate the private health facilities to contribute to scaling-up of health services including IMNCH/RH through advocacy, participation in training, policy and strategy formulation, contracting, supervision and regulation to deliver these services.	**Available policy document in use.**		123,983,746
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**9,791,759,692**
		2.3.1	To strengthen professional regulatory bodies and institutions				**521,121,127**
			2.3.1.1	Review, update and implement operational guidelines of all regulatory bodies at all levels.	Number of copies of reviewed operational guidelines distributed.		148,234,813

			2.3.1.2	Building capacity of regulatory staff to monitor compliance of providers to the guidelines.	No. of regulatory staff trained.		206,246,650
			2.3.1.3	Strengthen monitoring and evaluation activities	No. and report of monitoring visits.		5,827,673
			2.3.1.4	Develop and implement Nursing process programme to ensure achievement of patients satisfaction in health care especially in the hospital	1) Implementation of Nursing process programme up to 60-70% in all state hospitals 2) 80% satisfactory Nursing care to patients with good rsults 3) Availability of Nursing process materials and training of nurses on this	1) Lack of implementation of Nursing process 2) Shortage of staff 3) Non availability of materials	160,811,991
			2.3.1.5				-
		2.3.2	To develop and institutionalise quality assurance models				**8,462,692,612**
			2.3.2.1	Review available models and building consensus on the models to adopt.	Availability of signed copy of the adopted model.		335,207,758
			2.3.2.2	Develop quality assurance training manuals.	Availability of training manual on quality assurance developed.		72,210,168
			2.3.2.3	Build capacity of both public and private health care providers on quality assurance (TOTs,Step-down trainings, etc)	No. of public and private health care providers trained.		6,781,557,257
			2.3.2.4	Facilitate the implementation of quality assurance and improvement initatives in the state and LGAs	No. of HF/levels implementing.		173,240,828
			2.3.2.5	Adoption and dissemination of SERVICOM guidelines to all health facilities in the state	Availability of copies/numbers of guidelines at each HF.		1,100,476,601
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				**807,945,953**
			2.3.3.1	Strengthen management capabilities of health managers and health teams especially at the LGAs and ward levels	No. of personnels trained at different levels.		84,572,782
			2.3.3.2	Development of Integrated Supportive Supervision(ISS) tools and guidelines specifying modalities and frequencies of ISS visits at all levels.	Availability of tools and guidelines on ISS developed.		14,728,119
			2.3.3.3	Promote use of integrated supportive supervision to track the implementation of IMNCH and other health interventions.	No. of HF/levels implementing		708,645,052
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**5,311,598,233**
		2.4.1	To create effective demand for services				**5,311,598,233**
			2.4.1.1	Strengthen the use and implementation of existing national health promotion communication strategies based on National Health Promotion Policy, and its adaptation to reflect local realities	Availability of evaluation report on implementation of policy.		818,374,839
			2.4.1.2	Institutionalise bi- annual MNCH weeks,adoption/institutionalization of school health services in the primary and	Available estimate document presented.		104,527,264

				secondary schs eg school meal, deworming etc			
			2.4.1.3	Formation / reactivation of VDCs/WDCs;Co-ordination of their activities;Programme monitoring and evaluation	Lists of existing and functioninf VDCs/WDCs; Availability of copies of checklist used during monitoring		765,395,992
			2.4.1.4	Facilitate employment of skilled unemployed or retired Midwives at rural based health facilities as part of the Midwives Service scheme of the federal Government.	No. of retired midwives employed per HF.		762,853,008
			2.4.1.5	Disseminate information on nutrition care and key household practices through the community resource persons, mass media, other institutions, social and Faith Based Organizations for behaviour change.	**No. of FBOs involved in BCC activities**		2,860,447,129
	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**		**982,662,242**
		2.5.1	To improve financial access especially for the vulnerable groups				**982,662,242**
			2.5.1.1	Establish financial mechanisms that protect the poor and vulnerable groups (Handicapped, PLWHAs &TBL patients, OVCs, the Aged) including exemptions, subsidies, insurance and other methods in the utilization of IMNCH services.	Availability of policy.		791,143,712
			2.5.1.2	Establish mutual health funds to ensure financial access to IMNCH health services especially in the rural areas.	No. of existing centres implementing the scheme.		54,568,212
			2.5.1.3	Establish youth friendly/resource centres for OVCs including those orphaned by HIV/AIDS	Availability of checklist/monitoring report.		11,761,304
			2.5.1.4	Monitoring and evaluation process to ensure implementation			125,189,014
			2.5.1.5				-
		2.5.2	To provide physical infrastructure for enhanced performrnce				**-**
			2.5.2.1	Construction of House Officers', Optometrists', Pharmacists', Laboratory Scientists' and NYSC Doctors residential buildings and new staff quarters in health institutions			-
			2.5.2.2	Construction of new staff quarters in health institutions			-
			2.5.2.3	Rehabilitation/Maintenance of Health institutions			-
			2.5.2.4	Equipping of Eye Clinic at state secretariat / establishment of school refractive error programe and eye clinic at General hospital Ikot Ekpene			-
			2.5.2.5	Establishment of Physioterapy units in two General Hispitals in the state (Eket and Ikot Ekpene)			-
		2.5.3					**-**

			2.5.3.1	Equipppig of Government house clinic with screen couch, stretchers, trolleys and other consumable materials			-
			2.5.3.2	Construction and equipping of medical equipment warehouse			-
			2.5.3.3	Equippiing of staff clinic at Idongesit Nkanga secretariat complex and Wellington Bassey way with couch stretchers, trolley cupboard,beds,OP tables			-
			2.5.3.4	Provision/Maintenance of 6 No Body mortuaries in secondary health institutions			-
			2.5.3.5	Replacement/Maintenance of Hospital equipment and upgrading of facilities in all government owned hospitals			-
		2.5.4					-
			2.5.4.1	Expansion of Health facilities			-
			2.5.4.2	Purchase of Consumables / Provision of medical utility clinics and NYSC programmes			-
			2.5.4.3	Purchase/distribution of 10 No. Ambulances to hospitals and maintenance of both land and sea ambulances			-
			2.5.4.4	Construction of new hospitals and completion of ongoing hospitals			-
			2.5.4.5	Establishment of Medical laboratory and X-ray facilities in 6 No. hospitals			-
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							**27,938,608,591**
	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**		**2,161,219,148**
		3.1.1	To develop and institutionalize the Human Resources Policy framework		(1)Availability of HRH policy & strategic plan (2) Number of personnel employed annualy (3) Availability of monthly monitoring reports		**2,161,219,148**
			3.1.1.1	Adapt the National HRH Policy into a State HRH policy and develop its strategic plan to incorporate public private partnership (P.P.P) for provision of comprehensive and complementary services		(1) Change of government (2) Lack of political will	174,630,175
			3.1.1.2	Recruitment & training of health personnel based on updated state recruitment & training policy and need to ensure non restriction and a reflection of state character	revisit	Lack of political will	1,569,037,492
			3.1.1.3	Develop a policy framework to guide existence of private and public practitioners, streamlining intra-mural practice in the state health system		(1) Lack of funds. (2) Apathy by citizens toward PPP.	160,971,949
			3.1.1.4	Develop and implement a policy of task shifting and conduct staff auditing of HRH		(1) Lack of funds (2) Lack of vehicle (3) Lack of checklist (4)	198,044,277

