
**ABIA STATE GOVERNMENT**

# STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Abia State Ministry of Health

March 2010

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## Acronyms

| | |
|---|---|
| BHSS | Basic Health Services Scheme |
| CHEW | Community Health Extension Worker |
| HIV/AIDS | Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome |
| LGASHDP | Local Government Area Strategic Health Development Plan |
| M&E | Monitoring and Evaluation |
| NGOs | Non Government Organizations |
| NSHDP | National Strategic Health Development Plan |
| PHC | Primary Health Care |
| PPP | Public Private Partnerships |
| SHDP | State Strategic Health Development Plan |
| TBA | Traditional Birth Attendant |

**Acknowledgement**

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**Preface**

**Executive Summary**

The State has a mission to provide effective, efficient, high quality, accessible and affordable health services to people living in Abia State

It is located in the south eastern region of Nigeria and covers an area of about 5,243.7 sq. km being approximately 5.8 per cent of the total land area of Nigeria. The State was created on 27th August 1991 from the old Imo State. With its capital at Umuahia, seventeen LGAs, namely: Aba North, Aba South, Arochukwu Bende, lkwuano,Isiala Ngwa North, Isiala Ngwa South, lsuikwuato Obingwa Ohafia Osisioma Ugwunagbo Ukwa West, Ukwa East, Umuahia North, Umuahia South, , and Umunneochi.

Abia State has a population of 2.8million people and is divided roughly equally between females and males (1.39million and 1.43million respectively). The population is projected to grow at three per cent per annum meaning that the state will have a population of about 3,379,168 in 2015.

Abia state is inhabited mostly by the Igbo ethnic group who are predominantly Christians. The main occupations in Abia are trading, farming and civil service. The state is endowed with natural resources and there are vast amounts of arable land and a good number of streams. With its adequate seasonal rainfall, Abia has much arable land that produces yams, maize and potatoes, cassava and rice among many other crops. Up to 70 per cent of the population is involved in agriculture which contributes 27% of the GDP. Crude oil and gas are the other major contributors to the GDP of the state with 39% of the GDP.

However, economic development has been poor due to collapse of infrastructure and energy leading the manufacturing sector to accounts for only 2% of GDP. Environmental degradation due to unregulated exploration is another major challenge in the state.

The vulnerable groups are largely women of child bearing age and Under Five children who constitute 25 per cent and 21 percent of the state population respectively. The leading cause of ill health and death in Abia is malaria; accounting for over 35 per cent of mortality and more than 60 per cent of morbidity. The ten common causes of morbidity and mortality in the state are: (1) Malaria; (2) Complication of pregnancy and child birth; (3) Measles and other vaccine preventable diseases; (4) Diarrhoea; (5) Respiratory tract infections; (6) Hypertension; (7) Typhoid fever; (8) Trauma/ RTA; (9) HIV/AIDS; (10) Tuberculosis

Abia State government has the responsibility for secondary health care and the Abia State University Teaching Hospital Aba; while the local government has the responsibility for the primary health centres and health posts in their wards. The State Ministry of Health plans and develops health programmes and supervises implementation along the national health policy guidelines. The ministry through the hospital management board provides secondary health care services. There are a total of eight hundred and eighty two (882) health facilities both private and public in the state. The public facilities include one (1) state owned teaching hospital, one (1) federal medical centre, 10 General hospitals, 3 Cottage hospitals, one psychiatric hospital, two dental centres, one civil service clinic and one Leprosarium. The

private health facilities add up to 66.3 per cent (584 of the 882) in the state. The state ministry of health plays supervisory role over the LGAs in the implementation of PHC programmes and guidelines. Public primary health centres in the state add up to 501.

With regard to human resources, there are a total of 893 (338 male and 555 female) Health personnel at the State level and 2702 at the LGA level in 2008. At the State level includes 28 doctors (25 males and 3 females) and 222 Nurses (211 females and 11 males) and translates to 6204 persons per doctor and 3117 persons per nurse. In the last seven years, human resource for health has been on the decline with high attrition rate of health care workers. For instance, there were 41 doctors in the employ of the state in 2002; 38 in 2004 and 28 in 2008. The same goes for other cadres of health care workers, posing major challenges for the state with regard to meeting the health needs of the people.

Undergoing an analysis of the bottlenecks militating against the effective and efficient delivery of health services in Abia state, three major bottlenecks were identified namely

1. Commitment of political class in funding health activities:
2. Supplies, essential drugs and commodities.
3. human resource availability, especially in rural areas
4. Governance, including absenteeism

In delivering the State Minimum Package of Care, Abia State will review, cost, and implement cost effective intervention contained in minimum package of care in all the 291 wards. Furthermore, the state will develop corresponding programmatic and disease control packages including emergency obstetric care at all levels. Routine immunization will be targeted for all antigens and focus more on NIDs (polio eradication) and immunization of pregnant women against tetanus (tetanus toxiod). Guidelines for delivery of services will be provided at all levels, develop/review and widely distribute standard operating procedures

To strengthen specific communicable and non communicable disease control programmes, specific focus would be on:

1. Control of communicable diseases
2. Control of non communicable diseases
3. Capacity building for programme officers
4. Monitoring, supportive supervision and follow up of the activity
5. Procurement of commodities and equipment for the programme

To increase access to health care services and *improve geographical equity,* mapping of all health facilities that will offer different services in the state would be carried out. The state would develop/ review criteria for siting new health facilities at all levels, address poor attitude of health workers, upgrade and refurbish all substandard facilities at all levels and develop guidelines for implementing routine and outreach services

Following the framework of the National Strategic Health Development Plan (NSHDP), the Abia SSHDP has been set out in Eight Priority Areas. However, based on the situation analysis and the unique strengths and weaknesses of the state in the various departments that comprise the health sector, the Abia planning team re-ordered the Eight Priority Areas of the NSHDP in order of greatest importance as follows:

1. Health Service Delivery
2. Human Resources for Health
3. Partnerships for Health
4. Health Financing
5. Leadership and Governance for Health
6. Community Participation and Ownership
7. National Health Information System
8. Research for Health

In implementing the Strategic Plan, the State Government will provide policy guidelines and direction as well as develop plans and programs to meet state and national goals and ensure the implementation of plans in line with national health policy guidelines. Private Health care providers, including Faith-Based organizations will contribute to Health Service Delivery. Civil Society organizations including professional groups, and community groups and the media will help to promote accountability and transparency by constituting independent watchdog systems. Development partners will provide technical assistance and additional funding

Effective Monitoring and Evaluation (M & E) system will be instituted so that routine data collection, collation, analysis & interpretation, can be undertaken and immediate responses designed and provided to the programme for action. There will be focal points for Monitoring and evaluation in all departments to offer supportive supervision besides that of department of PRS and the respective M & E units of the 17 LGAs.

The M&E framework shall follow a cycle of baseline survey, annual work plan development and periodic supervision and review meetings.

## Vision and Mission

### *Vision*

*Be a front line state in the realisation of good health for all its citizens*

### *Mission*

*To align, develop and implement health policies and programmes to maximally benefit abians, using appropriate partnerships, technologies, strategies and networks to deliver on interventions and services as well as strengthen the health system.*

### *Goal*

*The overarching goal of Abia SSHDP is to serve as a frame work from which all health interventions and programmes will derive and a tool to be used to significantly and sustainably improve the health status of Abia people in the next six years.*

## Chapter 1: Background & Achievements

### *1.1.Background*

Located in the south eastern region of Nigeria, Abia State covers an area of about 5,243.7 sq. km - approximately 5.8 per cent of the total land area of Nigeria. The State was created on 27th August 1991 from the old Imo State. With its capital at Umuahia, it has seventeen LGAs, namely: : Aba North, Aba South, Arochukwu Bende, lkwuano,Isiala Ngwa North, Isiala Ngwa South, lsuikwuato Obingwa Ohafia Osisioma Ugwunagbo Ukwa West, Ukwa East, Umuahia North, Umuahia South, , and Umunneochi.

### *1.2. Achievements*

**Abia SSHDP development process**

Abia state Strategic Health Development Plan document was produced as a result of stages of consultation and planning meeting both at the national and state levels, some of which include:

- The State planning team and the state steering committee by the Honourable Commissioner for Health
- Inauguration of the state steering committee by the Hon Commissioner for health
- Meeting with relevant Permanent Secretaries to sensitize them on SSHDP
- Inauguration of the state Planning team by the Permanent Secretary
- Formation of the state reference Group
- Meeting of the state Planning team and formal take off of the state SHDP planning activities – 16th Sept 2009
- Training meeting with Directors and Program Officers of SMOH
- 3-day training meeting with LGA Program officers on SSHDP and LGA input in the plan
- Finalization meeting of SSHDP with state Program officers and Federal IMNCH Core Technical Team from FMOH
- Submission of completed state draft of SHDP to Abuja

In the 18 years of its existence, Abia has managed to forge a strong cohesion among its peoples.

In the area of health care some recent achievements include:

- The implementation of the Minimum HMIS package at the State and LGA levels with appropriate staff trained on data collation, analysis, dissemination and on the use of NHMIS forms
- Conduct of important research studies that have informed policy decisions. These studies include the manpower disposition/mix; infrastructural assessment; Public Private Partnerships (PPP); Health Data Assessment and comprehensive equipment inventory
- Conduct of situation analysis for IMNCH roll-out
- PPP MOU in PHC document between the SMOH and the private health practitioners in the state.
- Above documents were found very useful in the task of developing the state SHDP
- High quality and increased number of training for technical health workers at PHC facility levels, especially in LSS, IMCI, Malaria management, TB-DOTS Management, EOC, PC, Post Abortion Care, Safe Injection/ Routine Immunization. For instance, the degree of training in Post Abortion Care in collaboration with IPAS Nigeria earned the state the IPAS International recognition as "Äbia Model".
- The renovation and upgrade of a number of hospitals, including the Amachara General Hospital to ensure that referrals from the PHCs are adequately handled.
- Development and institution of a functional PHC management structure at the state and LGA levels in the last few years
- Institution of WARD HEALTH SYSTEM with designation of Ward health Centre in each Ward
- Distribution of monitoring and supervision vehicles to the 17 LGAs
- Establishment of a quarterly state PHC Forum a performance Review meeting with all stakeholder

## Chapter 2: Situation Analysis

### *2.1. Socio-economic context*

Abia state is inhabited mostly by the Igbo ethnic group who are predominantly Christians. The main occupations in Abia are trading, farming and employment in the state civil service. The state is endowed with natural resources and there are vast amounts of arable land and a good number of streams. With its adequate seasonal rainfall, Abia produces yams, maize and potatoes, cassava and rice among many other crops. Up to 70 per cent of the population is involved in agriculture which contributes 27% of the GDP. Another major contributor to the GDP of the state is crude oil and gas production with 39% of the GDP.
However, economic development has been poor due to collapse of infrastructure, environmental degradation and unregulated exploration. Specifically, owing to poor infrastructure and energy challenges, the manufacturing sector accounts for only 2% of GDP.

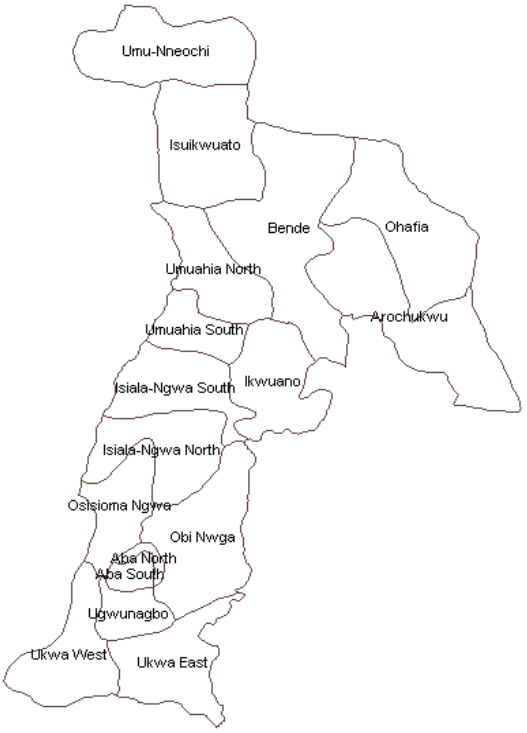
Electricity supply to the State from the national grid is very poor and irregular with the attendant impact on the health and well being of the people of the state. The consequent dependence on generators affects both personal economies and health care provision.

The status of social determinants for health indicate varying levels, Literacy rate is 88% female; 91% men; Households with improved source of drinking water is 81%, Households with improved sanitary facilities (not shared) is 39%, Households with electricity is 69% and Employment status (currently) is 59.7% female, 74.4% male

According to the 2007 census, Abia State has a population of about 2.8million[1] people, with the divisions roughly equal between females and males (1.41million and 1.43million respectively). The population is projected to grow at three per cent per annum meaning that the state will have a population of about 3,379,168 in 2015. Disaggregated population data indicates that the under five population is 569,076, Adolescents (10 – 24 years) is 977,910 and Women of Child Bearing Age (WCBA) (15-49 years) is 766,732 representing 25% of the total population.

[1] National Bureau Of Statistics, 2007

**Figure 1: Map of Abia State**




## *2.2. Health status of the population*

The most at risk groups are women of child bearing age and Under Five children who constitute 25 per cent and 21 percent of the state population respectively. The leading cause of ill health and death in Abia is malaria; accounting for over 35 per cent of mortality and more than 60 per cent of morbidity[2]. The ten common causes of morbidity and mortality in the state are:

1. Malaria
2. Diarrhoea
3. Respiratory tract infections
4. Hypertension
5. Typhoid fever
6. Trauma/ RTA
7. HIV/AIDS

[2] Abia State Health Data Bulletin, 2007

8. Tuberculosis
9. Complications of pregnancy and child birth
10. Measles and other vaccine preventable diseases

### *2.3. Diseases and conditions of priority concern*

The disease of highest priority concern is **malaria** as it affects people of all age groups, with fatal consequences for many. Of growing concern is **HIV and AIDS** as the National sentinel survey of pregnant women shows an increasing trend from 3.7% in 2004 to 5.0 in 2008. Also of concern are complications of pregnancy/ child birth and vaccine preventable diseases.

According to the Abia Health Bulletin (2007) only about 12% of the populace have access to quality medical care. Despite the existence of some standard general and private hospitals and clinics in some locations, utilization of services are also problematic due to poverty, lack of awareness.

### *2.4. Health services provision and utilization*

Abia State government has the responsibility for secondary health care through its secondary facilities and the Abia State University Teaching Hospital Abia; while the local government has the responsibility of the primary health centres and health posts in their wards.
The State Ministry of Health plans and develops health programmes and supervises implementation along the national health policy guidelines. The ministry through the hospital management board provides secondary health care services.

Available health service performance indicators include full immunization coverage at 39% with children that have not received any immunization (zero dose) placed at 17%; Stunting in Under 5 children at 24%, Diarrhoea in children is 4.5%. TFR is placed at 4.4, Use of modern FP method by married women 15-49 is 16%, ANC at 89% with Skilled attendants at birth as 87% with 74.4% Delivery in HF. Other services indicators are ITN ownership as 3%, ITN utilization at 3% children and 4% pregnant women; Malaria treatment (any anti-malarial drug) is 14% children and 5% pregnant women. Comprehensive knowledge of HIV is placed at 50% female, 44% men with Knowledge of TB at 95.1% female, 88.7% male.

There are a total of eight hundred and eighty two (882) health facilities both private and public in the state. The public facilities include one (1) state owned teaching hospital, one (1) federal medical centre, 10 General hospitals, 3 Cottage hospitals, one psychiatric hospital, two dental centres, one civil service clinic and one Leprosarium. The private health facilities add up to 66.3 per cent (584 of the 882) in the state. Public primary health centres in the state add up to 501.

With regard to human resources, there are a total of 893 (338 males and 555 females) Health personnel in Abia State in 2008[3]. That includes 28 doctors (25 males and 3 females) and 222 Nurses (211 females and 11 males) and translates to 6204 persons per doctor and 3117 persons per nurse. In the last seven years, human resources for health has been on the decline with high attrition rate of health care workers. For instance, there were 41 doctors in the employ of the state in 2002; 38 in 2004 and 28 in 2008. The same goes for other cadres of health care workers, posing major challenges for the state with regard to meeting the health needs of the people. There are a total of 2,702 health workers across the 17 LGAs in the state.

**Table 1:** Summary of Abia state situation analysis

| INDICATATORS | ABIA |
|---|---|
| **Total population** | 2,845,380 (1,415,082 females; 1,430,298 males) |
| **Under 5 years (20% of Total Pop)** | 569,076 |
| **Adolescents (10 – 24 years)** | 977,910 |
| **WCBA (15-49 years)** | 766,732 |
| **Literacy rate** | 88% female; 91% men |
| **Households with improved source of drinking water** | 81% |
| **Households with improved sanitary facilities (not shared)** | 39% |
| **Households with electricity** | 69% |
| **Employment status (currently)** | 59.7% female, 74.4% male |
| **TFR** | 4.4 |
| **Use of FP modern method by married women 15-49** | 16% |
| **ANC** | 89% |
| **Skilled attendants at birth** | 87% |
| **Delivery in HF** | 74.4% |
| **Full immunization coverage** | 39% |
| **Children that have not received any immunization (zero dose)** | 17% |
| **Stunting in Under 5 children** | 24% |
| **Diarrhea in children** | 4.5% |
| **ITN ownership** | 3% |
| **ITN utilization** | 3% children, 4% pregnant women |
| **Malaria treatment (any anti-malarial drug)** | 14% children, 5% pregnant women |
| **Comprehensive knowledge of HIV** | 50% female, 44% men |
| **Knowledge of TB** | 95.1% female, 88.7% male |

[3] Abia State Hospitals Management Board Statistical Data/ Information, 2008

### *2.5. Key issues and challenges*

With regard to delivering efficient and effective health care to the Abia populace, the bottleneck analysis shows that the key issues and challenges are in four areas:

- The major bottleneck is in supplies, essential drugs and commodities.
- A second bottleneck is in human resource availability, especially in rural areas of Abia State.
- A third bottleneck is governance, including absenteeism and poor attitude of health workers.
- Poor Political commitment towards funding health activity

## Chapter 3: Strategic Health Priorities

### 3.1 strategic orientations

The Eight Strategic Health Priorities for strengthening the health system in the State as detailed in Annex 1 and are as listed below;

1. Governance and Leadership
2. Health Service Delivery
3. Human Resource for Health
4. Health Financing
5. National Health Management Information Systems
6. Community Participation and Ownership
7. Partnership for Health
8. Research for Health

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

**Table 2: State Priority High Impact Services**

| 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 |
| Management of the 5 major contributors to maternal mortality: haemorrhage, sepsis, pre-eclampsia, post abortion complications ,obstructed labour |
| 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 |
| Management of the 5 major contributors to maternal mortality: haemorrhage, sepsis, pre-eclampsia, post abortion complications,obstructed labour |
| 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*

Currently the state has the following manpower in the secondary levels of health service delivery: 24 Doctors, 4 Dental Surgeons, 9 Lab Scientists, 1 Lab Technologist, 4 Lab Technicians, 14 Pharmacists, 7 Pharmacy Technicians, and 193 Nurses.

To implement the Abia SSHDP, the planning team analysis shows that secondary facility in each LGA would need to have the following in its employment list as minimum Staff complement :-

- 3 Doctors
- 40 Nurses
- 17 Pharmacists
- 4 Laboratory Technicians
- 60 community health extension workers
- 2 Monitoring and Evaluation Officers
- At least 2 Security personnel offering 24hr. Services in the Health centres

The implication is that the state needs a total minimum of 51 doctors (3 for each of the 17 secondary health facilities) as against the current 24 doctors. Similarly, 680 nurses will be required as against the 193 in the States employment; and for Laboratory Technicians, 68 will be required as against the current 34. For each cadre of health workers, there is a minimum of 50 per cent gap between current availability and need.

At the Primary health Care facilities:

The state Local Government system has a total of 2,072 health workers in the 17 LGAs made up of the following cadre:

- At least 30 program Focal Persons/LGA i.e.30*17=510
- At least 7 team members/LGA i.e.7*17=119
- At least one Doctor per LGA
- 3 Midwives for each Ward health centre i.e.291*3 =873
- At least 1 midwife for other health centres in Wards i.e. 310
- At least 1 Pharmacy Technician per Ward health centre=291
- At least 1 Lab Technician per LGA
- 3CHEWs per Ward health centre i.e. 291*3=873
- 2JCHEW/ other HCs in Wards i. e. 301*2=602
- 20 Ward health centre based client tracker/health data entry officer.
- 2 security Personnel offering 24 hrs services.

### *4.2. Physical/material resource requirements*

Additional building and reconstruction of health facilities are required. The state policy is that each LGA should have at least one secondary health facility while each political Ward should have a health centre albeit this ideal is yet to be fully realised. These facilities where they exist should also be refurbished and equipped to provide needed services e.g. Emergency Obstetric Care, Renal dialysis Unit, Cardiology Unit and Radiotherapy Units, WMHCP quality of interventions services at health centres..

### *4.3 Financial resource requirements*

The State is in great need of financial assistance. There is much financial gap between amount needed to carry out health activities and amount provided to health.

The total estimated financial requirement to implement the six –year strategic framework in Abia state is about **N53,667,794,559; fifty three billion, six hundred and sixty-seven million, seven hundred and ninety-four thousand, five hundred and fifty nine Naira only.** The breakdown of the costs according to Priority Areas is as follows:

**Table 3: Costing summary of Priority areas**

| | **Priority Area** | **Estimated Cost (NGN)** |
|---|---|---|
| **1** | Leadership and Governance for Health | NGN 536,677,946 |
| **2** | Health Service Delivery | NGN 32,807,894,252 |
| **3** | Human Resources for Health | NGN 14,465,667,837 |
| **4** | Financing for Health | NGN 2,905,825,825 |
| **5** | National Health Information System | NGN 805,016,918 |
| **6** | Community Participation and Ownership | NGN 536,677,946 |
| **7** | Partnerships for Health | NGN 536,677,946 |
| **8** | Research for Health | NGN 1,073,355,891 |
| | **TOTAL ESTIMATED COST** | **NGN 53,667,794,559** |

## Chapter 5: Financing Plan

### *5.1 Estimated cost of the strategic orientations*

The total estimated financial requirement to implement the six –year strategic framework in Abia state is about **N53,667,794,559; fifty three billion, six hundred and sixty-seven million, seven hundred and ninety-four thousand, five hundred and fifty nine Naira only**.

### *5.2. Assessment of the available and projected funds*

An assessment of the available and projected funds in Abia State for the purpose of financing the Strategic health development plan should be undertaken in the context of the fiscal, macro & micro financial environment s in the state as well as her recent past expenditure profile.

a. *Recent Expenditure Profile.*

(*Source: Abia State Ministry of Health Finance Department)*

**Table 4: State Recent Expenditure profile**

| Year | | Personnel Costs | Overhead cost | Capital Expenditure | |
|---|---|---|---|---|---|
| 2004 | Budgeted | 835,950,650.00 | 43,754.650,00 | 1,254,000,010,00 | |
| | Actual | 213,255,272 | 64,245,255.12 | 58,666,714.64 | |
| 2005 | Budgeted | 1,140,319,700.00 | 37,334,550.00 | 481,000,010 | |
| | Actual | 526,302,684.14 | 124,566,035.82 | 4,593,591.00 | |
| 2006 | Budgeted | 1,288,964,110.00 | 53,287,520.00 | 2,151,500,000.00 | |
| | Actual | 900,932,662.00 | 41,782,344.00 | 651,671,902.00 | |
| 2007 | Budgeted | 1,592,177,520.00 | 70,462,800.00 | 1,044,000,000.00 | |
| | Actual | 461,728,450.06 | 198,486,366.57 | 71,700,000.00 | |
| 2008 | Budgeted | 1,978,063,430 | 55,277,950.00 | 2,497,000,000.00 | |
| | Actual | 1,394,596,596.25 | 432,899,735.28 | 1,182,564,555.44 | |

An overview of the general expenditure profile as encapsulated in the table above shows that in the past 5 years, Abia state had budgeted about N15b to the health sector. This is a far cry from the 53billion costed for the SSHDP for the next six years. The situation is even more critical considering that the actual amount released for the period is about 40% of the budgeted amounts. Local Government health expenditure in the last 4 years is not available. A simple trend projection of the budgeted funds as in table 4 would show that this would amount to about 32% of the required funding for the SHDP. Thus if we assume all things being equal, we would expect the state to fund only 32% of the SHDP.

b. *Fiscal, micro & macro financial environment.*

Based on its position as a marginal oil producing state, Abia receives an average of N4-5b monthly from the Federation Accounts Allocation committee (4.9b for month of October 2009)[4]. However, the internally generated revenue profile is less than 20% of the statutory allocation, hence placing the state's finances in a volatile situation; subject to the inevitable fluctuations in the International crude Oil price. Revenue from Personal income tax is also low, while there are no major manufacturing industries in the state.

c. *Support from Development partners.*

Development partners working in the state include UNFPA, UNICEF, WHO World Bank and UNDP. They provide direct programmatic support and technical assistance to programmes. The quantum of their support is in the region of 5-10% of the health expenditure of Abia State.

### *5.3 Determination of the financing gap*

If we consider the projected 32% funding from the state government, and 10% from development partners, the total projected available funding will be about 42% of required resources to implement the SHDP. This leaves us with about 48% of funding gap or nearly NGN 25.8 billion naira over the period 2010-2015.

The above figure is also subject to variations based on the statutory receipts of the State Government from the Federation account.

[4] Federal Ministry of Finance figures, October 2009

### *5.4 Descriptions of ways of closing the financing gap*

Possible ways to close this financial gap include:

- Increase in Internally generated revenue in the state through an improved tax drive.

- Plugging of possible sources of financial leakage like proper staff audit at the ministry, entrenchment of fiscal responsibility and due process in the award of contracts.

- Creating a legislative framework that allows the allocation of more funds to the health sector by the State House of Assembly in line with the Abuja declaration, provisions of the National health act on funding of primary healthcare, etc.

- Increase in statutory allocation to the Oil producing states from the current 13%.

- Greater coordination & harmonization of donor assistance from development partners in line with the Paris declaration on Aid effectiveness, and Accra high level meeting. This will ensure that donor funds are better utilized, while parallel programmes by different donors and development partners are abolished.

## Chapter 6: Implementation Framework

### *6.1 Macro Structures*

The following will play various roles in the implementation of the plan:

**The State Government** will provide policy guidelines and direction as well as develop plans and programs to meet state and national goals and ensure the implementation of plans in line with national health policy guidelines.

**Structures in place to implement plan**

The Abia state Ministry of Health is the official representative of the Government of Abia state that has the mandate over the achievement of the health status aspirations of the state and it has the following Departments and parastatals :

- Department of Medical Services =Supervises all aspects of curative sector
- Department of Primary Health Care = supervises all aspects of preventive health sector
- Department of Public Health Disease control =Supervises all aspects of communicable and non communicable diseases.
- Department of Planning Research and Statistics = In charge of the sector on Health Planning, research and statistics
- Department of Nursing Services = in charge of state nursing and midwifery policy and training institutions
- Department of Pharmaceutical services = supervises all aspects of drugs and drug administration
- Department of Administration = In charge of ministry of health human resources
- Department of finance = in charge of ministry of health financial matters
- Parastatals
    - ✔ H**o**spital Management Board (HMB) = manages secondary level health service delivery through the General hospitals, Cottage hospitals and dental hospitals
    - ✔ Training Institutions :
        - Abia state University Teaching Hospital
        - 4 schools of midwifery, 3 schools of Nursing
        - 1 school of Health Technology
        - 1 school of Psychiatric Nursing
    - ✔ 1 Health System Development Project
    - ✔ 1 state Action Committee on HIV/AIDs

These macro structures of the state ministry of health are headed by Directors, Chief Executives and Project Managers as the case may be and carry out the following health related responsibilities under the leadership of the Permanent Secretary and the Honourable Commissioner for Health :

- Plan and manage the State Health Information System,
- Participate in national, inter-state and inter-sectoral co-ordination and Collaboration,
- Provide technical and logistics support to Local Government Health Authorities
- Plan, co-ordinate and monitor health services delivering during disasters,
- Conduct or facilities research on health and health services,
- Plan, manage and develop human resources for rendering of health institutions and health agencies.
- Control and manage the cost and financing of public health institutions and public health agencies
- Determine financial and other assistance received by the state from foreign governments and intergovernmental organizations, the conditions applicable to receiving such assistance and the mechanisms to ensure compliance with these conditions,
- Facilitate and promote the provision of comprehensive primary health services and community hospital services
- Provide and co-ordinate emergency medical services, pathology, forensic clinical medicines and related services.
- Control the quality of all health services and facilities,
- Provide health services under the specific state health services programmes
- Provide and maintain equipment, vehicle and healthcare facilities in the public sector,
- Ensure that Local Government Health Authorities consult with communities regarding health matters
- Ensure health system research; and
- Provide Service for the management, prevention and control of communicable and non-communicable disease.

### *6.2 Micro Structures*

At the micro level there exist structures established to help achieve the mission of the departments and parastatal. For instance in the Department of Primary Health Care these following exist:

- Development and institution of a functional PHC management structure at the state and LGA levels in the last few years (Quarterly PHC Forum, with all PHC Stakeholders, Monthly Program Technical review meeting with LGA FPs, monthly LGA bases meeting with Officers in charge of health facilities, Monthly State Strategic planning meeting, Programs Net-working team meetings etc)

- Institution of WARD HEALTH SYSTEM with designation of Ward health Centre and EOC?CEOCs in each Ward

- Distribution of monitoring and supervision vehicles to the 17 LGAs

- Establishment of a quarterly state PHC Forum a performance Review meeting with all stakeholder

**Private Health care providers**, including Faith-Based organizations will contribute to Health Service Delivery through provision of curative services and participation in the state initiated Public Private Partnership in delivery of Primary Health Care services.

**Civil Society organizations** including professional groups, and community groups, NGOs and the media will help to provide community based sensitization and mobilization services, promote accountability and transparency by constituting independent watchdog systems

**Development partners** will provide technical assistance and additional funding

**Table 5: Partners and their roles**

| ***Strategic partners*** | ***Roles and their Inter relations*** |
|---|---|
| ● Abia State University Teaching Hospital | Tertiary, teaching & Research. |
| ● Federal Medical Centre, Umuahia | Tertiary & specialist referral |
| ● Development Partners | |
| ● All secondary Health facilities services | Provide direct secondary health |
| ● School of Health Technology Officers | Training of Env. & Comm. Health |
| ● Schools of Nursing & Midwifery | Training base for Nurses |
| ● All PHC Health Facilities | Provide direct primary care |
| ● Private & Faith based practitioners | Strategic alternative service |
| ● Civil Society groups | Community Interface |
| ● Ward Development Committees | Community Participation organ |
| ● Individuals and families | Primary recipient stakeholders |
| ● Collaborating line Ministries and Agencies | Collaborative role in service utilization |

## Chapter 7: Monitoring and Evaluation

### *7.1 Proposed mechanisms for monitoring and evaluation*

70 indicators out of 113 indicators in the Sub-national Strategic Health Development Result Matrix were selected for Abia state. This represents 62% of the entire indicators in the Matrix.

In making the selections, the state was guided by: the concept of the scope and direction of health policies and development in the state, current activities taking place in the state, potentially possible ones, funding and manpower availability and alignment with the state SHDP Framework.

Targets were set with incremental trend in mind and increments that will result from build up of momentum over the period.

**Conclusion**

A lot of effort has gone into drawing up the Abia SSHDP. What is now required is the political will and commitment to translate the plan to reality. With the SSHDP the State hopes to achieve the MDG 4, 5 and 6. This will demand increased funding to the health sector, improved monitoring and evaluation, inter-sectoral collaboration, improved Public-Private Partnership and community participation

The objective of Abia SSHDP is to harmonize the design, coordination, management, organisation and delivery of PHC services the state, provide a coherent investment plan for health in the next six years and act as an advocacy document and a framework for coordinating and maximising the contributions of donors/development partner's to the strengthening of health activities in the state.