						Poor road network	
			3.1.1.5	Establish fora for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks			58,535,254
	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**		**376,576,803**
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		(1) Availability of revised scheme of service & HRH norms (2) Number of Health facilities with HRH units (3) Number of minutes of review meetings held.		**376,576,803**
			3.2.1.1	Modify scheme of service for all groups of health professionals to streamline progression in the service and career pathways to create healthcare demand and supply			56,096,285
			3.2.1.2	Develop, introduce and effectively utilize staffing norms based on workload to guide HRH planning			11,707,051
			3.2.1.3	Establish mechanisms for co-ordinating HRH planning and budgeting in MOH, MOEd, Finance, Civil Service Commission, Regulatory bodies, Private sector providers and NGOs in health.			46,828,203
			3.2.1.4	Adopt FGN circulars, guidelines and policies related to HRH			6,829,113
			3.2.1.5	Utilize service availability mapping and health sector priorities to determine staffing needs and review admission requirements and quota into health training institutions biennially			255,116,150
	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**		**5,911,011,928**
		3.3.1	To establish and strengthen the HRH Units		(1)Number of Health Establishments with HRH units(2)Availability of training guidelines and materials(3)Number of senatorial districts with HRH Corod. Units		**5,911,011,928**
			3.3.1.1	Establishment of HRH unit in the health planning departments in the state and LGAs.		Lack of political will and shortage of staff.	3,087,539,547

			3.3.1.2	Strengthen institutional capacity of HRH unit to perform HRH functions in the State and LGAs including conduct of State trainings on development of guidelines and re-trainings.		Lack of political will and shortage of staff.	1,560,940,115
			3.3.1.3	Establish a short course programme in HRH planning and management in the state health institutions.		Politicisation of sites	1,220,094,207
			3.3.1.4	Establish a course on HRH planning and Management in the curriculum of College of nursing when operational in the State			42,438,059
			3.3.5.5				-
	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**		**6,249,126,190**
		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				**1,963,857,782**
			3.4.1.1	Design special training programmes aimed at producing adequate cadres of health professionals in critical areas of need (eg Community midwives), strengthening pre-service education in health training institutions to provide necessary skills and competencies			56,096,285
			3.4.1.2	Establish / Expand training for community health workers, multipurpose Health workers and other cadres of supportive personnel in the state health institutions			1,617,036,400
			3.4.1.3	Promote the national Midwives Service Scheme and the Community Midwifery Programme in the state as well as update pre-service training curriculum and approaches to be in line with evidence based standards for MNCH and other specific programmes care			158,532,980
			3.4.1.4	Institutionalise continuous assessments of training institutions, curricula and programmes to reflect task shifting requirements.			51,218,348
			3.4.1.5	Conduct biennial review of functions and mandates of HRH regulatory bodies in the state.			80,973,768
		3.4.2	To strengthen health workforce training capacity and output based on service demand				**4,285,268,409**
			3.4.2.1	Annual appraisal and possible repairs or replacement of obsolete teaching and learning materials, infrastructure and financial support as incentive for retention of staff.			487,793,786
			3.4.2.2	Establish education quality assurance and review units in all training institutions in the state with incentives for satisfactory performance			2,946,274,466
			3.4.2.3	Promote human capital capacity building and continuing professional development			370,723,277

				(CPD) by state government and healthcare provider institutions.			
			3.4.2.4	Liaise with professional regulatory bodies to link sponsorship and bonding of healthcare providers to mitigate migration across states and outside the country			51,218,348
			3.4.2.5	Conduct training, retraining and periodic updates on IMNCH relevant areas: (IMCI, EMOC, ENCC, ETC) to ensure that all providers hace appropriate competencies, skills, attitudes and ethics.			429,258,532
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		**12,125,577,928**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				**7,732,507,093**
			3.5.1.1	Create a database of HRH and update annually with data from all health establishments in the state.			80,973,768
			3.5.1.2	Develop and provide job descriptions and specifications for all categories of health workers.			97,558,757
			3.5.1.3	Collaborate with UUTH and other Federal institutions located in the state to leverage available human resource so as to expand service coverage and quality			295,603,034
			3.5.1.4	Promote mandatory rotation of health workers to underserved rural areas, e. g through NYSC scheme for doctors, pharmacists and appropriate scheme for midwives and nurses.			3,629,185,767
			3.5.1.5	Posting of Health practitioners to rural areas with motivation e.g promotion, increase in allowance, rural posting allowance, hazard allowance and leveraging of the capacities of retired health professionals in the areas of need to bridge HRH gaps.			3,629,185,767
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				**4,393,070,835**
			3.5.2.1	Conduct regular re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics			134,631,085
			3.5.2.2	Provision of parameter fence, repair of dilapidated facilities, provision of bus shuttle to assist health institutions and workers and Advocacy to community/ opinion leaders on safety of health workers.	Revisit		-
			3.5.2.3	Establish a mechanism to monitor health worker performance, including use of client feedback (exit interviews, suggestion box).			348,284,763
			3.5.2.4	Establish performance improvement techniques and a framework for integrated supportive supervision to improve PHC and community based service delivery, with adequate committed resources for all			243,896,893