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*Annex 1: Details of Abia State Strategic Health Development Plan*

| ABIA STATE STRATEGIC HEALTH DEVELOPMENT PLAN | | | | | | |
|---|---|---|---|---|---|---|
| **PRIORITY** | | | | | | |
| **Goals** | | | | **BASELINE YEAR 2009** | **RISKS AND ASSUMPTIONS** | **TOTAL COS 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** | | | | | | **536,677,946** |
| | **1** | **To provide clear policy directions for health development** | | **All stakeholders are informed regarding health development policy directives by 2011** | | **436,910,485** |
| | | 1.1.1 | To improve Strategic Planning at State and LGA levels | State SHDP developed | | **31,587,320** |
| | | | 1.1.1.1 Re-orientation and strenghtening of the human resource capacities of the health sector at both State and LGA | | | 2,551,697 |
| | | | 1.1.1.2 Advocacy at State level in support of policy development and implementation. | | Political will present | 1,611,598 |
| | | | 1.1.1.3 Development of evidence-based, costed and priori tised strategic health plans | | | 2,578,557 |
| | | | 1.1.1.4 Optimize the contribution of the stakeholders at both State and LGAs. | | | 671,499 |
| | | | 1.1.1.5 Capacity building at both State and LGAs | | Appropriate trainable persons present | 24,173,969 |
| | | 1.1.2 | Ensure regular updating and access to the State Strategic Health Plan | Committee formed and yearly update of State SHDP done | | **4,123,005** |
| | | | 1.1.2.1 Formation of SHDP review committee | | SHDP review committee committed | 725,219 |
| | | | 1.1.2.2 Meeting of the committee at least once every six months | | | 1,987,637 |
| | | | 1.1.2.3 To provide hard copies of the State Strategic health plan to stakeholders | | | 67,150 |
| | | | 1.1.2.4 Establish a committee for the yearly development of operational activities | | | 402,899 |
| | | | 1.1.2.5 Meeting of the State Planning team at least once every 6 months | | | 940,099 |
| | | 1.1.3 | Establish intra-sectorial mechanism for policy synergy in the health sector | Bi-annual meeting of state council on health done | | **25,543,828** |
| | | | 1.1.3.1 State council on health meetings once every 6 months to consider and adopt health policies | | Funds available for meetings | 13,806,022 |
| | | | 1.1.3.2 Identify and implement capacity building and reorientation initiatives for health policy development at all levels | | | 11,737,805 |
| | | 1.1.4 | Building greater political commitment, defining the statutory and policy framework and managerial infrastructures for PHC at Community, Ward, LGA and State level | PHC committees at all levels established | | **302,771,955** |
| | | | 1.1.4.1 Formation of technical PHC committee forum/quarterly meetings | | | 3,867,835 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 1.1.4.2 | Reactivating of various PHC committees/quarterly meetings | | | 7,929,062 |
| | | | 1.1.4.3 | Passage of enabling law by the State House of Assembly | | | 134,300 |
| | | | 1.1.4.4 | Establishment of Abia PHC development Agency | | Political support present | 290,840,758 |
| | | 1.1.5 | Identify and implement capacity building and reorientation/initiatives for health policy development at all levels | | Capacity dev. For health policy | | **72,884,378** |
| | | | 1.1.5.1 | Develop, publish and institutionalise framework for the formulation and implementation of policies | | | 1,074,399 |
| | | | 1.1.5.2 | Hold Zonal training sessions with LGAs to explain and popularise the policy development frameworks | | | 9,669,588 |
| | | | 1.1.5.3 | Sustain implementation of the National Policy on HIV/AIDS in the workplace | | | 62,140,392 |
| | **1** | **To facilitate legislation and a regulatory framework for health development** | | | **Health Bill signed into law by end of 2009** | | 17,929,027 |
| | | 1.2.1 | Strengthen regulatory functions of government | | Public health Laws established and enforced with full cooperation of the PPP | | 13,147,953 |
| | | | 1.2.1.1 | The State government will set quality standards for and ensure compliance in delivery of health services | | | 322,320 |
| | | | 1.2.1.2 | The State Ministry of health will support the development of public/private partnership policies and plans in the LGAs in line with the national policy on PPP | | Private practitioners are registered and easily identified | 1,342,998 |
| | | | 1.2.1.3 | LGAs will be offered opportunites for technical support on implementation of the strategic plans to ensure that the regulatory function of government is strengthened and agreed quality standard are set, monitored and delivered | | | 9,669,588 |
| | | | 1.2.1.4 | Review committees will be set up to review and align laws of regulatory bodies | | | 201,450 |
| | | | 1.2.1.5 | Regular reviewing, updating and enforcing Public Health Acts and Laws as well as revising and streamlining roles and responsibilities of regulatory institutions to align with the National Health Bill that is to be passed into law | | | 1,611,598 |
| | | 1.2.2 | Defining and communicating roles and responsibilities of regulatory agencies to stakeholders | | Training of stakeholders on functions of regulatory agencies carried out | | 3,223,196 |
| | | | 1.2.2.1 | Training and sensitization of stakeholders on the functions of regulatory agencies | | | 3,223,196 |
| | | 1.2.3 | Update/enforce Public health acts and laws in line with the PHC approach | | 1. Appropriate public health legislation passed and each accented to at all levels. 2. Number of convictions for public health violations | | 1,074,399 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 1.2.3.1 | Review health legislation to ensure that gaps are filled in areas which need improvement | | Legislators are committed to public health | 523,769 |
| | | | 1.2.3.2 | Update/Review public health acts and laws by involving legislators | | | 523,769 |
| | | | 1.2.3.3 | Submit to legislators and advocate for enactment into law | | | 26,860 |
| | | 1.2.4 | Review/Streamline roles and responsibilities of regulatory institutions to align with Abia State Health Bill | | Responsibilities of regulatory institutions reviewed | | 483,479 |
| | | | 1.2.4.1 | Set up committees for review and alignment of regulatory bodies | | | 107,440 |
| | | | 1.2.4.2 | Amend roles and responsibilities of regulatory institutions | | Regulatory bodies existing | 194,735 |
| | | | 1.2.4.3 | Develop capacity of regulatory institutions to fulfill their roles and responsibilities | | | 181,305 |
| | **1** | **To strengthen accountability, transparency and responsiveness of the state health system** | | | **80% of States and the Federal level have an active health sector 'watch dog' by 2013** | | 15,886,439 |
| | | 1.3.1 | To improve accountability and transparency | | Mechanisms to ensure accountability and transprency established | | 11,684,085 |
| | | | 1.3.1.1 | The State and LGAs will institute stakeholders' dialogue and feedback forum for enlisting input into the health sector decision making | | | 2,739,717 |
| | | | 1.3.1.2 | Creation of platforms for interaction and collaboration with health sector advocacy groups | | | 2,739,717 |
| | | | 1.3.1.3 | Empower beneficiary communities through sensitization to manage and oversee their health projects and programmes | | | 1,369,858 |
| | | | 1.3.1.4 | Promote the emergence of independent health sector "watch dog" | | | 3,223,196 |
| | | | 1.3.1.5 | The State MOH will lead a process for improved access to information required for yearly joint review of the health sector and put such information in the public domain and on demand by stakeholders. | | | 1,611,598 |
| | | 1.3.2 | To improve the responsiveness of the State health system | | | | 4,202,354 |
| | | | 1.3.2.1 | Scale up leadership and management development | | | 268,600 |
| | | | 1.3.2.2 | Implementation of Zonal Health Management Policy | | | 3,933,754 |
| | **1** | **To enhance the performance of the state health system** | | | **1. 50% of States (and their LGAs) updating SHDP annually<br>2. 50% of States (and LGAs) with costed SHDP by end 2011** | | 65,951,994 |
| | | 1.4.1 | Improving and maintaining Sectoral Information base to enhance performance | | | | 270,547 |
| | | | 1.4.1.1 | Deepen and expand the analytical work at both State government and LGAs, which is required to understand health | | | 65,968 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | sector performance and to drive improvements and reform | | | |
| | | | 1.4.1.2 | In conjunction with development partners a prioritised list of areas for further analytical work will be outsourced to Universities, private sector research firms and research institutes. | | Collaboration with universities exist | 148,804 |
| | | | 1.4.1.3 | Linkages will be established with the relevant activities in the research and health information system priority areas of the framework. | | | 55,775 |
| | | 1.4.2 | Establishment of Abia State Primary Health Care Development Agency (PHCDA) | | PHCDA established by 2010. M&E established for quarterly supervision | | 8,057,990 |
| | | | 1.4.2.1 | Conduct situation analysis and micro planning for PHC | | | 4,028,995 |
| | | | 1.4.2.2 | Establish monitoring and evaluation unit for quarterly supervision | | | 4,028,995 |
| | | 1.4.3 | Develop health leadership at State level | | | | 940,099 |
| | | | 1.4.3.1 | Develop training guidelines and clear job description for Abia State health professionals | | Funds available | 940,099 |
| | | 1.4.4 | Develop health leadership at LGA level | | 1. 20% of LGAs have a Medical Officer of Health by 2013. 50% of LGAs have a Medical Officer of Health by 2015 | | 54,994,706 |
| | | | 1.4.4.1 | Ensure that Abia State provides a Medical Officer of Health to provide competent leadership at each LGA | | | 54,826,562 |
| | | | 1.4.4.2 | Develop training guidelines and clear job description for Abia State to provide to LGA Medical Officers of Health | | | 168,143 |
| | | 1.4.5 | Update SSHDP to ensure integrated management and provision of comprehensive minimum health package | | 50% of LGAs provide comprehensive minimum package by 2013 | | 1,688,653 |
| | | | 1.4.5.1 | Set up a process for updating the SSHDP | | | 87,503 |
| | | | 1.4.5.2 | Update and cost SSHDP following a situation analysis showing the gaps to address | | | 1,216,918 |
| | | | 1.4.5.3 | Create an environment for effective implementation of the SSHDP at all levels of the health system | | | 72,656 |
| | | | 1.4.5.4 | Clarify roles and responsibility of various stakeholders | | | 96,696 |
| | | | 1.4.5.5 | Institute an external review mechanism of senior citizen experts in health at each level | | | 214,880 |
| **HEALTH SERVICE DELIVERY** | | | | | | | |
| **2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare** | | | | | | | **32,807,894,252** |
| | **2** | **To ensure universal access to an essential package of care** | | | **Essential Package of Care adopted by all States by 2011** | | **2,370,732,365** |
| | | 2.1.1 | To review, cost, disseminate and implement the minimum package of care in an integrated manner | | | | **7,496,400** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 2.1.1.1 | Standard operating Procedures (SOPs) and guidelines will be made available for delivery of services at all levels | | | 472,601 |
| | | | 2.1.1.2 | Regular review and costing of the minimum package of care | | | 3,819,665 |
| | | | 2.1.1.3 | Make available these reviewed minimum package of care to stakeholders | | | 1,433,428 |
| | | | 2.1.1.4 | Ensure implementation of the minimum package of care by stakeholders through monitoring and evaluation | | | 505,916 |
| | | | 2.1.1.5 | Establish and implement guidelines for outreach services | | | 1,264,790 |
| | | 2.1.2 | To strengthen specific communicable and non communicable disease control programmes | | Achieve at least 80% immunization coverage in both mothers and children by 2011 | | **1,995,603,732** |
| | | | 2.1.2.1 | Strengthen routine immunization, NIDs (polio eradication) and immunization of pregnant and women of child bearing age against tetanus (tetanus toxoid) | | | 1,275,329,551 |
| | | | 2.1.2.2 | Improve access to ITN and anti-malaria drugs especially for mothers and children | | | 59,445,113 |
| | | | 2.1.2.3 | Improve school health programme like school meals among primary school children to reduce malnutrition | | | 84,319,309 |
| | | | 2.1.2.4 | Ensure early identification of MDR TB from the six focal sites in the state and treatment with second line TB drugs for MDR TB, strengthen HIV and onchocerciasis control | **xxxxxxxxxxxxxxxxxxxxxxxxxxx** | | 252,957,927 |
| | | | 2.1.2.5 | Establish free checks for non-communicable diseases like diabetes, hypertension and some cancers (breast, cervix and prostate) | | | 323,551,832 |
| | | 2.1.3 | To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels | | | | **284,527,077** |
| | | | 2.1.3.1 | Training all health workers on SOPs and guidelines for delivery of health services | | | 278,675,317 |
| | | | 2.1.3.2 | Develop SOPs and guidelines for delivery of services at all levels | | | 320,413 |
| | | | 2.1.3.3 | Distribute the SOPs and guidelines for delivery of services to each health facility | | | 1,686,386 |
| | | | 2.1.3.4 | Regularly update SOPs as need arises | | | 3,086,087 |
| | | | 2.1.3.5 | Monitor completeness and utilization of the SOPs | | | 758,874 |
| | | 2.1.4 | Consultation with MDG stakeholders, LGAs, communities and other stakeholders | | | | **57,514,245** |
| | | | 2.1.4.1 | Renovation of stores A and B of the state essential drug programme and seventeen essential drug store of the seventeen LGAs | | | 34,570,917 |
| | | | 2.1.4.2 | Mobilise and harmonize activities of stakeholders towards MDG achievements | | | 8,431,931 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 2.1.4.3 | Encourage regular consultations with stakeholders before any major activity is carried out | | | 5,059,159 |
| | | | 2.1.4.4 | Identify areas of community "felt needs" and including such in health programmes | | | 554,821 |
| | | | 2.1.4.5 | Include all stakeholders in such programme as obtaining survey of infant and maternal mortality | | | 8,897,418 |
| | | 2.1.5 | Establish or strengthen Health Facilities Maintenance/Finance Committee | | To increase the number of health facilities with Facility Maintenance/Finance Committee by 75% by end of 2012 | | **25,590,910** |
| | | | 2.1.5.1 | Increase the number of health facilities with Facility Maintenance/Finance Committee | | | 15,177,476 |
| | | | 2.1.5.2 | Strengthen the health facilities maintenance/finance committee | | | 421,597 |
| | | | 2.1.5.3 | Review membership of the maintainance/finance committees to enhance function | | | 42,160 |
| | | | 2.1.5.4 | Review performance of the the maintainance/finance committees every 6 months | | | 1,517,748 |
| | | | 2.1.5.5 | Make budgetary provision for effective performance of the the maintainance/finance committee | | | 8,431,931 |
| | **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** | | **20,158,248,595** |
| | | 2.2.1 | To improve geographical equity and access to health services | | Aleast 85% of PHC renovated by end of 2010 and 100% of the LGAs adopt the Ward Health System of PHC by 2011 | | **18,458,438,937** |
| | | | 2.2.1.1 | Mapping, categorizing and establishing Geographic Information System(GIS) for all health facilities (both public and private) in the state and develop criteria for siting of new facilities at all levels and site new health facility especially where necessary | | | 72,033,028 |
| | | | 2.2.1.2 | Build or upgrade dilapidated health facilities especially at the PHC level and build a State owned Specialist Hospital | | **Money is available** | 18,152,967,901 |
| | | | 2.2.1.3 | Establishment of a renal dialysis unit in the General Hospital Amachara | | | 185,797,598 |
| | | | 2.2.1.4 | Develop and implement guidelines for outreach services and for task shifting | | | 32,462,934 |
| | | | 2.2.1.5 | State adopt the Ward Health System (Tulsi Chanrai Model) of PHC and adapt it to the peculiar circumstances in the state | | | 15,177,476 |
| | | 2.2.2 | To ensure availability of drugs and equipment at all levels | | | | **887,557,537** |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 2.2.2.1 | Review of the essential medicines list and revive the drug revolving fund (DRF) programme in state and LGAs | | | 2,850,259 |
| | | | 2.2.2.2 | Establish a system to ensure procurement and distribution of essential drugs on a sustainable basis at all levels with emphasis on free health scheme | | | 295,117,582 |
| | | | 2.2.2.3 | Strengthen task force on Counterfeit and Fake Drugs | | | 35,584,521 |
| | | | 2.2.2.4 | Construct Ministry of Health office Annex/Furnishing, renovate Ministry of Health headquarter and elevate/modify buildings at General Hospital Amachara | | | 370,357,720 |
| | | | 2.2.2.5 | Build and equip a standard drug store at the state headquarter and 1 drug store at each LGA | | | 183,647,455 |
| | | 2.2.3 | To establish a system for the maintenance of equipment at all levels | | | | **283,148,456** |
| | | | 2.2.3.1 | Developing SOPs for regular maintenance of the equipments and procurement of "back up" for essential equipments | | | 151,775 |
| | | | 2.2.3.2 | Employment of equipment maintenance personnel and/or training and retraining of personnel to maintain the equipments. | | | 4,742,961 |
| | | | 2.2.3.3 | Identify/build a reliable medical equipment maintenance workshop in the State headquarter for training of maitenance officers | | | 33,727,724 |
| | | | 2.2.3.4 | Quaterly inventory of equipment including their functional state and Create budget lines for the maintenance of equipment at the resource center in government hospitals | | | 50,591,585 |
| | | | 2.2.3.5 | Procurement of office equipments and furniture | | | 193,934,411 |
| | | 2.2.4 | To strengthen referral system | | | | **517,973,516** |
| | | | 2.2.4.1 | Ensure availability of referral forms at all health facilities | | | 8,431,931 |
| | | | 2.2.4.2 | Regular training of health workers on referral practices | | | 5,059,159 |
| | | | 2.2.4.3 | Ensure availability of reliable community based transport system especially in times of emergency | | | 98,653,592 |
| | | | 2.2.4.4 | Improve communication between health facilities and Establish emergency Health Care Services | | | 404,732,684 |
| | | | 2.2.4.5 | Establish SOP for referral of cases | | | 1,096,151 |
| | | 2.2.5 | To foster collaboration with the private sector | | | | **11,130,149** |
| | | | 2.2.5.1 | Yearly update all categories of private health care providers by operational level and location | | | 6,492,587 |
| | | | 2.2.5.2 | Develop guidelines and standards for regulation of their practice and registration | | | 1,686,386 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | 2.2.5.3 | Develop guidelines for partnership, training and outsourcing of services | | | 421,597 |
| | | | 2.2.5.4 | Develop and implement joint performance monitoring mechanism | | | 1,686,386 |
| | | | 2.2.5.5 | Adapt and implement National policy on traditional medicine at both state and LGAs | | | 843,193 |
| | **2** | **To improve the quality of health care services** | | | **50% of health facilities participate in a Quality Improvement programme by end of 2012** | | **3,700,446,334** |
| | | 2.3.1 | To strengthen professional regulatory bodies and institutions | | | | **44,665,985** |
| | | | 2.3.1.1 | Review, update and implement operational guidelines of all regulatory bodies at all levels | | | 505,916 |
| | | | 2.3.1.2 | Build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines | | | 8,431,931 |
| | | | 2.3.1.3 | Create budget lines and provide necessary resources to empower regulators through the provision of necessary security | | | 25,295,793 |
| | | | 2.3.1.4 | Strengthen regular monitoring exercises with appropiate documentation and feedback | | | 5,227,797 |
| | | | 2.3.1.5 | Restructuring/redesigning of existing hospital pharmacies to meet PCN and NHIS requirements | | | 5,204,549 |
| | | 2.3.2 | To develop and institutionalise quality assurance models | | | | **371,170,515** |
| | | | 2.3.2.1 | Review available models and build consensus on the models to adopt, then develop quality assurance training modules to build capacity of both public and private care providers and conduct training of trainers (ToT) which will be cascaded to other health workers | | | 590,235 |
| | | | 2.3.2.2 | Strengthen Pharmacovigilance, Drug Information Service and Prescription Mornitoring | | | 97,877,223 |
| | | | 2.3.2.3 | Institutionalize and implement quality assurance and improvement initiatives at all levels | | | 161,620,460 |
| | | | 2.3.2.4 | Develop SERVICOM guidelines, build institutional capacity and train staff for its implementation at state and LGAs | xxxxxxxxxxxxxxxxxxxxxxxxxxxx | | 19,393,441 |
| | | | 2.3.2.5 | Strengthen Clinical Governance and Develop strategies for monitoring and implementation of quality of care | | | 91,689,156 |
| | | 2.3.3 | To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms | | | | **119,311,822** |
| | | | 2.3.3.1 | Strengthen the management capabilities of health managers and health teams especially at the LGAs and Ward levels through team building and leadership development programmes, and | | | 43,508,764 |

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| | | | | institutionalization of comprehensive ISS at all levels | | | |
| | | | 2.3.3.2 | Develop capacities of programme managers at state and LGA levels on the ISS mechanism | | | 421,597 |
| | | | 2.3.3.3 | Develop ISS tools and guidelines specifying modalities and frequencies of the ISS visits at state and LGAs | | | 421,597 |
| | | | 2.3.3.4 | Prepare a preceptor handbook | | | 2,107,983 |
| | | | 2.3.3.5 | Organise seminars/workshops on basic standards in health procedures | | | 72,851,883 |
| | | 2.3.4 | Stregthening implementation of intergrated maternal, newborn and child health (IMNCH) services for the free health programme | | | | **1,733,938,701** |
| | | | 2.3.4.1 | Upgrading of five general hospitals for Comprehensive Emergency Obstetric Care (EOC) services | | | 863,429,726 |
| | | | 2.3.4.2 | Training of TBAs on danger signs of pregnancy, and training of SCHEW on MLSS | | | 29,511,758 |
| | | | 2.3.4.3 | Adopting the national policy on IMNCH services provision of obstetric delivery kits and strengthen /expand the implementation of the Midwifery Service Scheme (MSS) | | | 5,059,159 |
| | | | 2.3.4.4 | Establishment of VVF treatment center and management support | | | 9,781,040 |
| | | | 2.3.4.5 | Ensure 24 hours services especially for IMNCH in all health facilities | | | 826,157,019 |
| | | 2.3.5 | To establish Quality Assurance / Control Unit | | | | **1,431,359,309** |
| | | | 2.3.5.1 | Establish quality assurance unit in State Ministry of Health and the secondary health facilities | | | 67,455,447 |
| | | | 2.3.5.2 | Establish drug inventory unit to document drug availability and expiration dates | | | 1,855,025 |
| | | | 2.3.5.3 | Highlight Ethical Standards in health management of cases in both LGAs and State | | | 725,146 |
| | | | 2.3.5.4 | To establish regularity of quality assurance / control tests and produce Clinical Governance Handbook | | | 2,951,176 |
| | | | 2.3.5.5 | Completion of 6 New General Hospitals, construction of Staff Qtrs in the 6 General Hospitals and construct resident doctors' qtrs | | | 1,358,372,515 |
| | **2** | **To increase demand for health care services** | | | **Average demand rises to 2 visits per person per annum by end 2011** | | **1,374,953,752** |
| | | 2.4.1 | To create effective demand for services | | | | **19,014,004** |
| | | | 2.4.1.1 | Provide budget lines for health promotion through Behavioural Change Communication (BCC) | | | 421,597 |
| | | | 2.4.1.2 | Put in place a programme monitoring and evaluation system for effectiveness of the BCC strategy | | | 455,324 |

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| | | | 2.4.1.3 | Train staff on Behavioural Change Communication Skills | | | 15,632,800 |
| | | | 2.4.1.4 | Produce and disseminate hand books on patient's right and reponsibility to health care | | | 2,335,645 |
| | | | 2.4.1.5 | Support local adaptation of the national strategy to reflect local realities | | | 168,639 |
| | | 2.4.2 | To introduce patient friendly initiatives | | | | **192,680,677** |
| | | | 2.4.2.1 | To improve patient/health worker relationship | | | 16,863,862 |
| | | | 2.4.2.2 | To establish public relations office especially in secondary health facilities and produce directional signs in 17 hospitals in the state for easy access to health services | | | 8,431,931 |
| | | | 2.4.2.3 | Shorten time taken for patient to be seen by health staff (i.e. waiting time) through regular meetings, seminars and workshops in 17 hospitals in the State | | | 46,375,620 |
| | | | 2.4.2.4 | To establish or strengthen baby friendly hospitals in State and LGAs | | | 75,887,378 |
| | | | 2.4.2.5 | Purchase vehicles and ambulances to assist patients in times of need (purchase of WD pickup vehicle Hilux 4x4 2700DLX x 2) | | | 45,121,886 |
| | | 2.4.3 | To actively engage the CHEW, TBAs, VHW and other stakeholders | | | | **143,680,103** |
| | | | 2.4.3.1 | To improve home visitations of CHEW, TBAs and VHW | | | 91,064,854 |
| | | | 2.4.3.2 | To appropiately identify and train CHEW, TBA and VHW who live and work in the community | | | 7,588,738 |
| | | | 2.4.3.3 | | | | - |
| | | | 2.4.3.4 | Engage all health workers and other stakeholders in advocacy and disemination of information on the services available in health facilities | | | 9,612,401 |
| | | | 2.4.3.5 | Strengthen Infection Prevention and Control of Health Care Waste Management | | | 35,414,110 |
| | | 2.4.4 | Establish specialized health programmes targeted at areas of health needs | | | | **971,516,962** |
| | | | 2.4.4.1 | Identify and prioritise health needs of the community and disseminate the Health Promotion Policy and implement the policy provisions | | | 2,173,752 |
| | | | 2.4.4.2 | | | | - |
| | | | 2.4.4.3 | Improve existing health services at the PHC and WHC to make health more accessible to people | | | 455,324,269 |
| | | | 2.4.4.4 | Establish a state blood bank for easy access of blood and blood products, train and employ staff to manage it | | | 421,596,546 |
| | | | 2.4.4.5 | Provision of Maternity complex in radio-diagnosis center in General Hospital Amachara | xxxxxxxxxxxxxxxxxxxxxxxxxxxx | | 92,422,395 |

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| | | 2.4.5 | To strengthen IEC strategies at both the LGAs and State | | | | **48,062,006** |
| | | | 2.4.5.1 | Develop IEC materials relevant to either rural or urban communities | | | 2,529,579 |
| | | | 2.4.5.2 | Develop mechanisms for distributing the IEC materials by community members | | | 421,597 |
| | | | 2.4.5.3 | 2 yearly updating of the IEC materials making them relevant to present health needs | | | 7,167,141 |
| | | | 2.4.5.4 | Distribute, Monitor and evaluate the effective use of the IEC materials | | | 30,354,951 |
| | | | 2.4.5.5 | Production of Ministry of Health News bulletins | | | 7,588,738 |
| | **3** | **To provide financial access especially for the vulnerable groups** | | | **1. Vulnerable groups identified and quantified by end 2010<br>2. Vulnerable people access services free by end 2015** | | **5,203,513,206** |
| | | 2.5.1 | To improve financial access especially for the vulnerable groups | | | | **4,639,248,389** |
| | | | 2.5.1.1 | Explore and scale up financial protection for the vulnerable groups like vouchers, health cards, pre payment schemes | | | 843,193,091 |
| | | | 2.5.1.2 | To provide free health services for underfives and mothers | | | 3,372,772,366 |
| | | | 2.5.1.3 | To assist in provision of essential care to the physically challenged | | | 421,596,546 |
| | | | 2.5.1.4 | Encourage NGOs and other Multi-national companies to assist in health care financing of vulnerable groups as part of their social responsibilities | | | 1,686,386 |
| | | 2.5.2 | Prevention of mother to child transmission of HIV/AIDS | | | | **392,084,788** |
| | | | 2.5.2.1 | Establishment of state HIV/AIDS laboratory that provides free or subsidized services | | | 67,455,447 |
| | | | 2.5.2.2 | Establishment of three new ART sites to provide free or subsidized drugs | | | 25,295,793 |
| | | | 2.5.2.3 | Provision of support to infected HIV/AIDS patients | | | 252,957,927 |
| | | | 2.5.2.4 | Establishment of special care facilities for management of HIV positive pregnant women | | | 46,375,620 |
| | | 2.5.3 | Strengthening financial assistance of the physically challenged people | | | | **172,180,029** |
| | | | 2.5.3.1 | To evaluate the existing schools of the physically challenged | | | 168,639 |
| | | | 2.5.3.2 | Establish and strengthen schools of skill acquisition for the physically challenged | | | 36,257,303 |
| | | | 2.5.3.3 | Provision of State Community Mental Health Services | | | 135,754,088 |
| **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** | | | | | | | **14,465,667,837** |
| | **3** | **To formulate comprehensive policies and plans for HRH for health development** | | | **All States and LGAs are actively using adaptations of the** | | **2,665,537,833** |

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| | | | | | **National HRH policy and Plan by end of 2015** | | |
| | | 3.1.1 | To develop and institutionalize the Human Resources Policy framework | | | | **227,848,099** |
| | | | 3.1.1.1 | Adapt the National HRH Policy and Strategic Plan to guide human resource development at state and LGAs (each general hospital to have 8 lab scientists, 16 lab tech, 3 radiographers, 8 X-ray tech, 6 general practitioners) | | | 14,576,725 |
| | | | 3.1.1.2 | Adopt national policies on training and recruitment of health personnel against gender and geographical discrimination | | | 99,954,688 |
| | | | 3.1.1.3 | Develop a policy framework to guide existence of private and public practitioners at all levels of health service delivery | | | 867,662 |
| | | | 3.1.1.4 | Develop and implement guidelines on task shifting | | | 1,388,260 |
| | | | 3.1.1.5 | Establish monitoring framework for private health practitioners to institutionalize HRH policy | | | 111,060,764 |
| | | 3.1.2 | To develop mechanisms for monitoring implementation of Human Resource Policy | | | | **209,938,163** |
| | | | 3.1.2.1 | Regularly review policy on staff recruitment, orientation promotions and retirement | | | 6,941,298 |
| | | | 3.1.2.2 | Monitor the adaptation of the state non-discriminatory policies | | | 1,388,260 |
| | | | 3.1.2.3 | Monitor and evaluate nursing and midwifery practice | | | 8,329,557 |
| | | | 3.1.2.4 | Create/strengthen HRH units at all levels to perform HRH functions | | | 124,943,360 |
| | | | 3.1.2.5 | Employment of 112 Medical Officers | | | 68,335,688 |
| | | 3.1.3 | Establish a programme to fund in-service training, human capital capacity building and Continuing Professional Development (CPD) by government and healthcare provider institutions and coordination of same by professional regulatory bodies | | | | **1,318,152,447** |
| | | | 3.1.3.1 | Establish a bonding and selection processes fo health worker in- service training | | | 16,659,115 |
| | | | 3.1.3.3 | Capacity building/study tour to overseas for key staff | | | 10,411,947 |
| | | | 3.1.3.4 | Establish regular Consultancies for the State Ministry of Health | | | 1,249,433,599 |
| | | | 3.1.3.5 | Conduct workshops and trainings for Health Professionals across the State | | | 41,647,787 |
| | | 3.1.4 | To improve system for management and performance of the health workforce; to improve recruitment, utilization, retention, task shifting and performance | | | | **498,710,033** |
| | | | 3.1.4.1 | Create a state database of Human Resources for Health | | | 2,290,628 |
| | | | 3.1.4.2 | Develop and provide job descriptions and specifications for all categories of health workers | | | 694,130 |

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| | | | 3.1.4.3 | Appointment of 150 Pharmacy Technicians | | | 163,988,160 |
| | | | 3.1.4.4 | Promote the National Midwifery Scheme and the Community Midwifery Programme | | | 48,015,733 |
| | | | 3.1.4.5 | Employ 1000 newly qualified nurse/midwife | | | 283,721,382 |
| | | 3.1.5 | To develop and implement retention strategies including management of migration, development and implementation of bilateral and multilateral agreements to reverse and contain the crises | | | | **410,889,090** |
| | | | 3.1.5.1 | To develop and implement incentives to retain health workers particularly in deprived areas | | | 83,295,573 |
| | | | 3.1.5.2 | Design and embark on a campaign to encourage retired trained health professionals to return to the service | | | 152,709 |
| | | | 3.1.5.3 | Payment of Honorarium to outreach Nurses (10), Pharmacists (10), Physiotherapist (1), and Medical Consultants (8) | | | 59,473,039 |
| | | | 3.1.5.4 | Abia Participation at National Council on Health (NCH) meeting and organization of yearly State Council on Health (SCH) | | | 20,017,671 |
| | | | 3.1.5.5 | Appointment of 189 Laboratory Technicians | | | 247,950,098 |
| | **3** | **To provide a framework for objective analysis, implementation and monitoring of HRH performance** | | | **The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012** | | **1,089,019,616** |
| | | 3.2.1 | To reappraise the principles of health workforce requirements and recruitment at all levels | | | | **2,755,695** |
| | | | 3.2.1.1 | Develop and streamline career pathways for all groups of professionals critically needed to foster demand and supply creation in the health sector | | | 1,541,662 |
| | | | 3.2.1.2 | Develop, introduce and utilize staffing norms based on workload services availability and health sector priorities. | | | 208,239 |
| | | | 3.2.1.3 | Establish coordinating mechanisms for consistency in HRH planning and budgeting by Ministries of Health, Finance, Education, Civil Service Commission, Regulatory bodies, Private Sector Providers, NGOs in health and other institutions | | | 149,238 |
| | | | 3.2.1.4 | Strengthen State and LGA capacities to access and implement federal government circulars, guidelines and policies related to HRH | | | 159,650 |
| | | | 3.2.1.5 | Review entry criteria and admission quotas of prospective health care providers into training institutions | | | 696,906 |
| | | 3.2.2 | To strengthen monitoring and evaluation of HRH performance at both State and LGAs | | | | **774,099,302** |
| | | | 3.2.2.1 | Establish a committee to routinely monitor and evaluate HRH performance | | | 832,956 |
| | | | 3.2.2.2 | To develop criteria for objective evaluation of HRH performance | | | 216,568 |

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| | | | 3.2.2.3 | Personnel Audit/Physical identification exercise | | | 3,044,674 |
| | | | 3.2.2.4 | Accreditation of Gen. Hospital Amachara for Housemanship and Residency training | | | 10,411,947 |
| | | | 3.2.2.5 | Employment of College Health Technology (CHT) past graduates | | | 759,593,157 |
| | | 3.2.3 | To acquire equipments that facilitate HRH development | | | | **4,116,190** |
| | | | 3.2.3.1 | Purchase of teaching aids e.g. Projectors, laptops and internet facilities | | | 867,662 |
| | | | 3.2.3.2 | Ensure reliable alternative to power supply e.g. generators | | | 3,248,527 |
| | | 3.2.4 | Develop a model to project the professional staff needs of the State and liase with Ministry of Education and training institutions to plan how to train sufficient graduates | | | | **308,048,429** |
| | | | 3.2.4.1 | Collect baseline data, consult professionals and examine international literature to identify appropiate health professional targets | | | 152,709 |
| | | | 3.2.4.2 | Construct a model to protect training and output requirements to provide for the health professional needs of the State | | | 2,221,215 |
| | | | 3.2.4.3 | Construction of House Officers Quarters (Phase 1) in General Hospital, Amachara | xxxxxxxxxxxxxxxxxxxxxxxxxxxx | | 259,395,431 |
| | | | 3.2.4.4 | Training of Heaith Professionals in the Medical and Dental cadre | | | 46,279,075 |
| | **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<br>2. 10% of LGAs have functional HRH Units by end 2010** | | **10,626,433,489** |
| | | 3.3.1 | To establish and strengthen the HRH Units | | | | **3,415,119** |
| | | | 3.3.1.1 | Create/strengthen HRH units at all levels to perform HRH functions | | | 1,735,324 |
| | | | 3.3.1.2 | Establish training programmes in human resource for health planning and mangement at state and LGAs to enhance the HRH managers | | | 1,679,794 |
| | | 3.3.2 | Design and implement training programmes/build technical capacity at all levels of the health sector | | | | **87,815,779** |
| | | | 3.3.2.1 | Establish a training programme/manual (Mid-level Management training) for the training of managers in human resource planning and management | | | 71,148,302 |
| | | | 3.3.2.2 | Identify existing training institutions that are willing and able to provide training courses for HRH management and planning | | | 138,826 |
| | | | 3.3.2.3 | Train managers in human resource planning and management for health. | | | 8,572,503 |
| | | | 3.3.2.4 | Monitor training courses and output on HRH management and planning | | | 246,416 |
| | | | 3.3.2.5 | Monitoring and Evaluating Programmes/Capital Projects of the Ministry | xxxxxxxxxxxxxxxxxxxxxxxxxxxx | | 7,709,732 |