				types and levels of care (both private and public).			
			3.5.2.5	Institute a system of recognition, motivation and reward for those working in rural areas as well as sanctions			3,666,258,094
	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**		**1,115,096,594**
		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				**1,115,096,594**
			3.6.1.1	Promote intra and inter-professional respect, harmony and team work among all disciplines of health care workers for optimum health service delivery			39,023,503
			3.6.1.2	Engage with Staff and Health professional groups / Stakeholders(e.g NAMM, NMA, PAPHNOM, Pharmacist,CHEWS,P.HP. Etc) to discuss challenges affecting HRH management, design and monitoring of services proposed to enhance cooperation amongst all actors. and to profer solution.			121,948,446
			3.6.1.3	Establishing effective dialogue and complaints channels between management and staff of public and private sectors as well as HRH regulatory bodies and associations			82,924,944
			3.6.1.4	Community Dental programme to be introduced for better oral health care delivery. Introduction of dental Unit in the School of Health technology for training of Dental Surgery Assistants / Technicians			871,199,702
FINANCING FOR HEALTH							
4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**3,228,918,642**
	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**		**74,866,023**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy		A state plan developed and circulated to relevant stakeholders		**74,866,023**
			4.1.1.1	Set up a State Technical Working Committee and Train members of TWC on the implementation of state and LGAs HFSP		Change of government policy	19,672,683
			4.1.1.2	Develop, disseminate and Implement the costed and prioritised state and LGAs health financing strategic plans			55,193,340
	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**		**533,771,840**
		4.2.1	To strengthen systems for financial risk health protection		1. State Formal Sector folded into the NHIS by mid		**533,771,840**

					2010; 2. 80% of Public servants enrolled into NHIS by end 2010; 3. NHIS protects all Akwa Ibom citizens by end 2015		
			4.2.1.1	Advocacy and sensitasation of stakeholders on National Health Insurance Scheme		Political will	179,859,950
			4.2.1.2	Strengthen the capacity of the NHIS to provide effective regulatory framework for social health Insurance and protection programmes in the state		Labour Union compliance	222,880,918
			4.2.1.3	Folding the State Formal Sector into the NHIS and strengthening the State TC on the implementation of the NHIS			131,030,972
			4.2.1.4	Ensure universal coverage of the state by NHIS			-
	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**		**2,495,998,003**
		4.3.1	To improve financing of the Health Sector		1. Budgetary allocation increased by an average of 5% per annum until 2015; 2. Free medical services to the poor and vulnerable groups established by end 2015		**2,246,721,700**
			4.3.1.1	Ensure increased Budgetary Allocations to at least 15% of State and LGAs expenditure and allocation of 60% of proposed NPHCDA fund to IMNCH services in LGAs and communities		political will	182,233,338
			4.3.1.2	Attract alternative Financing e.g. grants from F.G., VAT, sin tax, pre-payment schemes, donations from corporations,charities, etc.		Poor Budgetary implementation	77,359,980
			4.3.1.3	Establish special funds for chronic and emerging diseases eg. Mental Health, Cancer, Diabetes, HIV etc			25,045,995
			4.3.1.4	Establish special Health model to protect the Poor and other Vulnerable groups			1,941,695,425
			4.3.1.5	Strengthen the financial and management systems for the effective and efficient use of these resources			20,386,960
		4.3.2	To improve coordination of donor funding mechanisms				**249,276,303**
			4.3.2.1	Create an Agency (data bank) to coordinate all donor resources to the State		Data bank established by end 2011	85,961,769
			4.3.2.2	Map and ensure coordination of the activities of NGO;s/CBO"s working with donor Agencies		60% of NGOs /CBOs sensitized and their activities coordinated by end 2012	85,985,819

			4.3.2.3	Conduct a detailed assessment of coordination structures and functions which exist in the country and appropriate models for effective coordination in the state.			31,305,540
			4.3.2.4	Explore common basket funding options for coordinating government and donor resources such as joint funding agreements, sector-wide approaches (SWAps) and sectoral multi-donor budget support systems			46,023,176
	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**		**124,282,777**
		4.4.1	To improve Health Budget execution, monitoring and reporting				**92,748,764**
			4.4.1.1	Develop state costed strategic as well as annual operational plans	60% of LGAs have trasparent budgeting and financing management system in place by end of 2015	Approvals may not be secured for release	49,267,485
			4.4.1.2	Train accounting officers and Auditors on timely financial reporting process		Diversion of funds to other projects	10,772,838
			4.4.1.3	Develop State health accounts for increased financial tranparency and public expenditure review			31,425,789
			4.4.1.4	Establish mechanism for tracking health budget			1,282,653
			4.4.1.5				-
		4.4.2	To strengthen financial management skills				**31,534,012**
			4.4.2.1	Embark on hands-on training for staff in budgetting, accounting, auditing, planning, monitoring and evaluation	60% of relevant staff trained by end 2011	Transfer of pooled staff	31,534,012
			4.4.2.2				-
			4.4.2.3				-
			4.4.2.4				-
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							**1,418,961,799**
	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**		**85,926,987**

					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				**14,675,824**
			5.1.1.1	Cost and provide adequate budget for production of the forms and Production of standardised forms (yearly)			13,477,490
			5.1.1.2	Distribution of forms to all health facilities (public/private) and Monitoring of the correct use of forms			1,198,334
			5.1.1.3				-
			5.1.1.4				-
			5.1.1.5				-
		5.1.2	To periodically review of NHMIS data collection forms				**32,969,383**
			5.1.2.1	Collect monthly feedback from health data producers and users on the appropriate use of forms			595,594
			5.1.2.2	Conduct annual health data producers and users conference/workshop to review the existing forms			2,256,605
			5.1.2.3	Produce report on the outcome of the health data producers and users conference			99,266
			5.1.2.4	Organize monthly health data consultative committee meeting and present report for discussion and recommendation			7,742,717
			5.1.2.5	Train and re-train health facilities staff on the use of forms quarterly			22,275,201
		5.1.3	To coordinate data collection from vertical programmes				**7,722,864**
			5.1.3.1	Constitude health data consultative committee (HDCC) in the state			-
			5.1.3.2	Conduct monthly health data consultative committee (HDCC) meeting to discuse health data isues			496,328
			5.1.3.3	Ensure that there is integration of health management information system (HMIS) with M&E system in the state			-
			5.1.3.4	Conduct monthly HMIS review meeting with M&E officers, PHCCoordinators and heads of medical records units of hospitals			6,541,603
			5.1.3.5	Conduct Quaterly HMIS review meetings with state MOH Programme oficers DSNOs,Heads of pharmacies of hospitals and lab scientists			684,933
		5.1.4	To build capacity of health workers for data management				**30,558,916**
			5.1.4.1	Bi-annual training & re-training of 500 personnel (31 M&E Officers, 69 Medical Records Officers from Hospitals, 400 Heads of Public Health facilities) on the use of NHMIS tools			5,221,371
			5.1.4.2	Bi-annul training & re training of 131 personnel (31 M&E Officers, 31 PHC Co-ordinators, 69 Medical Records Officers on Health Data Management & Utilization)			1,618,029
			5.1.4.3	Training of 50 Health Program Officers, 40 Pharmacists, 40 Lab. Scientists on Data Collection, Analysis & Utilization			1,295,416

			5.1.4.4	Quarterly data quality assessment joint review meeting with State HMIS, DSNOs and LGAs M & E Officers			962,876
			5.1.4.5	Identify and train 3000 Village Health Workers / TBAs on the use of community health records and information system			21,461,223
		5.1.5	To provide a legal framework for activities of the NHMIS programme				-
			5.1.5.1	Mapping of all (Private & Public) Health Facilities in the State and produce 1000 copies of maps/directory			-
			5.1.5.2	Sensitization workshop on the importance of Health Management Information System and need for effective participation by Private Health Practitioners for 300 No. Private Health Facilities Medical Directors			-
			5.1.5.3	Develop legal framework for activities of HMIS programme and pursue the promulgation of an enabling law and bye laws that will make supply of health data to State Ministry of Health and LGA departments of health mandatory			-
			5.1.5.4	Organise training workshop on vital registration system for 400 No. Health staff incharge of Health facilities in collaboration with National Population Commission once a year.			-
			5.1.5.5	Organise quarterly sensitization/advocacy meeting for policy makers in the State & LGAs on the value and usefulness of data through the HMIS.			-
		5.1.6	To improve coverage of data collection				-
			5.1.6.1	Conduct monthly HMIS review meeting with M&E officers, PHCCoordinators and heads of medical records units of hospitals during Integrated Supportive Supervision visits to ensure that data is collected from all facilities in the state.			-
			5.1.6.2	Conduct Quarterly HMIS review meetings with State MOH Programme oficers DSNOs, Heads of Pharmacy of hospitals and lab scientists to review and assess data quality			-
			5.1.6.3	Quarterly collection and collation of retrospective data from both public and private health facilities			-
			5.1.6.4	Provide for appropriate motivation of state HMIS officers and 31 LGA M&E Officers for monitoring and data validation			-
			5.1.6.5	Support the National Population Commission to strengthen registration of births and deaths in the state and LGAs to capture vital statistics required for health planning			-
		5.1.7	To ensure supportive supervision of data collection at all levels				-
			5.1.7.1	Purchase of 3no 4-wheel drive vehicles for monitoring & supervision			-
			5.1.7.2	Purchase of 35No motorcycles for state & LGA officers			-
			5.1.7.3	Production of checklists for effective monitoring and supervision			-

			5.1.7.4	Establish suportive supervisory mechanisms for data collection in LGAs			-
			5.1.7.5				-
	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**		**1,089,143,195**
		5.2.1	To strengthen the use of information technology in HIS				**74,111,700**
			5.2.1.1	Procurement of 45no desktop and 45no Laptops computers for State HMIS Officers & LGA M&E Officers			17,867,809
			5.2.1.2	Provision of internet facilities for State Health Management Information System & all the 31 LGA M&E Units for easy dissemination of information			50,823,989
			5.2.1.3	Training & re-training of 20 State HMIS officers & 31 LGA M&E officers on the use of District Health Information Software (DHIS) and statistical packages eg. Excel, SPSS, EPIINFO & Health Mapper			5,201,518
			5.2.1.4	Establish PPP collaboration in the management of data warehouses			218,384
			5.2.1.5	Technical support for routine maintenance and repairs of system hardware/software as well as annual upgrading of the existing DHIS & other statistical software			-
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				**958,568,227**
			5.2.2.1	Production of 1000 copies of NHMIS policy document and their distribution to all health institutions/ facilities in the state			496,328
			5.2.2.2	Production and distribution to all health institutions of adequate number of Revised NHMIS forms and registers			496,328
			5.2.2.3	Procurement of HIS minimum package (padded seats, writing desks, shelves, file cabinets, power supply, internet services, computers and computer accessories etc) for all HMIS units in all Health Facilities in the state and the LGAs.			892,060,273
			5.2.2.4	Procurement of Geographic Position System (GPS) and Personal Data Assistant (PDA) for state HMIS and the 31 LGAs M&E Officers			63,529,986
			5.2.2.5	Monitor appropriate use of computer hradware systems and build capacity of relevant staff on database analysis, storage and transmission			1,985,312
		5.2.3	To further institutionalize HMIS management and utilization				**56,463,268**
			5.2.3.1	Create vacancy positions for the 100 Medical Records Technicians in the state budget yearly			3,379,001
			5.2.3.2	Present proposal for the recruitment of 100 Medical Records Technician yearly for the next five years			19,853
			5.2.3.3	Carry out monthly monitoring and supervision to validate data in order to ensure data quality and collect outstanding data			175,700
			5.2.3.4	Training of 120 No Health staff on HMIS monitoring and evaluation			52,888,714

	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**		**65,619,527**
		5.3.1	To strengthen the Hospital Information System				**31,367,931**
			5.3.1.1	Establish / Strenghthen patient information management system			4,414,341
			5.3.1.2	Procurement of internal classification of diseases vol. I & II, 11th Edition for all Hospitals			2,084,578
			5.3.1.3	Training and retraining of Medical Records staff on basic Medical Records keeping, disease index and establish disease mapping system.			7,456,832
			5.3.1.4	Procurement of at least 1 Desktop computers, printers and accessories,filling system equipment for Medical Records for each Hospital			4,169,155
			5.3.1.5	Training of Medical Record personnel on the use of computers and statistical package (SPSS, EPI INFO, Health mapping)			13,243,024
		5.3.2	To strengthen the Disease Surveillance System				**34,251,597**
			5.3.2.1	Production of Disease Surveillance System data collection tools			496,328
			5.3.2.2	Procurement 1No. 4-wheel Drive surveillance vehicle for State Epidemiology unit , 32 no Laptop computers and 35No. Motorcycles for State Officer & DSNOs			24,022,276
			5.3.2.3	Initiate and strengthen community based surveillance to strengthen disease Surveillance System.			7,753,636
			5.3.2.4	Ensure regular reporting of notifiable diseases by all health facilities and conduct monthly monitoring and supportive supervision visit with LGA DSNOs			954,935
			5.3.2.5	Quarterly joint DSN review meeting with State HMIS and LGAs M & E Officer			1,024,421
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**172,868,071**
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				**31,533,704**
			5.4.1.1	LGA level quarterly HIS review meetings with Heads of Health Facilities to be held at each LGA.			27,106,458
			5.4.1.2	Production of HIS Quality Assurance (QA) manual to be used at state and LGAs level of Health Care delivery for data quality assurance			992,656
			5.4.1.3	Conduct bi-annual evaluation of HMIS activities in the State			2,938,262
			5.4.1.4	Production and distribution of sufficient quantities of HMIS monitoring checklist and facilitate its use in the state and LGAs			496,328
			5.4.1.5	Provide incentive and motivation for Health Data Consultative Committee members for effective monitoring of HMIS activities.			-
		5.4.2	To strengthen data transmission				**141,334,366**