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| | | 3.3.3 | Re-orientation of health workforce towards positive attitudinal change | | More than 50% of health service users report being treated with care, respect and dignity by 2013 | | **533,786** |
| | | | 3.3.3.1 | Develop and promote a course for health providers to train health workers on interpersonal Communication (IPC) skills | No of health workers at state and LGA levels trained on Interpersonal Communication (IPC) skills | | 149,238 |
| | | | 3.3.3.2 | Develop and promote a course for health providers to re-train workers on work ethics | No. of health workers at state and LGA levels trained on work ethics | | 238,781 |
| | | | 3.3.3.3 | Develop and institute a system of recognition, reward and sanction | State and LGAs have instituted a system of recognition, reward and sanction | | 62,472 |
| | | | 3.3.3.4 | Create a complaint/feedback mechanism | | | 83,296 |
| | | 3.3.4 | Establish multi-sectoral HRH system for planning, management and development at State and LGA level | | 1. Functioning State intersectoral HRH Committees in at least 6 LGAs by end of 2009.<br>2. Functioning intersectoral Committees in all LGAs by end of 2015 | | **10,529,206,005** |
| | | | 3.3.4.1 | Establish State level intersectoral committee to discuss issues of human resource for health and meet quaterly | No of functional intersectoral committees in place at State and LGA levels | | 2,221,215 |
| | | | 3.3.4.2 | Promote the establishment of State level intersectoral committee to discuss issues of human resource for health | | | 1,756,148 |
| | | | 3.3.4.3 | Encourage the establishment of LGA level intersectoral committee to discuss issues of human resources for health | | | 29,986,406 |
| | | | 3.3.4.4 | Salaries of existing employees | | | 10,495,242,235 |
| | | 3.3.5 | Promote proactive regular engagement with various professional groups so as to promote dialogue and harmony | | 1. Functioning State Health Professions Fora in at least 6 LGAs by end of 2009.<br>2. Functioning State Health Professions Fora in all LGAs by end of 2015 | | **5,462,801** |
| | | | 3.3.5.1 | Establish a State level forum for meetings of professional groups | | | 1,527,086 |
| | | | 3.3.5.2 | Conduct regular meetings of State representatives of professional groups with SMOH management | | | 2,255,922 |
| | | | 3.3.5.3 | Promote the establishment at State leve a forum for regular meetings of professional groups | | | 83,296 |
| | | | 3.3.5.4 | Encourage the establishment at LGA level a forum for regular meetings of professional groups at local level | | | 1,249,434 |
| | | | 3.3.5.5 | Monitor the meetings that are taking place and the matters discussed and | | | 347,065 |

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| | | | | resolved at the State and LGA Health Professional Fora | | | |
| | **3** | **To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers** | | | **One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015** | | **34,534,352** |
| | | 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 | | | | **5,089,360** |
| | | | 3.4.1.1 | Review training programmes of health related institutions in HRH in line with national priorities | | | 279,040 |
| | | | 3.4.1.2 | Design and implement special training programmes aimed at producing cadres of health professional in critical areas of need | | | 1,735,324 |
| | | | 3.4.1.3 | Promote the national Midwives Service Scheme and the Community Midwifery programme | | | 2,540,515 |
| | | | 3.4.1.4 | Review admission criteria for relevant disciplines in response to the HRH crisis in disavantaged areas of the state and strengthen adequate production of qualified health professionals through appropriate accreditation and regulatory bodies | | | 222,122 |
| | | | 3.4.1.5 | Conduct regular review of functions and mandates of HRH regulatory bodies and strengthen public private partnership in HRH development | | | 312,358 |
| | | 3.4.2 | To strengthen health workforce training capacity and output based on service demand | | 1. 2 schools of midwifery renovated by end of 2013.<br>2. 300 delivery kits supplied by 2013. 3. 120 midwives and 100 SCHEWs trained for emergency obstetric care by 2013 | | **5,811,671** |
| | | | 3.4.2.1 | Map the capacity for production of health care providers by training institutions in Abia State | | | 937,075 |
| | | | 3.4.2.2 | Review of training curricula of identified training institutions to reflect the disease burden situation in the state | | | 382,188 |
| | | | 3.4.2.3 | Promote human capital capacity building and continuing professional development (CPD) | | | 846,838 |
| | | | 3.4.2.4 | Ensure periodic upgrading of teaching and learning material, infrastructure and financial support as incentive for retention of staff. | | | 2,659,905 |
| | | | 3.4.2.5 | Establish mechanisms for identifying areas of service demand and train manpower accordingly | | | 985,664 |

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| | | 3.4.3 | To improve or strengthen communication and collaboration between ministry of health and and other health related ministries and training institutions | | | **2,488,178** |
| | | | 3.4.3.1 | To establish areas of cooperation in terms of HRH between Ministry of health and training institutions | | 916,251 |
| | | | 3.4.3.2 | Establish curriculum review committee with representatives from the Ministry of health and training institutions | | 369,346 |
| | | | 3.4.3.3 | Establish HRH committee that will regularly review manpower needs and communicate same to training institutions | | 139,173 |
| | | | 3.4.3.4 | Monitor and evaluate functions of the committee on yearly basis | | 1,063,407 |
| | | 3.4.4 | Establish the situation of training institutions and include training on quaity assurance | 1. Comprehensive data base of Health training institutional capacity (infrastructure, teachers, other resources) established and maintained by end of 2009.<br>2. Incentive programme implemented for academic staff in 2011 | | **18,331,836** |
| | | | 3.4.4.1 | Establish quality assurance units and education units in all training institutions with incentives for satisfactory performance | | 1,499,320 |
| | | | 3.4.4.2 | Set up and strengthen training institutions for production of health care providers based on need | No of training institutions for production of health care providers set up | | 1,499,320 |
| | | | 3.4.4.3 | Provide teaching Aids and materials for training institutions | No and type of infrastructure, teaching and learning materials provided by training institution. Level of financial support provided for training institutions. | Availability of fund in the context of global economic meltdown | 1,749,207 |
| | | | 3.4.4.4 | Ensure Full accreditation of schools | No of training institutions with quality assurance units and education units | | 13,583,988 |
| | | | 3.4.4.5 | Establish an incentives and regular upgrading structure for academic staff so as to ensure their retention | Incentives and upgrading structures for academic staff established | | - |
| | | 3.4.5 | Review and refine the functions, mandates and responsibilities of professional regulatory bodies with a view to strengthening adequate production of various health professionals | 1. Initial review of functions and mandates of all health professions regulatory bodies completed by end 2010.<br>2. 50% of training insitutions have amended curriculae for health professions by end 2011. 3. 10% | | **2,813,308** |

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| | | | | | increased production of key auxilliary workers by end of 2011 | | |
| | | | 3.4.5.1 | Establish a process to review the functions and mandates of regulatory bodies on an on-giong process with the aim of strengthening adequate production and registration of health professionals | No of regulatory bodies with functions and mandates reviewed | | 555,304 |
| | | | 3.4.5.2 | Establish or strengthen the regular monitoring process to ensure that training curricula and programmes are reviewed and appropriately accredited and that the regulatory bodies ensure that they reflect multi-tasking and task shifting as appropriate | No of training curricula and programmes reviewed by accrediting and regulatory bodies | | 451,184 |
| | | | 3.4.5.3 | With the regulatory bodies and training institutions review admission criteria for disciplines in response to HRH crisis in disadvantaged areas of the State | No of disciplines with admission requirements reviewed in response to HRH | Potential risk of reducing quality of products from the training institutions | 222,122 |
| | | | 3.4.5.4 | Continuously review assessment conducted by training institutions to meet accreditation and professional requirement | No of training institutions at State levels assessd to meet accreditation | | 860,721 |
| | | | 3.4.5.5 | Establish or expand training of auxilliary cadres of HRH such as community health workers and multipurpose health workers | No of training centers established for training of auxilliary cadres of HRH such as community health workers and multipurpoe health workers | | 723,977 |
| | **4** | **To improve organizational and performance-based management systems for human resources for health** | | | **50% of States have implemented performance management systems by end 2012** | | **48,146,924** |
| | | 3.5.1 | To achieve equitable distribution, right mix of the right quality and quantity of human resources for health | | | | **4,914,439** |
| | | | 3.5.1.1 | Create a database of HRH and develop and provide job descriptions and specifications for all categories of health workers/House numbering | | | 2,221,215 |
| | | | 3.5.1.2 | Redeploy staff equitably between rural and urban areas and at the different levels of the health care system in relation to needs, paying attention to staff mix | | | 832,956 |
| | | | 3.5.1.3 | State MoH will collaborate with Federal institutions located in the state to leverage available human resource so as to expand service coverage and quality | | | 569,186 |
| | | | 3.5.1.4 | To promote mandatory rotation of health workers to underserved rural areas, e.g through NYSC scheme for doctors, pharmacists and appropriate scheme for midwives and nurses | | | 388,713 |
| | | | 3.5.1.5 | Institute use of intra or extra mural private practice services to improve | | | 902,369 |

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| | | | | services in underserved areas as well as provision of incentives for health workers in underserved areas | | | |
| | | 3.5.2 | To establish mechanisms to strengthen and monitor performance of health workers at all levels | | | | **12,052,175** |
| | | | 3.5.2.1 | Conduct routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics | | | 1,041,195 |
| | | | 3.5.2.2 | Institute a system of recognition, reward and sanctions | | | 1,055,077 |
| | | | 3.5.2.3 | Establish and institutionalize a framework for an integrated supportive supervision with adequate committed resources for all types and levels of care providers across public and private sectors. | | | 916,251 |
| | | | 3.5.2.4 | Establish mechanisms to monitor health worker performance, including use of client feedback (exit interviews) | | | 710,095 |
| | | | 3.5.2.5 | Development of a check list for objective assessment of performance of health workers in both LGAs and State | | | 8,329,557 |
| | | 3.5.3 | To develop objective assessment mechanisms of health cadre | | | | **2,346,159** |
| | | | 3.5.3.1 | Evaluate existing appraisal mechanisms of health staff | | | 499,773 |
| | | | 3.5.3.2 | Establish a 6 monthly appraisal of staff using objective, verifiable method | | | 388,713 |
| | | | 3.5.3.3 | An appraisal committee should be strengthened and protected from intimidation | | | 69,413 |
| | | | 3.5.3.4 | Staff complaint forum should be set up for agrieved staff. These should meet every 6 months | | | 416,478 |
| | | | 3.5.3.5 | Budgetary provision for the appraisal committee to be made | | | 971,782 |
| | | 3.5.4 | Motivation of the health workforce by the creation of incentives for health workers along with recognition of hard work and service with emphasis on those that will attract and retrain staff in ruarl and deprived locations | | Workplace satisfaction improved by 5% per year from 2010 | | **2,290,628** |
| | | | 3.5.4.1 | Define performance incentives and management system and encourage SMOH to implement | No of LGAs that have defined performance incentives and management system.<br>No of LGAs that are implementiing defined performance incentives and management system | | 208,239 |
| | | | 3.5.4.2 | Develop guidelines and recommendations on additional incentives for health workers working in rural and deprived areas | No of LGAs providing additional incentives for health workers working in rural and deprived areas | | 166,591 |
| | | | 3.5.4.3 | Develop guidelines on what constitutes an enabling work environment and | No of LGA work places providing enabling work environment | | 166,591 |

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| | | | | promote the compliance with the standards at State and LGAs | | | |
| | | | 3.5.4.4 | Establish mechanisms to minimize work place hazards through management of physical risks and mental stress as well as full compliance with prevention and protection guidelines | No of LGA work places with mechanisms to minimize work place hazards. No of LGA work places that are fully compliant with prevention and protection guidelines | | 222,122 |
| | | | 3.5.4.5 | Intervene where ever possible to ensure that health workers are paid on time | Proportion of health workers at LGA levels that are paid on time | | 1,527,086 |
| | | 3.5.5 | Develop and institute a system for mandatory deployment of newly qualified health workers to underserved rural areas (includes NYSC scheme for doctors, pharmacists, midwives and nurses) | | | | **26,543,523** |
| | | | 3.5.5.1 | Establish and maintain database of fresh graduates of professionals for one year mandatory health services in rural areas and for re-absorption and posting for services in rural areas respectively | State and LGAs have established database of fresh graduates of health professionals | Availability of enabling legislation | 1,388,260 |
| | | | 3.5.5.2 | Work with the SMOH to ensure that facilities have accomodation and adequate professional supervision for deployed junior staff (Construction of staff quarters) | | | 25,155,263 |
| | **4** | **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** | | **1,995,623** |
| | | 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 | | | | **1,717,971** |
| | | | 3.6.1.1 | Establish effective dialogue and complaints channels between management and staff of public and private sectors as well as HRH regulatory bodies and associations. | | | 1,631,205 |
| | | | 3.6.1.2 | Involvement of workers and professional groups in management teams, design and monitoring of services to enhance cooperation amongst all actors | | | 86,766 |
| | | 3.6.2 | Develop and institutionalize forum for policy review, supervisory and monitoring support framework for private and public practitioners at all levels of health service delivery in the state | | All health practitioner policies professionally reviewed by end of 2013 | | **277,652** |
| | | | 3.6.2.1 | Joint policy review forum organized for private and public practitioners and meetings taking place quarterly | No of joint review for a organized for policy review supervisory and monitoring support framework for private and public practitioners at State level and fore all of health care delivery | | 277,652 |
| **FINANCING FOR HEALTH** | | | | | | | |
| **4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels** | | | | | | | **2,905,825,825** |

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| | **4** | **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** | | **89,246,656** |
| | | 4.1.1 | To develop and implement evidence-based, costed health financing strategic plans at LGA and State levels in line with the National Health Financing Policy | | State and LGAs to have devloped costed Health Financing Strategic Plans by 2010 | | **6,796,976** |
| | | | 4.1.1.1 | Technical working groups for health financing at LGA and State will be set up | | | 944,753 |
| | | | 4.1.1.2 | Capacity will be built for the development and implementation of the Strategic plan at both LGA and State | | | 734,808 |
| | | | 4.1.1.3 | Draft the Strategic Plans at all levels | | | 1,889,507 |
| | | | 4.1.1.4 | Yearly review of the strategic plan at both LGA and state | | | 3,227,907 |
| | | 4.1.2 | To establish accurate accounting and auditing mechanisms at both State and LGAs | | | | **82,187,248** |
| | | | 4.1.2.1 | Establish Ministerial Due Process | | | 82,187,248 |
| | | 4.1.3 | To strengthen legislation on health insurance | | | | **262,432** |
| | | | 4.1.3.1 | Evaluate and strenghten the existing legislation on health insurance | | | 262,432 |
| | **4** | **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** | | **1,618,677,509** |
| | | 4.2.1 | To strengthen systems for financial risk health protection | | 40% coverage of the population by end of 2015<br>80% coverage of vulnerable groups by end of 2015 | | **2,902,492** |
| | | | 4.2.1.1 | LGAs will be supported to explore existing and innovative social health protection approaches-social health insurance, other pre-paid schemes, community-based health insurance schemes, etc - for sustainable health financing with protective measures against the financial risks associated with ill health. | | | 944,753 |
| | | | 4.2.1.2 | Technical support will be provided to LGAs to rapidly scale up successful approaches to achieve wider population coverage. | | | 682,322 |
| | | | 4.2.1.3 | The capacity of the health insurance scheme will be strengthened to provide effective regulatory framework for social health insurance and protection programmes in the state | | | 1,275,417 |
| | | 4.2.2 | To establish and strengthen community health financing mechanism at the LGAs | | | | **944,753** |
| | | | 4.2.2.1 | Identify different communities or groups with existing community financing mechanism | | | 262,432 |
| | | | 4.2.2.2 | Establish and strengthen mechnism that will encourage and strengthen community financing | | | 682,322 |

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| | | 4.2.3 | To improve coverage of Abia people on the National Health Insurance Scheme | | | | **1,580,489,526** |
| | | | 4.2.3.1 | Carry out a situation analysis and obtain percentage of people presently on NHIS | | | 2,624,315 |
| | | | 4.2.3.2 | To ensure a phased coverage of NHIS starting with the formal sector and eventually covering all | | | 1,575,638,742 |
| | | | 4.2.3.3 | To identify the most appropriate payment mechanisms for the NHIS bearing in mind the national method | | | 645,581 |
| | | | 4.2.3.4 | To identify the diseases that will initially be covered by te NHIS | | | 220,442 |
| | | | 4.2.3.5 | Monitor and evaluate the implementation of the scheme every 6 months | | | 1,360,445 |
| | | 4.2.4 | To harmonize all the various health insurance scheme to improve its effectiveness | | | | **875,471** |
| | | | 4.2.4.1 | Establish a forum for regular discussions and Identification of various existing financing options and harnessing | | | 179,503 |
| | | | 4.2.4.2 | Carry out public enligthenment campaigns to highlight need for health insurance | | | 695,968 |
| | | 4.2.5 | To provide free maternal and child health services | | | | **33,465,265** |
| | | | 4.2.5.1 | Estabilsh Ward PHC and LGA Gen health facilities in all LGAs that provide free MCH services | | | 33,465,265 |
| | **4** | **To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner** | | | **Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015** | | **1,151,083,880** |
| | | 4.3.1 | To improve financing of the Health Sector | | | | **315,862,557** |
| | | | 4.3.1.1 | State government and LGAs will allocate 7.5% and 5% of their budgets respectively to PHC activities | | | - |
| | | | 4.3.1.2 | Yearly alignment of MOH budget with the SSHDP | | | 944,753 |
| | | | 4.3.1.3 | Existing and potential financing strategies will be considered e.g.pre-payment schemes, and health insurance schemes, grants from the Federal Government, proportion of Value Added Tax (VAT), "sin tax" from alcohol and cigarette and donations from corporations and charities. | | | - |
| | | | 4.3.1.4 | Establishment of special funds for chronic and emerging diseases (e.g. mental health, cancers, diabetics etc. | | | 314,917,803 |
| | | | 4.3.1.5 | Establish Committee on the impact of poverty on gender and develop financing safety net options | | | - |
| | | 4.3.2 | To improve coordination of donor funding mechanisms | | State and LGAs to have functional donor coordinating mechanisms by end of 2010 | | **13,868,455** |