			5.4.2.1	Annual Training and quarterly re-fresher of HMIS and M&E Officers on the use of Internet			1,081,995
			5.4.2.2	Provision for monthly payment of internet services provision in all health institutions			79,412,483
			5.4.2.3	Provision of wireless internet connection to State HMIS Officers and 31 LGA M&E Officers			60,750,549
			5.4.2.4	Provision of mobile telephone and recharge vouchers for State HMIS Officers			89,339
	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**		**5,404,019**
		5.5.1	To institutionalize data analysis and dissemination at all levels				**5,404,019**
			5.5.1.1	Conduct monthly Data collation, analysis and presentation by all LGAs and Health Institutions during review meetings			569,785
			5.5.1.2	Production, presentation and dissemination of periodic Health Data Bulletin and annual HMIS report			2,977,968
			5.5.1.3	Training of HMIS personnel on data analysis, storage, transmission and retrieval			1,856,267
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**945,974,533**
	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**		**457,580,817**
		6.1.1	To provide an enabling policy framework for community participation				**4,851,241**
			6.1.1.1	Adapt the national policy on community participation in health to the state policy to foster effective community participation			597,043
			6.1.1.2	Re-activation / Formation of Viillage health development committees and coordinate their activities			4,254,197
		6.1.2	To provide an enabling implementation framework and environment for community participation				**452,729,576**
			6.1.2.1	Develop and utilize participatory tools and implementation approaches to enhance community involvement in planning, management of health interventions			15,622,218
			6.1.2.2	Update and adapt existing guidelines for setting up village health committees and similar structures for health development activities, protecting common interest and fostering collectivity.			3,196,640
			6.1.2.3	Create enabling environment for the implementation of policies through awareness campaign and involvement of community representatives in			9,497,905

				inter-sectoral stakeholders in decision making at all levels			
			6.1.2.4	Recruit, train and deployment of Independent Support NGOs/CBOs to monitor health campaigns e.g immunization			55,156,051
			6.1.2.5	Involvement of Village Health Development Committee in planning, implementation and monitoring and evaluation of PHC activities including IMNCH- Birth preparednes, new born care etc			369,256,762
	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**		**186,153,477**
		6.2.1	To build capacity within communities to 'own' their health services				**165,841,137**
			6.2.1.1	Institute empowerment mechanisms to improve the knowledge and capacities of community representatives to enhance their performrnce using basic interpretation of data and information			93,742,314
			6.2.1.2	Identification and mapping out of key community stakeholders and resources, assessing their capacity needs, empowering them with requisite skills, funding and knowledge for emergency response and preparedness for IMNCH conditions and other positive actions			1,596,252
			6.2.1.3	Promote male involvement as part of shared responsibility and collective action to improve community development committees and household health practice, re-orienting their roles and responsibilities as community resource persons (CORPS)			63,987,492
			6.2.1.4	Regular meetings between community, faith based groups, NGOs, government structures for maximum impact, sharing information education and communication (IEC) of MNCH services			3,309,247
			6.2.1.5	Define and communicate the roles and functions of community stakeholders and structures for maximum impact and positive actions			3,205,833
		6.2.2	To provide community Dental education Programme				**20,312,339**
			6.2.2.1	Develope and disseminate manual on community dental education programme to all communities through the community development committees			18,211,887
			6.2.2.2	Advocacy/Sensitisation to stakeholders and gatekeepers as well as Capacity building / Training of village health workers on the implementation of community dental education programme			2,100,452
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees**		**263,127,990**

				that include community representatives by end 2011		
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				**35,366,136**
			6.3.1.1	Review, assessment and strengthening of levels of linkages of existing health care delivery structures with the LGAs, Wards and communities to promote greater involvement of communities in the MNCH activities			11,995,272
			6.3.1.2	Develop/adapt guidelines for strengthening community health services linkages with substantial participation of community stakeholders			252,330
			6.3.1.3	Restructuring of health delivery structures to ensure promotion of adequate community participation in their health development			18,940,611
			6.3.1.4	Institute periodic meetings between and among community development committees to facilitate exchange of experiences and collegiate learning			2,247,530
			6.3.1.5	Institute of monthly meetings of management committees for all health facilities with representatives of LGA and State Health authorities in mandatory attendance			1,930,394
		6.3.2	To provide potable water in the 31 LGAs in the state				**37,541,334**
			6.3.2.1	Provision of Pipe- borne water to high risk communities through the provision of 155 boreholes with water treatment plants and water reservoirs in the 31 LGAs of the State			35,620,362
			6.3.2.2	Recruitment, training and Re-training of qualified water engineers to manage the water boreholes, their treatment plants and reserviours.			1,920,972
		6.3.3	To strengthen host communities to manage waste and Sanitation Services in health facilities				**64,917,536**
			6.3.3.1	Provision of standardized waste management facilities in hospitals and other health faciilities in the state			18,522,588
			6.3.3.2	Establishment of waste recycling, Sewage treatment /Management plants in health facilities and provision of waste management trucks			42,744,435
			6.3.3.3	Training and Re-training of Professional Environmental Health Officers (EHOs) and community development committee representatives on integrated waste management practices			3,650,513
		6.3.4	Provision of Occupational Health / Safety Services				**112,782,110**
			6.3.4.1	Provide Occupational health and safety units in all hospitals/PHCCs in all LGAs			108,584,653
			6.3.4.2	Training and Recruiment of occupational Health experts/Consultants			1,858,004
			6.3.4.3	Provision of Occupational health Equipment/ Training of Health workers			1,122,041
			6.3.4.4	Regular Enlightenment Seminar/Workshops on Occupational health hazards			556,712