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| | | | 4.3.2.1 | International development partners will align their support to the state and ensure it is captured within the broad budgetary estimates and SHDP on a yearly basis | | | - |
| | | | 4.3.2.2 | Annual reviews of Donor Agency assistance to the state and alignment with SSHDP | | | 9,447,534 |
| | | | 4.3.2.3 | State MOH inter-Agency Coordination Committee planning Activities | | | 4,420,921 |
| | | | 4.3.2.4 | Mechanisms for coordinating donor resources with that of State and LGAs will take the form of common basket funding through options such as joint funding agreements, secto-wide approaches (SWAps) and sectoral multi-donor budget support etc. | | | - |
| | | | 4.3.2.5 | The implementation of Paris declaration on aid effectiveness with a follow up of the Accra agenda will be promoted | | | - |
| | | 4.3.3 | Identify all other possible sources of heaalth funding | | | | **814,398,434** |
| | | | 4.3.3.1 | Identify and encourage philantropy and counterpart funding for Specialist Hospital on PPP basis | | | 629,835,607 |
| | | | 4.3.3.2 | Establish a committee responsible to finding ways to improve Public-Private Partnership in health funding | | | 703,316 |
| | | | 4.3.3.3 | Set up a committee to identify possible foreign partners to assist in health financing in the state | | | 157,459 |
| | | | 4.3.3.4 | Abia participation in HSDP 111 (counterpart fund contribution) | | | 183,702,052 |
| | | 4.3.4 | Government at both State and LGA levels to allocate at least 15% of their total budgets on health | | | | **6,009,681** |
| | | | 4.3.4.1 | Secure statutory protection through LGA and State Assembly to allocate 15% of budgets to health sector | | | 2,262,160 |
| | | | 4.3.4.2 | Ensure that 45% of the health buget is allocated to capital expenditure | | | 278,177 |
| | | | 4.3.4.3 | Ensure that one tenth of the target 15% allocation (i.e. 1.5%) should be earmarked for social health protection programmes | | | 104,973 |
| | | | 4.3.4.4 | Ensure that 2% of the consolidated fund from the Federation Account is released for Primary Health Care as provided in the National Health Bill | | | 3,149,178 |
| | | | 4.3.4.5 | Ensure that 2% of the total health budget is allocated to research for health at all levels | | | 215,194 |
| | | 4.3.5 | 10% of VAT to be dedicated to social health programmes | | | | **944,753** |
| | | | 4.3.5.1 | Work with the SMOH and other key stakeholders to secure support for allocating a dedicated portion of VAT for social health protection programmes | | | 78,729 |

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| | | | 4.3.5.2 | Draft a bill for the State Assembly to pass to secure 10% of VAT for social health protection programmes | | | 603,592 |
| | | | 4.3.5.3 | Get the State Assembly to pass a bill to secure 10% of VAT for social health protection programmes | | | 262,432 |
| | **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<br>2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012** | | **46,817,780** |
| | | 4.4.1 | To improve Health Budget execution, monitoring and reporting | | | | **13,488,979** |
| | | | 4.4.1.1 | The State Ministry of health to train and retrain LGAs on developing costed, annual operational plans. | | | 12,596,712 |
| | | | 4.4.1.2 | Capacity building on internal accounting procedure, financial management and report writing. | | | 524,863 |
| | | | 4.4.1.3 | Credible mechanisms will be put in place to increase financial transparency through the development of State and LGA Health Accounts (SHA and LHAs) and Public Expenditure Reviews (PERs) tracking of health bugets) | | | 367,404 |
| | | 4.4.2 | To strengthen financial management skills | | | | **29,602,274** |
| | | | 4.4.2.1 | Conduct yearly monitoring/supervision of State financial management systems | | | 10,707,205 |
| | | | 4.4.2.2 | Yearly retraining of the health staff invoved in finance at both LGA and State | | | 18,895,068 |
| | | 4.4.3 | To ensure equity in allocation and distribution of health resources | | | | **3,726,527** |
| | | | 4.4.3.1 | Conduct yearly inventory health resources e.g. manpower and materials | | | 2,834,260 |
| | | | 4.4.3.2 | To identify areas of health need and relative resource distribution | | | 892,267 |
| **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** | | | | | | | **805,016,918** |
| | **5** | **To improve data collection and transmission** | | | **1. 50% of LGAs making routine NHMIS returns to State level by end 2010<br>2. 60% of States making routine NHMIS returns to Federal level by end 2010** | | **422,710,696** |
| | | 5.1.1 | To ensure that NHMIS forms are available at all health service delivery points at all levels | | | | **217,154,546** |
| | | | 5.1.1.1 | Printing of data collection forms for all facilities in the state and LGAs | xxxxxxxxxxxxxxxxxxxxxxxxxxxxxx | | 203,480,647 |

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| | | | 5.1.1.2 | Distribute forms to appropriate facilities to ensure their utilisation | | | - |
| | | | 5.1.1.3 | Produce forms every 6 months | | | 6,104,419 |
| | | | 5.1.1.4 | Ensure the forms are available at the health facilities | | | 2,441,768 |
| | | | 5.1.1.5 | Appoint a point person whose responsibility it is to ensure the forms are always available | | | 5,127,712 |
| | | 5.1.2 | Periodically review NHMIS data collection forms | | | | **26,316,830** |
| | | | 5.1.2.1 | State and LGAs to create mechanisms to ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools | | | 610,442 |
| | | | 5.1.2.2 | State and LGAs to establish mechanisms for annual review of the NHMIS | | | 1,695,672 |
| | | | 5.1.2.3 | State to establish SHMIS review committee and adapt it to NHMIS | | | 3,662,652 |
| | | | 5.1.2.4 | Budgetary allocation made available for activities of the committee activities | | | 20,348,065 |
| | | | 5.1.2.5 | Establishment of an "Alert Mechanism" for emergency review or introduction of new NHMIS data collection forms | | | - |
| | | 5.1.3 | To coordinate data collection from vertical programmes | | | | **27,809,022** |
| | | | 5.1.3.1 | Revitalise the Health Data Consultative Committee in the state in collaboration with partners and other government agencies to streamline and strenghten data collection systems. | | | 5,087,016 |
| | | | 5.1.3.2 | Establish and strenghten linkages and harmonized data collection mechanism at state and LGA level | | | 169,567 |
| | | | 5.1.3.3 | Ensure appropriate and timely transmission of collected data | | | 20,348,065 |
| | | | 5.1.3.4 | Identify various vertical programmes going on in the State and LGAs | | | 169,567 |
| | | | 5.1.3.5 | Hold regular meetings with programme managers in the State | | | 2,034,806 |
| | | 5.1.4 | To build capacity of health workers for data management | | | | **151,430,298** |
| | | | 5.1.4.1 | Conduct comprehensive training and re-training of service providers on data collection tools, analysis and utilization of data for action in health programming and policy formulation | | | 20,348,065 |
| | | | 5.1.4.2 | Establish adequate monitoring systems at state level to ensure data quality | | | 36,626,516 |
| | | | 5.1.4.3 | Recruitment of health information personnel, where grossly inadequate, to support the system | | | 51,277,123 |
| | | | 5.1.4.4 | To provide ICT equipments to data managers | | | 2,482,464 |
| | | | 5.1.4.5 | To create or strengthen data management unit at both State and LGAs | | | 40,696,129 |
| | | 5.1.5 | To provide a legal framework for activities of the NHMIS programme | | | | - |

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| | | | 5.1.5.1 | Establishment of sanction of private care providers that fail to submit health data to the relevant health authorities | | | - |
| | | | 5.1.5.2 | Establish mechanisms to enforce these sanctions | | | - |
| | | | 5.1.5.3 | Put in place additional legal framework for activities of the NHMIS programme in both state and LGAs | | | - |
| | | | 5.1.5.4 | Embark upon systemic advocacy to policy makers to make them understand the value and usefulness of data as well as promulgate an enabling law and bye laws to make this mandatory | | | - |
| | | | 5.1.5.5 | Strenghten vital registration system in the state and LGAs | | | - |
| | | 5.1.6 | To improve coverage of data collection | | | | - |
| | | | 5.1.6.1 | Develop innovative strategies to collect data from all public and private health facilities and equally improve the collection of community based data | | | - |
| | | | 5.1.6.2 | Ensure presence of adequate number of data collecting tools | | | - |
| | | | 5.1.6.3 | Improve follow up mechanisms for defaulting health facilities | | | - |
| | | | 5.1.6.4 | Conduct household enumeration as part of assigning each JCHEW to 300 households for collection of vital statistics, etc. | | | - |
| | | | 5.1.6.5 | Ensure that all levels (including Ward Health Facilities) are involved in data collection | | | - |
| | | 5.1.7 | To ensure supportive supervision of data collection at all levels | | | | - |
| | | | 5.1.7.1 | Carry out supportive supervision of data collection at all levels | | | - |
| | | | 5.1.7.2 | Provide adequate logistitics to supervise data collection at lower levels | | | - |
| | | | 5.1.7.3 | Identify personnels that will be responsible for supervising data collection | | | - |
| | | | 5.1.7.4 | Develop a check list for the supervisors of data collection | | | - |
| | | | 5.1.7.5 | Establish an independent body to assist in supervising data collection | | | - |
| | **5** | **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** | | **101,740,324** |
| | | 5.2.1 | To strengthen the use of information technology in HIS | | | | - |
| | | | 5.2.1.1 | Strenghten use of information technology on HIS by training and re-training | | | - |
| | | | 5.2.1.2 | Promote decentralized software-based systems for data collection/analysis | | | - |
| | | | 5.2.1.3 | Establish mechanisms to enhance the wide use of e-health data eg. through electronic Management Intelligence | | | - |

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| | | | | Information System, websites, patient infromation system, etc. | | | |
| | | | 5.2.1.4 | Establish public-private partnerships in the management of data warehouses | | | - |
| | | | 5.2.1.5 | Provide computers and internet facilities for State and all LGAs | | | - |
| | | 5.2.2 | To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management | | | | **-** |
| | | | 5.2.2.1 | An HIS Minimum Package at both state and LGA levels of data management will be defined | | | - |
| | | | 5.2.2.2 | Provide adequate and timely availability of the NHMIS Minimum Package at state and LGA levels for data management, inclusive of basic infrastructure for data storage, analysis and transmission systems (computers, power supply and internet). | | | - |
| | | | 5.2.2.3 | Monitor appropiate use of computers hardware systems | | | - |
| | | | 5.2.2.4 | Acquire systems for database software at both state and LGA levels | | | - |
| | | | 5.2.2.5 | Build capacity of relevant staff on the database | | | - |
| | | 5.2.3 | Improve monitoring and evaluation | | | | **101,740,324** |
| | | | 5.2.3.1 | Provision of ICT gadgets to M & E unit | | | - |
| | | | 5.2.3.2 | Capacity building on data collection, M&E activities for PRS staff | | | 101,740,324 |
| | **5** | **To strengthen sub-systems in the Health Information System** | | | **1. NHMIS modules strengthened by end 2010<br>2. NHMIS annually reviewed and new versions released** | | **280,565,899** |
| | | 5.3.1 | To strengthen the Hospital Information System | | | | **-** |
| | | | 5.3.1.1 | SMoH to establish and strenghten patient information systems as well as systems for mapping disease | | | - |
| | | | 5.3.1.2 | Develop guidelines and technical specifications for the establishment and strengthening of patient information system | | | - |
| | | 5.3.2 | To strengthen the Disease Surveillance System | | | | **24,315,937** |
| | | | 5.3.2.1 | State and LGAs to ensure that regular reporting of notifiable diseases by all health facilities is carried out | | | - |
| | | | 5.3.2.2 | Initiate and strengthen community based surveillance to strengthen disease Surveillance System | | | - |
| | | | 5.3.2.3 | Training and re-training of community based focal persons in disease surveillance and notification | | | 24,315,937 |
| | | | 5.3.2.4 | Establish state GIS to assist in disease surviellance and notification | | | - |
| | | 5.3.3 | To involve all stake holders in disease surviellance and notification (DSN) | | | | **-** |

| | | | | | | | |
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| | | | 5.3.3.1 | Establish committees that inolve all stakeholders including traditional institutions | | | - |
| | | | 5.3.3.2 | Establish ways to enocourage and reward those who are actively involved in DSN | | | - |
| | | 5.3.4 | To establish regular house numbering exercise and establish Home based records | | | | **256,249,961** |
| | | | 5.3.4.1 | To carry out an updated house hold numbering exercise | | | 149,897,410 |
| | | | 5.3.4.2 | Produce and distribute home based records | | | 106,352,552 |
| | **5** | **To monitor and evaluate the NHMIS** | | | **NHMIS evaluated annually** | | **-** |
| | | 5.4.1 | To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs | | | | **-** |
| | | | 5.4.1.1 | Provide timely availability of logisitics materials (vehicles or motorcycles) and facility use by NHMIS field monitoring instruments at all levels | No of vehicles purchased | | - |
| | | | 5.4.1.2 | HIS Quality Assurance (QA) manual (Handbook) to be used at each level of health care delivery | Quality data produced | | - |
| | | | 5.4.1.3 | Institute HIS review meetings at LGA level and bi-annual review meetings at state level. | | | - |
| | | | 5.4.1.4 | Train key SMOH officers in the use of the field monitoring check list instrument for NHMIS programme | Monitoring conducted with check list | | - |
| | | 5.4.2 | To strengthen data transmission | | | | **-** |
| | | | 5.4.2.1 | Build institutional and human capacities for timely and complete transmission of data in line with relevant guidelines | Timeliness of data transmission | | - |
| | | | 5.4.2.2 | Monitor monthly and quaterly transmission of HMIS data and evaluate the problems that prevent complete and regular transmission of HMIS data | | | - |
| | **6** | **To strengthen analysis of data and dissemination of health information** | | | **1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly** | | **-** |
| | | 5.5.1 | To institutionalize data analysis and dissemination at all levels | | | | **-** |
| | | | 5.5.1.1 | Strengthen institutional and human capacities for appropriate data analysis and dissemination of information and data to inform decision making and programming | | Availability of capacity to analyze data at LGA level | - |
| | | | 5.5.1.2 | Production of periodic health data bulletin and annual reports by state Department of Planning, Research and Statistics | No of bulletin produced | | - |
| | | | 5.5.1.3 | Develop guidelines and a training programme on data analysis for use at all levels | No of health facilities with analyzed data | | - |

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| | | | 5.5.1.4 | Promote the use of data at all levels for informed decision making using pilot sites | No of decision made based on analyzed data | | - |
| | | | 5.5.1.5 | Monitor Annual Reports of the National Director of Planning Research and Statistics by the State | Report of Director DPRS available | | - |
| **COMMUNITY PARTICIPATION AND OWNERSHIP** | | | | | | | |
| **6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes** | | | | | | | 536,677,945.59 |
| | **6** | **To strengthen community participation in health development** | | | **All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012** | | - |
| | | 6.1.1 | To provide an enabling policy framework for community participation | | | | 675,525.00 |
| | | | 6.1.1.1 | Create an enabling policy environment to foster effective community participation in health actions through the appropiate revision of community participation section of the National Health Policy and finalization of the Community Development Policy | Updated guidelines available by end of 2009 | | - |
| | | 6.1.2 | To provide an enabling implementation framework and environment for community participation | | | | 100,002,420.00 |
| | | | 6.1.2.1 | Update and adapt the guidelines for establishing community development | Updated guidelines available by end of 2009 | | - |
| | | | 6.1.2.2 | Develop and utilise participatory tools and approaches to enhance community involvement in planning, management, monitoring and evaluation of health interventions | | | - |
| | | | 6.1.2.3 | Establish inter-sectoral stakeholder committees involving community representatives at all levels so as to enhance collaboration | Committees established at each level by 2010 | | - |
| | | 6.1.3 | Reactivate and sustain Village Development Committee (VDC) and Ward Health Committee (WHC) | | | | 100,000,000.59 |
| | | | 6.1.3.1 | Establish or reactiate the VDC and WHC | | | - |
| | | | 6.1.3.2 | Define the roles of these committees | | | - |
| | | | 6.1.3.3 | Make budgetary allocation for the sustenance of the VDC and WHC | | | - |
| | | | 6.1.3.4 | Ensure regular meetings of these committee at least once every 6 months | | | - |
| | | | 6.1.3.5 | Establish community dialogue with TBAs, CBO,youths and other groups | | | - |
| | **6** | **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** | | - |
| | | 6.2.1 | To build capacity within communities to 'own' their health services | | | | 136,000,000.00 |
| | | | 6.2.1.1 | Develop, upgrade or modify existing participatory tools for mobilising | | | - |