			6.3.4.5	Payment of adequate compensation / Medical attention for hazards, accidents and injuries sustained at workplaces			660,700
		6.3.5	Capacity building for Stakeholders in the Community on Implementation and interpretation of health data				**12,520,873**
			6.3.5.1	Mobilize community for participation, planning and identification, mapping out of their necessary needs			-
			6.3.5.2	Advocacy, sensitization, media enlightenment and capcity building for community health providers and community development committees on delivery of best practice services			1,884,633
			6.3.5.3	Monitoring and evaluation of community projects			10,636,240
			6.3.5.4				-
			6.3.5.5				-
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		**37,924,138**
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				**37,924,138**
			6.4.1.1	Develop and implement relevant community development programmes			18,990,824
			6.4.1.2	Ensure constant engagement through acceptable approaches and advocacy to community gatekeepers to increase awareness on community participation and health promotion			299,326
			6.4.1.3	Formulate action plans to facilitate the development of heath promotion capacities at community levels to institutionalize community based services and allocate the budget for implementation			18,599,517
			6.4.1.4	Ensure support to LGAs to link health with other sectors using health promotion guidelines			34,471
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement guidelines by end 2010**		**1,188,111**
		6.5.1	To develop and implement systematic measurement of community involvement				**1,188,111**
			6.5.1.1	Using locally adapted models, establish simple mechanisms to support communities to measure impact and document lessons learnt and best practices from specific community-level approaches, methods and initiatives			1,130,659
			6.5.1.2	Disseminate findings from such efforts to enhance knowledge sharing amongst stakeholders.			57,452
PARTNERSHIPS FOR HEALTH							

7. To enhance harmonized implementation of essential health services in line with national health policy goals							**945,974,533**
	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**		**945,974,533**
		7.1.1	To promote Public Private Partnerships (PPP)				**140,295,844**
			7.1.1.1	Adapt the national policy on PPP with a view to leverage technical and financial resources and improved management approaches for improved service delivery in the state			21,049,294
			7.1.1.2	Conduct bi-annual advocacy and sensitization fora on PPP, privatisation, public assets management etc. and encourage the private sector set up health facilities in rural and under-served areas			14,910,683
			7.1.1.3	Establish contracting and outsourcing leases, concessions, social marketing and franchising mechanisms (e.g health commodities, or technical support at no cost)			46,138,216
			7.1.1.4	Establish PPP unit in the SMOH to promote, oversee, monitor and develop strategies for implementing PPP initiatives in line with existing state policy on PPP			35,910,799
			7.1.1.5	Establish joint quarterly monitoring visits by public and private care providers with adequate feedback			22,286,852
		7.1.2	To institutionalize a framework for coordination of Development Partners				**25,021,369**
			7.1.2.1	Establish a Development Partners Forum comprising all health development partners in the State and enforce compliance			3,891,012
			7.1.2.2	Institute the Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners in the state			4,215,263
			7.1.2.3	Establish mechanisms for resource coordination through common basket funding models such as Joint funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support			16,915,094
			7.1.2.4				-
			7.1.2.5				-
		7.1.3	To facilitate inter-sectoral collaboration				**26,507,520**
			7.1.3.1	Establish an inter-sectoral ministerial forum in the state, involving all relevant MDAs directly engaged in the implementation of specific health programmes – such as Environment in Malaria control and prevention,			6,663,358

				Agriculture in nutrition programmes, Water Resources in control of water borne or related diseases, Women Affairs in Maternal, Newborn and Child Health, and Information in Behaviour Change Communication (BCC) programmes.			
			7.1.3.2	Conduct quarterly review meetings of the Committee to align programmes and review strategies			19,844,162
			7.1.3.3				-
			7.1.3.4				-
			7.1.3.5				-
		7.1.4	To engage professional groups				**43,309,126**
			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 thus influencing regulation and legislation to allow for competency-based practice by all types of health professionals according to the principles of "continuum of care".			39,374,880
			7.1.4.2	Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes			3,934,246
			7.1.4.3	Promote effective communication to facilitate relationships between professional groups and SMOH as well as promote linkages with academic institutions to undertake research, education and monitoring through existing networks			-
			7.1.4.4	Strengthen collaboration through bi annual meetings between SMOH and professional groups to advocate for increased coverage of essential interventions, particularly increased funding			-
			7.1.4.5	Convene quarterly public lectures through a coordinated approach by professional associations to enhance the provision of skilled care by health professionals			-
		7.1.5	To engage with communities				**272,826,202**
			7.1.5.1	Provide monthly information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels			2,539,966
			7.1.5.2	Provide information packages for community consumption to include rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services			73,987,595
			7.1.5.3	Jointly develop indicators on health system performance for the State, LGAs and facilities to improve transparency and accountability of the government to its citizens			38,860,402
			7.1.5.4	Institute mechanisms for competition between LGAs and facilities for satisfactory performance in delivery of community support programmes for health			270,209

			7.1.5.5	Conduct monthly capacity building events for communities on prevention and management of priority health conditions through appropriate self-mediated mechanisms such as Behaviour Change Communication (BCC), Social marketing, Public Awareness Campaign, Information, Education and Communication resources (IEC), etc.			157,168,029
		7.1.6	To engage with traditional health practitioners				**438,014,472**
			7.1.6.1	Institute monthly meetings and support research activities to gain more insight and evaluate traditional health practices			42,152,631
			7.1.6.2	Organise traditional medicine practitioners into bodies/organisations that are easy to regulate and actually regulate their practice			7,700,961
			7.1.6.3	Adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful			50,907,408
			7.1.6.4	Quarterly, train and refresh traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system and discourage traditional health practitioners from advertising themselves and making false claims in the public media.			167,880,958
			7.1.6.5	Ensure cooperation of traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene, immunisation and family planning.			169,372,513
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							**1,891,949,065**
	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**		**337,820,904**
		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				**30,416,147**
			8.1.1.1	Develop and disseminate State health research policy and LGA health research strategies through Technical groups and Steering committees			30,416,147
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				**116,144,983**
			8.1.2.1	Strengthen capacities of health research unit in SMOH and HMB to coordinate and encourage research efforts, linking researchers and creating communities of practice.			23,101,824