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| | | | | communities in planning and management | | | |
| | | | 6.2.1.2 | Identify and map out key community stakeholders and resources with community assessment of capacity needs. | Community stakeholders certified and mapped out by December 2010 | | - |
| | | | 6.2.1.3 | Re-orient community development committees and community-based health care providers on their roles and responsibilities and mobilize reources and allocate funds for community level activities | | | - |
| | | | 6.2.1.4 | Establish community dialogue between communities and government structures for maximum impact and information, education and communication (IEC) activities and media used to enlghten andempower communities for positive impact | | | - |
| | | | 6.2.1.5 | Involve communities at all levels in program planning, implementation and monitoring | | | - |
| | **6** | **To strengthen the community - health services linkages** | | | **50% of public health facilities in all States have active Committees that include community representatives by end 2011** | | - |
| | | 6.3.1 | To restructure and strengthen the interface between the community and the health services delivery points | | | | 85,000,000.00 |
| | | | 6.3.1.1 | Review and assess level of linkages of the existing health delivery structures | | | |
| | | | 6.3.1.2 | Provide technical guidance and support to community-health service linkage | | | |
| | | | 6.3.1.3 | Restructure health delivery structure to ensure adequate promotion of community participation in health development | | | - |
| | | | 6.3.1.4 | Promote the exchange of experiences between community development committees | | | - |
| | | | 6.3.1.5 | Develop guidelines for strengthening the community-health services interphase | | | - |
| | **6** | **To increase national capacity for integrated multisectoral health promotion** | | | **50% of States have active intersectoral committees with other Ministries and private sector by end 2011** | | - |
| | | 6.4.1 | To develop and implement multisectoral policies and actions that facilitate community involvement in health development | | | | 95,000,000.00 |
| | | | 6.4.1.1 | Undertake advocacy to community gatekeepers to increase their awareness on community participation and health promotion | | | |
| | | | 6.4.1.2 | Develop and implement community health development programmes | | | - |

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| | | | 6.4.1.3 | Formulate action plans to facilitate the development of health promotion capacities at the community levels | | | - |
| | | | 6.4.1.4 | Use the health promotion guidelines to link health with other sectors | | | - |
| | | | 6.4.1.5 | Empower communities with health knowledge, behavioural communication change and uptake mechanisms | | | - |
| | **6.5** | **To strengthen evidence-based community participation and ownership efforts in health activities through researches** | | | **Health research policy adapted to include evidence-based community involvement guidelines by end 2010** | | - |
| | | 6.5.1 | To develop and implement systematic measurement of community involvement | | | | 20,000,000.00 |
| | | | 6.5.1.1 | Use locally adapted models to establish simple mechanisms to support communities to measure impact | | | - |
| | | | 6.5.1.2 | Document lessons learnt and best practices from specific community-level approaches, methods and initiatives | | | - |
| | | | 6.5.1.3 | Disseminate above findings to enhance knowledge sharing among stakeholders | | | - |
| **PARTNERSHIPS FOR HEALTH** | | | | | | | |
| **7. To enhance harmonized implementation of essential health services in line with national health policy goals** | | | | | | | **536,677,946** |
| | **7** | **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<br>2. FMOH has an active PPP forum that meets quarterly by end 2010<br>3. All States have similar active committees by end 2011** | | **536,677,946** |
| | | 7.1.1 | To promote Public Private Partnerships (PPP) | | | | **419,192,778** |
| | | | 7.1.1.1 | State to develop strategies for full implementation of PPP initiatives in line with the national policy | | | - |
| | | | 7.1.1.2 | Establishment of PPP units at all levels to promote, oversee and monitor PPP initiatives | | | - |
| | | | 7.1.1.3 | Undertake mechanisms for engaging the private sector - such as contracting or out-sourcing, leases, concessions, social marketing,, franchising mechanism and provision incentives (e.g. health commodities, or technical support at no cost) | | | - |
| | | | 7.1.1.4 | Explore other options that encourage the private sector set up health facilities in rural and under-served areas e.g. construction of canteen for catering services under PPP at General Hospitals Amachara, Umunnato and Umunneochi | | | 419,192,778 |
| | | | 7.1.1.5 | Establish joint monitoring visits by public care providers with adequate feedback | | | - |

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| | | 7.1.2 | To institutionalize a framework for coordination of Development Partners | | | | - |
| | | | 7.1.2.1 | Establish Development Partners Forum comprising only health development partners at state level as single entry point for engaging with partners. | | | - |
| | | | 7.1.2.2 | Establish and strengthen Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners | | | - |
| | | | 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 | | | - |
| | | 7.1.3 | To facilitate inter-sectoral collaboration | | | | **117,485,167** |
| | | | 7.1.3.1 | Establish an inter-sectoral ministerial forum at all levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes - such as Environment in Malaria control and prevention, Agriculture in nuitrition programmes, Water Resources in control of water borne or related diseases, etc. | | | - |
| | | | 7.1.3.2 | In collaboration with Ministry of Env and other donor agencies to strengthen infection prevention, control and health care waste management in the PHC | | | 117,485,167 |
| | | | 7.1.3.3 | In collaboration with other stakeholders, stregthen food safety and inspection services | | | - |
| | | 7.1.4 | To engage professional groups | | | | - |
| | | | 7.1.4.1 | Promote effective partnership with professional groups through joint setting of standards of training by health institutions, subsequent practices and professional competency assessments | | | - |
| | | | 7.1.4.2 | Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes | | | - |
| | | | 7.1.4.3 | Promote effective communication to facilitate relationships between professional groups and Ministry of Health | | | - |
| | | | 7.1.4.4 | Strengthen collaboration between government and professional groups to advocate for increased coverage of essential interventions, particularly increased funding | | | - |
| | | | 7.1.4.5 | Convene public lectures through a coordinated approach by professional associations to enhance the provision of skilled care by healthprofessionls | | | - |
| | | 7.1.5 | To engage with communities | | | | - |

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| | | | 7.1.5.1 | Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels | | | - |
| | | | 7.1.5.2 | Information packages for community consumption should include rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services | | | - |
| | | | 7.1.5.3 | Develop indicators on health system performance at State, LGAs and facilities to improve transparency and accountability of the government to its citizens. | | | - |
| | | | 7.1.5.4 | Institute mechanisms for competition between LGAs and facilities for satisfactory performance in delivery of community support programmes for health | | | - |
| | | | 7.1.5.5 | Establish and empower Health Service Charters at all levels, with Civil Society Organizations, traditional and religious institutions to promote the concept of citizen's rights and entitlement to quality, accessible basic health services | | | - |
| | | 7.1.6 | To engage with traditional health practitioners | | | | - |
| | | | 7.1.6.1 | Seek to have better understanding of traditional health practices and support research activities to gain more insight and evaluate them | | | - |
| | | | 7.1.6.2 | Organise traditional medicine practitioners into bodies/organisatons that are easy to regulate and actually regulate their practice | | | - |
| | | | 7.1.6.3 | Adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful | | | - |
| | | | 7.1.6.4 | Train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system | | | - |
| | | | 7.1.6.5 | Seek the cooperation of traditional practitioners in promoting health programmes in such priority areas a s nutrition, enironmental sanitation, personal hygiene, immunisation and family planning | | | - |
| **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** | | | | | | | **1,073,355,891.19** |
| | **8** | **To strengthen the stewardship role of governments at all levels for research and knowledge management systems** | | | **1. ENHR Committee established by end 2009 to guide health research priorities<br>2. FMOH publishes an Essential Health** | | **158,154,281** |

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| | | | | | **Research agenda annually from 2010** | | |
| | | 8.1.1 | To finalise the Health Research Policy at State level and develop health research policies at State levels and health research strategies at State and LGA levels | | | | **15,117,689** |
| | | | 8.1.1.1 | Convene Technical working groups to finalise or develop State and LGA health research policies and strategies | | | - |
| | | | 8.1.1.2 | Establish Health research steering committees at all levels to shepherd research activities at all levels | | | - |
| | | | 8.1.1.3 | Put in place Health Research Ethics Committee (HREC) in Abia State | | | 15,117,689 |
| | | | 8.1.1.4 | Provide guidelines for the Abia-HREC | | | - |
| | | | 8.1.1.5 | Monitor and evaluate the activities of Abia-HREC | | | - |
| | | 8.1.2 | To establish and or strengthen mechanisms for health research at all levels | | | | **18,606,386** |
| | | | 8.1.2.1 | Establish or strengthen the capacities of health research divisions and units at all levels to coordinate and encourage research efforts, linking researchers and creating communities of practice | | | - |
| | | | 8.1.2.2 | Strengthen Departments of Planning Research and Statistics (DPRS) as well as create active research units in the State and LGAs to undertake operations research and other research-related activities | | | - |
| | | | 8.1.2.3 | Ensure the coordinated implementation of the Essential National Health Research (ENHR) guidelines | | | - |
| | | | 8.1.2.4 | Provide technical assistance to develop and strengthen Health Research in all hospitals and health institutions in the state | | | 6,977,395 |
| | | | 8.1.2.5 | Provide assistance to strengthen Clinical Governance and SERVICOM units in the state to enhance research in the hospitals | | | 11,628,991 |
| | | 8.1.3 | To institutionalize processes for setting health research agenda and priorities | | | | **15,117,689** |
| | | | 8.1.3.1 | Establish and or strengthen functional institutional structures for research | | | - |
| | | | 8.1.3.2 | Expand health research agenda to include broad and multidimentional determinants of health and ensure cross-linkages with areas beyond traditional boundaries and categories | | | - |
| | | | 8.1.3.3 | Develop guidelines for collaborative health research agenda at all levels | | | - |
| | | | 8.1.3.4 | Implement essential National Research programme | | | 3,488,697 |
| | | | 8.1.3.5 | Expansion of the health research agenda to include broad and multidimension of health with cross linkages beyond its traditional bounderies and categories | | | 11,628,991 |

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| | | 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 | | | | **55,819,158** |
| | | | 8.1.4.1 | Establish a forum of health research officers at the SMoH and LGA | | | 5,814,496 |
| | | | 8.1.4.2 | Annual convening of multi-stakeholders forum to identify research priorities and harmonize research efforts | | | 20,932,184 |
| | | | 8.1.4.3 | Governments at all levels to support the development of collaborative research proposals and their implementation between governments and public and private health research organizations | | | - |
| | | | 8.1.4.4 | Develop and disseminate guidelines for a collaborative reseach agenda | | | 5,814,496 |
| | | | 8.1.4.5 | Support development of collaborative research proposals and their implementation | | | 23,257,982 |
| | | 8.1.5 | To mobilise adequate financial resources to support health research at all levels | | | | **-** |
| | | | 8.1.5.1 | At least 2% of health budget will be allocated for health research at all levels | | | - |
| | | | 8.1.5.2 | Funds for health research to be deployed in a targeted manner while expanding beneficiaries of funding to researchers from both public and non-public health research organizations and individuals | | | - |
| | | | 8.1.5.3 | To explore opportunities for accessing funds from bilateral and multilateral organizations and research funding agencies | | | - |
| | | | 8.1.5.4 | Establish transparent independent state research funding agency | | | - |
| | | 8.1.6 | To establish ethical standards and practise codes for health research at all levels | | | | **53,493,360** |
| | | | 8.1.6.1 | Establish and or strengthen health research ethical mechanisms, guidelines and ethical review committees at state and LGA levels | | | 11,628,991 |
| | | | 8.1.6.2 | Strengthen similar mechanisms in tertiary health and education institutions | | | - |
| | | | 8.1.6.3 | Establish monitoring and evaluation system to regulate research and use of research findings at all levels in the state | | | 23,257,982 |
| | | | 8.1.6.4 | Strengthen the established Abia-REC | | | 18,606,386 |
| | **8** | **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** | | **326,774,654** |
| | | 8.2.1 | To strengthen identified health research institutions at all levels | | | | **17,443,487** |
| | | | 8.2.1.1 | Strengthen identified health research institutions identified by inventory of all public and private institutions and organizations undertaking health research | | | 4,651,596 |

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| | | | 8.2.1.2 | Conduct periodic capacity assessment of health research organizations and institutions | | | 5,814,496 |
| | | | 8.2.1.3 | Develop and implement measures to address identified research capacity gaps and weaknesses | | | 4,651,596 |
| | | | 8.2.1.4 | Ensure the development and implementation of resource mobilization strategies targeting private sector, foundation and individuals for health research | | | 1,162,899 |
| | | | 8.2.1.5 | Publicize/advertise information to encourage health workers to carry out research | | | 1,162,899 |
| | | 8.2.2 | To create a critical mass of health researchers at all levels | | | | **30,235,377** |
| | | | 8.2.2.1 | Develop appropriate training interventions for research, based on the identified needs at all levels | | | 1,162,899 |
| | | | 8.2.2.2 | Government to provide competitive research grants for prospective researchers | | | 23,257,982 |
| | | | 8.2.2.3 | Motivate increased PhD training in health institutions through award of PhD studentship scholarships | | | - |
| | | | 8.2.2.4 | Motivate and encourage health institutions to encourage their students on health research through seminars and workshops | | | 5,814,496 |
| | | | 8.2.2.5 | Training of Health Research Fellows in South Africa | | | - |
| | | 8.2.3 | To develop transparent approaches for using research findings to aid evidence-based policy making at all levels | | | | **6,977,395** |
| | | | 8.2.3.1 | To evolve mechanisms for translating research findings into policies | | | - |
| | | | 8.2.3.2 | Establish close liason and linkages between research users (e.g. policy makers, development partners) and researchers | | | 2,325,798 |
| | | | 8.2.3.3 | Involve a wide range of actors including research producers in policy-making consultations | | | 4,651,596 |
| | | 8.2.4 | To undertake research on identified critical priority areas | | | | **272,118,395** |
| | | | 8.2.4.1 | Establish a process for the bi-annual estimation of the burden of identified priority disease | | | 20,932,184 |
| | | | 8.2.4.2 | Undertake bi-annual studies in human resources for health | | | 55,819,158 |
| | | | 8.2.4.3 | Undertake bi-annual studies in health system governance | | | 55,819,158 |
| | | | 8.2.4.4 | Conduct bi-annual studies in health delivery system | | | 69,773,947 |
| | | | 8.2.4.5 | Conduct studies on financial risk protection, equity, efficiency and value of different financing mechanism bi-annually | | | 69,773,947 |

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| | **8** | **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<br>2. FMOH and State Health Research Units manage an accessible repository by end 2012** | | **425,621,079** |
| | | 8.3.1 | To develop strategies for getting research findings into strategies and practices | | | | **76,751,342** |
| | | | 8.3.1.1 | Establish ways and means of getting research into strategic units in the state | | | 76,751,342 |
| | | 8.3.2 | To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system | | | | **27,909,579** |
| | | | 8.3.2.1 | Institute the state bi-annual health research policy forum | | | 11,628,991 |
| | | | 8.3.2.2 | Conduct needs assessment to inform required health research in Abia State | | | 4,651,596 |
| | | | 8.3.2.3 | Promote and provide guidelines for annual operations research to be conducted by health institutions, hospitals and departments in MOH | | | 11,628,991 |
| | | 8.3.3 | To conduct regular monitoring and evaluation of all research actitivies | | | | **320,960,158** |
| | | | 8.3.3.1 | M&E of all research work will be done regularly both before, during and after the programme | | | 286,073,184 |
| | | | 8.3.3.2 | Purchase of IT facilities to enhance monitoring and communication of findings | | | 34,886,974 |
| | **8** | **To develop, implement and institutionalize health research communication strategies at all levels** | | | **A national health research communication strategy is in place by end 2012** | | **162,805,877** |
| | | 8.4.1 | To create a framework for sharing research knowledge and its applications | | | | **4,651,596** |
| | | | 8.4.1.1 | Develop and implement a framework for sharing research knowledge in all government hospitals and health institutions | Framework for sharing knowledge developed by 2011 | The skills and other resources for developing the framework exists | 4,651,596 |
| | | 8.4.2 | To establish channels for sharing of research findings between researchers, policy makers and development practitioners | | | | **158,154,281** |
| | | | 8.4.2.1 | Present an annual health conference at the state level | Annual health conference held in the State | Political Will and resources are available | 69,773,947 |
| | | | 8.4.2.2 | Conduct bi-annual seminars and workshops on key thematic areas e.g. human resources, MDGs, finance, health research etc. at the state level | Annual health workshop held in the State | Political Will and resources are available | 69,773,947 |
| | | | 8.4.2.3 | Prepare guidelines and develop capacity of researchers to produce policy briefs | HR institutions produce and disseminate 100 policy brief per year | Availability of appropiate learning resources and willingness of researchers to produce policy briefs | 11,628,991 |

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| | | | 8.4.2.4 | Support a critical mass of high quality sector journals | | | 6,977,395 |
| | | | 8.4.2.5 | Circulate identified journals to SMOH and LGAs regularly | Journals distributed (electronically and in print) quarterly to SMOH, all LGAs, Development partners, etc. | Availability of resources and a good distribution system | - |
| **TOTAL** | | | | | | | **53,667,794,559** |