			8.1.2.2	Strengthen the Departments of Planning Research and Statistics (DPRS) in addition to the creation of active research units in LGAs to undertake operations research and other research-related activities.			60,587,731
			8.1.2.3	Ensure implementation of the Essential National Health Research (ENHR) guidelines in the state.			32,455,429
		8.1.3	To institutionalize processes for setting health research agenda and priorities				**80,796,183**
			8.1.3.1	Establish functional institutional structures for research (eg Ethical review Committee)			14,500,721
			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.			33,147,731
			8.1.3.3	Develop and distribute guidelines for collaborative health research agenda in the state and LGAs			33,147,731
		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				**86,123,900**
			8.1.4.1	Establish strong links will be established between the users of research such as policy makers and the producers of research such as universities			21,935,445
			8.1.4.2	Establish a forum of health research officers in the SMOH and LGAs			5,109,491
			8.1.4.3	Convene annual multi-stakeholders forum to identify research priorities and harmonize research efforts			47,911,828
			8.1.4.4	Support the development of collaborative research proposals and their implementation between governments and public and private health research organisations			11,167,136
			8.1.4.5				-
		8.1.5	To mobilise adequate financial resources to support health research at all levels				**14,316,358**
			8.1.5.1	Advocate and ensure that at least 2% of health budget will be allocated for health research in the state and LGAs, in line with the recommendation of African governments.			10,478,596
			8.1.5.2	Effectively deploy mobilised funds for health research in a targeted manner			1,918,881
			8.1.5.3	Expand beneficiaries of funding to researchers from both public and non-public health research organizations and individuals			1,918,881
		8.1.6	To establish ethical standards and practise codes for health research at all levels				**10,023,332**
			8.1.6.1	Establish health research ethical mechanisms, guidelines and ethical review committees in SMOH			997,066
			8.1.6.2	Establish health research ethical mechanisms, guidelines and ethical review committees in tertiary health and education institutions in the state			7,784,637
			8.1.6.3	Establish monitoring and evaluation system to regulate research and use of research findings in the state			1,241,629

	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		**1,125,638,244**
		8.2.1	To strengthen identified health research institutions at all levels				**99,747,956**
			8.2.1.1	Map and strengthen all health research institutions identified by inventory of all public and private institutions and organizations undertaking health research.			32,022,740
			8.2.1.2	Conduct annual capacity assessment of health research organizations and institutions in the state			11,061,785
			8.2.1.3	Develop and implement measures to address identified research capacity gaps/weaknesses in conjunction with health research organizations/institutions and development partners.			28,331,715
			8.2.1.4	Develop and implement resource mobilization strategies targeting the private sector, foundations and individuals for health research			28,331,715
			8.2.1.5				-
		8.2.2	To create a critical mass of health researchers at all levels				**979,724,265**
			8.2.2.1	Create a critical mass of researchers in conjunction with training institutions in the state			5,700,206
			8.2.2.2	Develop appropriate training interventions for research, based on the identified health needs of the state and LGAs			49,183,557
			8.2.2.3	Provide competitive annual research grants for prospective researchers			415,388,851
			8.2.2.4	Motivate increased PhD training in health in tertiary institutions through award of annual PhD studentship scholarships.			509,451,651
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				**4,590,265**
			8.2.3.1	Evolve mechanisms for translating research findings into policies to achieve evidence-based policy formulation.			2,295,132
			8.2.3.2	Establish close liaison and linkages between research users (e.g. policy makers, development partners) and researchers in the state.			2,295,132
		8.2.4	To undertake research on identified critical priority areas				**41,575,758**
			8.2.4.1	Commission and undertake biennial research, systematical on a number of topical areas to immediately strengthen the health system, such as estimating the burden of different diseases			8,315,152
			8.2.4.2	Commission and undertaking biennial Human Resources for Health studies			8,315,152
			8.2.4.3	Commission and undertakle biennial Health System Governance studies			8,315,152
			8.2.4.4	Commission and undertaking biennial Health Systems Delivery studies			8,315,152
			8.2.4.5	Commission and undertake biennial financial risk protection, equity, efficiency			8,315,152

				and value of different health financing mechanisms.			
	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**		**198,856,285**
		8.3.1	To develop strategies for getting research findings into strategies and practices				**74,919,139**
			8.3.1.1	Utilize research outputs in the short to medium term to improve strategies and practices in the health sector by establishing getting research into strategies (GRISP) units in SMOH and tertiary Health institutions in the state.			3,574,386
			8.3.1.2	Institute and convene a bi-annual Health Research-Policy fora in the state			71,344,753
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				**123,937,146**
			8.3.2.1	Conduct biennial needs assessment to identify health research gaps in the state and LGAs			11,061,785
			8.3.2.2	Undertake operations research by SMOH, Departments and Agencies.			37,625,120
			8.3.2.3	Contract public and non-public research organizations/institutes to collaborate with SMOH in the conduct of operations research thereby addressing gaps in research capacity in government institutions.			75,250,240
	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**		**229,633,633**
		8.4.1	To create a framework for sharing research knowledge and its applications				**122,522,441**
			8.4.1.1	Ensure the publishing of research findings in academic journals as well as develop a framework for sharing research knowledge in the state.			56,437,680
			8.4.1.2	Convene annual health conferences, seminars and workshops in the State on key thematic areas (financing, human resources, MDGs, health research, etc)			51,034,713
			8.4.1.3	Ensure participation at annual international conferences on health and mainstream best practices in the State and LGAs			15,050,048
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**107,111,192**
			8.4.2.1	State government and donors in the state will 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.			103,348,680

			8.4.2.2	Ensure access and wide dissemination of selected national journals that address issues related to Essential National Health Research (ENHR) principles to all stakeholders in the state and LGAs			3,762,512
TOTAL							**94,597,453,260.06**