*Annex 2: Results/M&E Matrix for the Strategic Health Development Plan*

| ABIA STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX | | | | | | |
|---|---|---|---|---|---|---|
| **OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system** | | | | | | |
| **OUTPUTS** | **INDICATORS** | **SOURCES OF DATA** | **Baseline** | **Milestone** | **Milestone** | **Target** |
| | | | **2008/9** | **2011** | **2013** | **2015** |
| **PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH** | | | | | | |
| **NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria** | | | | | | |
| **OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels** | | | | | | |
| **OUTCOME 2. Transparent and accountable health systems management** | | | | | | |
| **1. Improved Policy Direction for Health Development** | 1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities | LGA s Operational Plans | 0 | 50 | 75 | 100% |
| | 2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies) | SSHDP Annual Review Report | TBD | 25 | 50 | 75% |
| **2. Improved Legislative and Regulatory Frameworks for Health Development** | 3. State adopting the National Health Bill? (Yes/No) | SMOH | 0 | 25 | 50 | 75 |
| | 4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels | Laws and bye-Laws | 6% | 15% | 75% | 100% |
| | 5. % of LGAs enforcing traditional medical practice by-laws | LGA Annual Report | TBD | 25% | 50% | 75% |
| **3. Strengthened accountability, transparency and responsiveness of the State health system** | 6. % of LGAs which have established a Health Watch Group | LGA Annual Report | 0 | 50 | 75 | 100 |
| | 7. % of recommendations from health watch groups being implemented | Health Watch Groups' Reports | 0 | 25 | 50 | 75 |
| | 8. % LGAs aligning their health programmes to the SSHDP | LGA Annual Report | 0 | 50 | 75 | 100 |
| | 9. % DPs aligning their health programmes to the SSHDP at the LGA level | LGA Annual Report | No Baseline | 50 | 75 | 100 |
| | 10. % of LGAs with functional peer review mechanisms | SSHDP and LGA Annual Review Report | 25% | 50% | 75% | 100% |
| | 11. % LGAs implementing their peer review recommendations | LGA / SSHDP Annual Review Report | 25% | 50 | 75 | 100% |
| | 12. Number of LGA Health Watch Reports published | Health Watch Report | 0 | 50 | 75 | 100 |

| | | | | | | |
|---|---|---|---|---|---|---|
| | 13. Number of "Annual Health of the LGA" Reports published and disseminated annually | Health of the State Report | TBD | 50 | 75 | 100% |
| **4. Enhanced performance of the State health system** | 14. % LGA public health facilities using the essential drug list | Facility Survey Report | 5% | 40 | 80 | 100% |
| | 15. % private health facilities using the essential drug list by LGA | Private facility survey | 0 | 10 | 25 | 50% |
| | 16. % of LGA public sector institutions implementing the drug procurement policy | Facility Survey Report | 29.40% | 50 | 75 | 100% |
| | 17. % of private sector institutions implementing the drug procurement policy within each LGA | Facility Survey Report | 3.7 | 10 | 25 | 50% |
| | 18. % LGA health facilities not-experiencing essential drug/commodity stockouts in the last three months | Facility Survey Report | 10% | 25 | 50 | 75% |
| | 19. % of LGAs implementing a performance based budgeting system | Facility Survey Report | TBD | 25 | 50 | 75% |
| | 20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA | LGA Annual Review Report | 25 | 50 | 75 | 120 |
| | 21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7) | States/ LGA Report and Facility Survey Report | 42 | 52 | 62 | 80 |
| **STRATEGIC AREA 2: HEALTH SERVICES DELIVERY** | | | | | | |
| **NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare** | | | | | | |
| **Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas** | | | | | | |
| **Outcome 4: Improved quality of primary health care services** | | | | | | |
| **Outcome 5: Increased use of primary health care services** | | | | | | |
| **5. Improved access to essential package of Health care** | 22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards. | NPHCDA Survey Report | TBD | 25 | 50 | 75% |
| | 23. % health facilities implementing the complete package of essential health care | NPHCDA Survey Report | TBD | 50 | 75 | 100% |
| | 24. % of the population having access to an essential care package | MICS/NDHS | TBD | 40 | 75 | 100% |
| | 25. Contraceptive prevalence rate | NDHS | 16% | 24% | 36% | 60% |
| | 26. Number of new users of modern contraceptive methods (male/female) | NDHS/HMIS | 40% | 2 - 30% | 5 - 50% | 10 - 75% |

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| | 27. % of new users of modern contraceptive methods by type (male/female) | NDHS/HMIS | TBD | 2 - 30% | 5 - 50% | 10 - 75% |
| | 28. % service delivery points without stock out of family planning commodities in the last three months | Health facility Survey | 50% | 10 - 45% | 20 - 75% | 100% |
| | 29. % of facilities providing Youth Friendly RH services | Health facility Survey | 0.05% | 20 - 40% | 30 - 60% | 40 - 75% |
| | 30. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy) | NDHS/MICS | 13% | 10% | 7% | 4% |
| | 31. % of pregnant women with 4 ANC visits performed according to standards* | NDHS | 89% | 92% | 97% | 99% |
| | 32. Proportion of births attended by skilled health personnel | HMIS | 87% | 90% | 95% | 98% |
| | 33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive) | EmOC Sentinel Survey and Health Facility Survey | 30% | 10 - 40% | 25 - 50% | 40 - 75% |
| | 34. Caesarean section rate | EmOC Sentinel Survey and Health Facility Survey | 0.1 - 5.6% | 1.0 - 10% | 5.0 - 20% | 10 - 30 % |
| | 35. Case fertility rate among women with obstretic complications in EmOC facilities per complication | HMIS | TBD | 10 - 60% | 7 - 40% | 5 - 25% |
| | 36. Perinatal mortality rate** | HMIS | 37 - 53/1000LBs | 25 - 45/1000LBs | 15 - 30/1000LBs | 10 - 20/1000 LBs |
| | 37. % women receiving immediate post partum family planning method before discharge | HMIS | 30% | 50% | 75% | 100% |
| | 38. % of women who received postnatal care based on standards within 48h after delivery | MICS | 0.5 - 22.4% | 10 - 40% | 25 - 60% | 50 - 75% |
| | 39. Number of women presented to the facility with or for an obstetric fistula | NDHS/HMIS | No Baseline | | | ?? |
| | 40. Number of interventions performed to repair an obstetric fistula | HMIS | No Baseline | | | ?? |
| | 41. Proportion of women screened for cervical cancer | HMIS | 1% | 10% | 30% | 50% |
| | 42. % of newborn with infection receiving treatment | MICS | No Baseline | 10% | 25% | 50% |
| | 43. % of children exclusively breastfed 0-6 months | NDHS/MICS | 17% | 30% | 45% | 60% |

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| | 44. Proportion of 12-23 months-old children fully immunized | NDHS/MICS | 39.00% | 45% | 60% | 65% |
| | 45. % children <5 years stunted (height for age <2 SD) | NDHSMICS | 24.00% | 20% | 15% | 8% |
| | 46. % of under-five that slept under LLINs the previous night | NDHS/MICS | 3.00% | 25% | 50% | 75% |
| | 47. % of under-five children receiving appropriate malaria treatment within 24 hours | NDHS/MICS | 14% | 25% | 40% | 60% |
| | 48. % malaria successfully treated using the approved protocol and ACT; | MICS | TBD | ??? | ??? | ??? |
| | 49. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures | MICS | TBD | ??? | ??? | ??? |
| | 50. % of women who received intermittent preventive treatment for malaria during pregnancy | NDHS/MICS | 5% | 25% | 50% | 75% |
| | 51. HIV prevalence rate among adults 15 years and above | NDHS | 5% | 4% | 2.80% | 1.50% |
| | 52. HIV prevalence in pregnant women | NARHS | | ??? | ??? | ??? |
| | 53. Proportion of population with advanced HIV infection with access to antiretroviral drugs | NMIS | | ??? | ??? | ??? |
| | 54.Condom use at last high risk sex | NDHS/MICS | 3.70% | 7% | 20% | 45% |
| | 55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS | NDHS/MICS | 47% | 60% | 80% | 95% |
| | 56. Prevalence of tuberculosis | NARHS | 3.70% | 2% | 1.50% | 1% |
| | 57.Death rates associated with tuberculosis | NMIS | 9% | 7% | 4% | 2% |
| | 58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course | NMIS | 76% | 80% | 90% | 98% |
| **Output 6. Improved quality of Health care services** | 59. % of staff with skills to deliver quality health care appropriate for their categories | Facility Survey Report | 20% | 40% | 50% | 65% |
| | 60. % of facilities with capacity to deliver quality health care | Facility Survey Report | 20% | 40% | 60% | 75% |
| | 61. % of health workers who received personal supervision in the last 6 months by type of facility | Facility Survey Report | 10% | 40% | 75% | 85% |
| | 62. % of health workers who received in-service | HR survey Report | TBD | 10 - 25% | 25 - 50% | 50 - 75% |

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| | training in the past 12 months by category of worker | | | | | |
| | 63. % of health facilities with all essential drugs available at all times | Facility Survey Report | 2% | 25% | 40% | 75% |
| | 64. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels | Facility Survey Report | 2% | 15% | 40% | 75% |
| | 65. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis | Facility Survey Report | 0 | 10% | 35% | 60% |
| **Output 7. Increased demand for health services** | 66. Proportion of the population utilizing essential services package | MICS | TBD | 25 - 50% | 50 -75% | 75 - 100% |
| | 67. % of the population adequately informed of the 5 most beneficial health practices | MICS | 5% | 25% | 50% | 75% |
| **PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH** | | | | | | |
| **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care** | | | | | | |
| **Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development** | | | | | | |
| **Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015** | | | | | | |
| **Output 8. Improved policies and Plans and strategies for HRH** | 68. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural). | Facility Survey Report | TBD | 20 - 40% | 30 - 60% | 50 - 75% |
| | 69. Retention rate of HRH | HR survey Report | 2% | 20% | 35% | 50% |
| | 70. % LGAs actively using adaptations of National/State HRH policy and plans | HR survey Report | TBD | 10 - 30% | 30 - 50% | 50 - 75% |
| | 71. Stock (and density) of HRH | HR survey Report | 1 CHW:4500 pop; 1 Nurse or MW:3117 pop; 1 Dr & Dentist:6204 pop; 1 Pharmacist: 20,000 pop; | 1 CHW:4000 pop; 1 Nurse or MW:3000 pop; 1 Dr & Dentist:5000 pop; 1 Pharmacist: 18,000 pop; | 1 CHW:3000 pop; 1 Nurse or MW:2900 pop; 1 Dr & Dentist:4500 pop; 1 Pharmacist: 15,000 pop; | 1 CHW:2000 pop; 1 Nurse or MW:2500 pop; 1 Dr & Dentist4000 pop; 1 Pharmacist: 10,000 pop; |
| | 72. Distribution of HRH by geographical location | MICS | TBD | ??? | ??? | ??? |
| | 73. Increased number of trained staff based on | HR survey Report | TBD | 10 - 20% | 25 - 50% | 50 - 75% |

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| | approved staffing norms by qualification | | | | | |
| | 74. % of LGAs implementing performance-based managment systems | HR survey Report | TBD | 25 - 30% | 30 - 50% | 50 - 80% |
| | 75. % of staff satisfied with the performance based management system | HR survey Report | TBD | 10 - 25% | 25 - 50% | 50 - 75% |
| **Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance** | 76. % LGAs making availabile consistent flow of HRH information | NHMIS | 85% | 90% | 100% | 100% |
| | 77. CHEW/10,000 population density | MICS | 4500 | 1:4000 pop | 1:3000 pop | 1:2000 pop |
| | 78. Nurse density/10,000 population | MICS | 1Nurse:3117 | 1:3000 pop | 1:2500 pop | 1:2000 pop |
| | 79. Qualified registered midwives density per 10,000 population and per geographic area | NHIS/Facility survey report/EmOC Needs Assessment | 1:10,000 | 1:8000 pop | 1:6000 pop | 1:4000 pop |
| | 80. Medical doctor density per 10,000 population | MICS | 1Dr:6000 | 1:5000 pop | 1:4000 pop | 1:3000 pop |
| | 81. Other health service providers density/10,000 population | MICS | 1:10,000 | 1:4000 pop | 1:3000 pop | 1:2000 pop |
| | 82. HRH database mechanism in place at LGA level | HRH Database | 0 | 50% | 75% | 100% |
| **Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers** | | | | | | |
| **PRIORITY AREA 4: FINANCING FOR HEALTH** | | | | | | |
| **NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels** | | | | | | |
| **Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy** | | | | | | |
| **Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services** | | | | | | |
| **Output 11: Improved protection from financial catastrophy and impoversihment** | 83. % of LGAs implementing state specific safety nets | SSHDP review report | TBD | 10 -25% | 25 - 50% | 50 - 75% |

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| **as a result of using health services in the State** | | | | | | |
| | 84. Decreased proportion of informal payments within the public health care system within each LGA | MICS | 83% | 75% | 50% | 25% |
| | 85. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34) | State and LGA Budgets | 0 | 25 - 40% | 40 - 60% | 60 80% |
| | 86. LGAs allocating health funding increased by average of 5% every year | State and LGA Budgets | 5% | 25% | 40% | 60% |
| **Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels** | 87. LGAs health budgets fully alligned to support state health goals and policies | State and LGA Budgets | 30% | 45% | 60% | 100% |
| | 88.Out-of pocket expenditure as a % of total health expenditure | National Health Accounts 2003 - 2005 | 70% | 60% | 50% | 40% |
| | 89. % of LGA budget allocated to the health sector. | National Health Accounts 2003 - 2005 | 2% | 10% | 20% | 30% |
| | 90. Proportion of LGAs having transparent budgeting and finacial management systems | SSHDP review report | TBD | 25% | 40% | 60% |
| | 91. % of LGAs having operational supportive supervision and monitoring systems | SSHDP review report | 10% | 25% | 60% | 80% |
| **PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM** | | | | | | |
| **Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation** | | | | | | |
| **Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels** | | | | | | |
| **Output 13: Improved Health Data Collection, Analysis, Dissemination, Monitoring and Evaluation** | 92. % of LGAs making routine NHMIS returns to states | NHMIS Report January to June 2008; March 2009 | 95% | 100% | 100% | 100% |
| | 93. % of LGAs receiving feedback on NHMIS from SMOH | | 0 | 25% | 50% | 100% |
| | 94. % of health facility staff trained to use the NHMIS infrastructure | Training Reports | 50% | 70% | 90% | 100% |
| | 95. % of health facilities benefitting from HMIS supervisory visits from SMOH | NHMIS Report | 0 | 25% | 40% | 75% |

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| | 96.% of HMIS operators at the LGA level trained in analysis of data using the operational manual | Training Reports | 0 | 255% | 355% | 605% |
| | 97. % of LGA PHC Coordinator trained in data dissemination | Training Reports | 50% | 70% | 85% | 100% |
| | 98. % of LGAs publishing annual HMIS reports | HMIS Reports | TBD | 25% | 50% | 75% |
| | 99. % of LGA plans using the HMIS data | NHMIS Report | 25% | 40% | 75% | 100% |
| **PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP** | | | | | | |
| **Outcome 12. Strengthened community participation in health development** | | | | | | |
| **Outcome 13. Increased capacity for integrated multi-sectoral health promotion** | | | | | | |
| **Output 14: Strengthened Community Participation in Health Development** | 100. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended) | SSHDP review report | 5% | 25% | 50% | 75% |
| | 101. % of wards holding quarterly health committee meetings | HDC Reports | 5% | 25% | 50% | 75% |
| | 102. % HDCs whose members have had training in community mobilization | HDC Reports | 25% | 40% | 75% | 100% |
| | 103. % increase in community health actions | HDC Reports | 7% | 10% | 25% | 50% |
| | 104. % of health actions jointly implemented with HDCs and other related committees | HDC Reports | 7 | 25% | 40% | 60% |
| | 105. % of LGAs implementing an Integrated Health Communication Plan | HPC Reports | TBD | 25% | 40% | 60% |
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| **PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH** | | | | | | |
| **Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP** | | | | | | |
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| **Output 15: Improved Health Sector Partners' Collaboration and Coordination** | 106. Increased number of new PPP initiatives per year per LGA | SSHDP Report | 5% | 25% | 40% | 60% |
| | 107. % LGAs holding annual multi-sectoral development partner meetings | SSHDP Report | 50% | 80% | 95% | 100% |
| **PRIORITY AREA 8: RESEARCH FOR HEALTH** | | | | | | |
| **Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.** | | | | | | |
| **Output 16: Strengthened stewardship role of government for research and knowledge management systems** | 108. % of LGAs partnering with researchers | Research Reports | TBD | 10% | 25% | 50% |

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| | 109. % of State health budget spent on health research and evaluation | State budget | 0 | 1% | 1.50% | 2% |
| | 110. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices | LGA Annual SHDP Reports | TBD | 10% | 25% | 50% |
| | 111. % of LGAs participating in state research ethics review board for researches in their locations | LGA Annual SHDP Reports | TBD | 40% | 75% | 100% |
| | 112. % of health research in LGAs available in the state health research depository | State Health Reseach Depository | 2% | 15% | 35% | 60% |
| **Output 17: Health research communication strategies developed and implemented** | 113. % LGAs aware of state health research communication strategy | Health Research Communication Strategy | TBD | 40% | 75% | 100% |