Annex 4: Results/M&E Matrix for Monitoring Implementation of the Plan

AKWA IBOM STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Akwa Ibomites and people resident in the state through the development of a strengthened and sustainable health care delivery system						
AKSSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Akwa Ibom state.						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
OUTCOME: 1. Improved strategic health plans implemented at state and LGA 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. Improved Legislative and Regulatory Frameworks for Health Development	2. LGAs adopting the National Health Bill? (Yes/No)	LGAs' Reports	0	25	50	75
3. Strengthened accountability, transparency and responsiveness of the State health system	3. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	10	30	50
	4. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	10	15	25
	5. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	10	20	25
	6. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	10	25	35
	7. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	TBD	15	25	35%
	8. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report	No Baseline	10	20	35%
	9. Number of LGA Health Watch Reports published	Health Watch Report	0	10	20	35
	10. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD	10	15	25%
4. Enhanced performance of the State health system	11. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	5	15	40%
	12. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	5	10	15%
	13. % of LGA public sector institutions implementing	Facility Survey Report	TBD	5	20	30%

	the drug procurement policy					
	14. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	5	10	15%
	15. % LGA health facilities not–experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	3	15	30%
	16. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	2	5	10%
	17. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	1	2	3
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
AKSSHDP 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	18. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	TBD	5	15	25%
	19. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	5%	20%	35%
	20. % of the population having access to an essential care package	MICS/NDHS	TBD	5%	20%	40%
	21. Contraceptive prevalence rate	MICS	32.3	35.00	45	70
	22. % increase of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD	5%	20%	35%
	23. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	5%	15%	30%
	24. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10%	35%	60%
	25. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	1%	5%	15%
	26. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy)	NDHS/MICS	TBD	35	25	15

	27. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	TBD	5%	15%	35%
	28. Proportion of births attended by skilled health personnel	MICS	27%	30%	40%	60%
	29. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	3	10	15%
	30. Perinatal mortality rate/1000**	HMIS	TBD	5	10	15
	31. % of women who received postnatal care based on standards within 48h after delivery	MICS	TBD	5	15	25
	32. % of newborn with infection receiving treatment	MICS	No Baseline	5	10	20%
	33. % of children exclusively breastfed 0-6 months	MICS	4.50%	10%	20%	40%
	34. Proportion of 12-23 months-old children fully immunized	NDHS	32.00%	50	65	85
	35. % children <5 years stunted (height for age <2 SD)	NDHS	28.00%	40	55	70%
	36. % of under-five that slept under LLINs the previous night	NDHS	14.00%	45	65	80
	37. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS	14%	25%	45%	60%
	38. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS	13	20	30	45
	39. HIV prevalence rate among adults 15 years and above	NDHS				
	40.Condom use at last high risk sex	MICS	38.9	45	55	70
	41. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	MICS	14.6	20	35	60
	42. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	15	20	45
Output 6. Improved quality of Health care services	43. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	10	20	40
	44. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	10	15	35

	45. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	15	25	40
	46. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	5	15	30
	47. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	10	20	40
	48. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	5	15	35
	49. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	1	5	25
Output 7. Increased demand for health services	50. Proportion of the population utilizing essential services package	MICS	TBD	15	35	60
	51. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	10	25	45
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
AKSSHDP 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 State government implements comprehensive HRH policies and plans for health development in line with the Federal policy guidelines.						
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	52. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	5	15	25
	53. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	5	15	30
	54. Stock (and density) of HRH	HR survey Report	TBD	3CHW:10000 pop; 1-2 Nurse:1000 or 4MW:10000 pop; 4 Dr & Dentist:10000 pop; 6 Pharmacist: 10,000 pop;	4 CHW:3000 pop; 3 Nurse or5 MW:10000 pop; 4 Dr & Dentist:7000 pop; 7Pharmacist: 10,000 pop;	5 CHW:2000 pop; 4 Nurse or MW:4000 pop; 5 Dr & Dentist:10000 pop; 8 Pharmacist: 10,000 pop;
	55. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	5	15	20
	56. % of LGAs implementing	HR survey Report	TBD	5	10	30

	performance-based managment systems					
	57. % of staff satisfied with the performance based management system	HR survey Report	TBD	5	10	30
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	58. % LGAs making availabile consistent flow of HRH information	NHMIS	15	25	75	100%
	59. CHEW/10,000 population density	MICS	TBD	3:10000	4:10000 pop	5:10000 pop
	60. Nurse density/10,000 population	MICS	TBD	1:1000 pop	1:1000 -2:1000 pop	1:1000 -2:1000 pop
	61. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	6:10000 pop	7:10000	8:10000
	62. Medical doctor density per 10,000 population	MICS	TBD	3:10000 pop	4:10000 pop	5:10000 pop
	63. Other health service providers density/10,000 population	MICS	TBD	1:10000 pop	2:10000 pop	3:10000 pop
	64. HRH database mechanism in place at LGA level	HRH Database	TBD	15	35	70%
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						
AKSSHDP 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 and state levels						
Outcome 8. Health financing strategies implemented at State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Akwa Ibom 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	65. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10%	25%	45%
	66. Decreased proportion of informal payments within the public health care system within each LGA	MICS/SHA	TBD	15%	20%	30%
	67. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	5	10	20

	68. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	5	15	30
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	69. LGAs health budgets fully alligned to support state health goals and policies	State and LGA Budgets	TBD	10	15	30%
	70.Out-of pocket expenditure as a % of total health expenditure	National Health Accounts 2003 - 2005	TBD	10%	15%	25%
	71. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	5%	10%	15%
	72. Proportion of LGAs having transparent budgeting and finacial management systems	SSHDP review report	TBD	10%	20%	30%
	73. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	5%	10	25%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation	74. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	35	40	70	90
	75. % of LGAs receiving feedback on NHMIS from SMOH		TBD	5	20	45
	76. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	5	10	30
	77. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	5	15	20
	78. % of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	10%	20%	50%
	79. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	5%	15%	30%
	80. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	3%	5%	15%
	81. % of LGA plans using the HMIS data	NHMIS Report	TBD	10%	15%	25%
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	82. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	2%	10%	30%
	83. % of wards holding quarterly health committee meetings	HDC Reports	TBD	5%	10%	15%
	84. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	3%	5%	10%
	85. % increase in community health actions	HDC Reports	TBD	3%	5%	10%
	86. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	5%	10%	15%
	87. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	10%	20%	50%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms State and LGA levels contribute to achievement of the goals and objectives of the National Health System.						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	88. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	3%	5%	10%
	89. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	5%	10%	30%
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	90. % of LGAs partnering with researchers	Research Reports	TBD	2%	5%	10%
	91. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	92. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	1%	3%	5%
	93. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	TBD	1%	2%	3%
	94. % of health research in LGAs available in the state health research depository	State Health Reseach Depository	TBD	1%	3%	5%

Output 17: Health research communication strategies developed and implemented	95. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	1%	5%	15%