KANO STATE GOVERNMENT OF NIGERIA

STATE STRATEGIC HEALTH DEVELOPMENT PLAN

(2010 – 2015)

March 2010

Government of Kano State
Ministry of Health, Kano State
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List of Acronyms and Abbreviations

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

NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Ethics Committee
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPf	National Strategic Health Development Plan Framework
NSTDA	National Science and Technology Development Agency
NYSC	National Youth Service Corps
OAU	Organisation of African Unity
ODA	Oversea Development Assistance
OPS	Organised Private Sector
PATHS	Partnership for Transforming Health Systems
PEPFAR	President's Emergency Plan for AIDS Relief
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
QA	Quality Assurance
RDBs	Research data banks
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group
UN-System	United Nations-System
VAT	Value Added Tax
VHW	Village health workers
VOC	Vote-of-charge
WHO	World Health Organization

Acknowledgement

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

Vision

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

Mission Statement

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

The overarching goal of the KNSHDP is *to significantly improve the health status of all residents of Kano State through the development of a strengthened and sustainable health care delivery system.*

Executive Summary

Kano State formally came into being on April 1, 1968. It is situated in a semi-arid region located between latitudes 10.30oN to 13oN and longitude 7.40oE and 10.39oE. Kano city is at 472.45 metres above sea level. The state is bordered by Jigawa State in the north-east, Katsina State in the north-west and Kaduna State is on the southern boundary. It has a total land area of 20,760 square kilometres with 1, 754, 200 hectares agricultural and 75,000 hectares forest vegetation and grazing land. The state is noted for its fairly stable climate with relatively minor changes in temperature and humidity.

The health policy in Kano State is strictly based on the Nigerian National Health Policy, put in place since 1986, which is based on the concept and practice of Primary Health Care (PHC). The Primary Health Care system in Nigeria is operated by the Department of Public Health of the Ministry of Health. According to the National Health Policy, the State Government is responsible for secondary health facilities, while the LGAs are responsible for pimary health care facilities. The two are linked through the 2-way referral system.

Health services in the State are more concentrated in the urban areas as opposed to the rural areas where most of the health problems exist. Eighty nine percent (89%) of all doctors and 73% of nurses in the employment of State Government are located in the metropolis[11]. In 2006, there were 970 Primary Health Care facilities in the State, 704 of which were providing routine Immunization services, with a varying schedule and frequency per week.

The state has somewhere between one secondary health facility to 120,000 and 200,000 population per hospital facility[1], putting it in the middle of the league. For primary care however, Kano actually comes at the bottom of the national league table. Out of a national range of states where primary health care coverage offers one facility to just over 2,000 persons up to others where coverage offers only one facility to around 13,500 persons, Kano comes in the bottom category with only one facility for somewhere between 9,000 and 13,500 persons. The SMOH four-year plan of 2007 states as an objective the construction of one primary health centre in each political ward in collaboration with LGAs by 2011.

This plan discusses eight evidenced-based priority areas identified to improve the performance of the health sector in Kano State, through a holistic approach at the state and LGA levels. They are: leadership and governance, service delivery, human resources for health, health financing, health information system, community participation and ownership, partnerships for health and research for health.

For each of these priority areas, the plan specifies a goal with strategic objectives and corresponding interventions; and the required activities that is expected to contribute to the attainment of the stated objectives and goals of the plan. However, the Essential Package of Health Services for Kano State by service delivery mode which is defined in the plan as well, reflects the priority high impact interventions to be delivered in the state.

[1] Nation-wide the range is from around 6,000 people per hospital (in the South where there are many private facilities) to 4.9 million per hospital (in Katsina)

Adequate human resources is a major challenge of the Kano State health care service delivery system. For example, in Kano State there were only 1.78 doctors per 100,000 in the government services at primary and secondary levels compared to 28 doctors for every 100,000 population (itself a low figure) nationally.

A special committee which will be made up of all the stakeholders, including development partners will be set up to guide the implementation of the SSHDP throughout the 6 year period. The committee shall be led by the SMoH and implementation will be phased as Phase 1:2010-2011; Phase 2:2012-2013 and Phase 3:2014-2015. Operational plans will be developed annually and a 2 year financing rolling plan will be produced to support the implementation process. Regular meetings will be held to review progress based on the M&E reports and appropriate measures will be taken to keep implementation in focus.

An M&E framework is being developed for tracking progress during implementation. The M&E System will be used to identify gaps, operational problems and recommend appropriate measures through regular reports. Supportive supervision will be strengthened and institutionalized, while the HMIS will be organized to provide credible and reliable source of data.

Data will be disaggregated by geography, gender, age and income level for targeting those in greatest need; (vi) Each level of service within the LGA health system should have a role and responsibility in monitoring and evaluation of their plans; (vii) LGAHMT should take the overall responsibility to guide and provide support to lower levels to undertake their monitoring and evaluation activities; and (viii) the health facility staff and/or community health workers should provide support to communities in monitoring activities undertaken at community level.

Chapter 1: Background

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

The Federal Government of Nigeria recognizes that, in order to achieve the country health targets, inclusive of the health-related MDGs, particularly for its poorest and most vulnerable population, the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a ***National Strategic Health Development Plan (NSHDP),*** *with appropriate costing.* The NSHDP would result from the harmonization of Federal, States' and local governments' health plans, thereafter serving as the basis for national ownership, resource mobilisation/allocation and mutual accountability by all stakeholders – government, development partners, civil society, private sector, communities, etc. The framework is based on the principles of the Four Ones: one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. It also provides the template to concretize the health sector development component of the 7-point Agenda, Vision 2020 and a platform for achieving the MDGs.

This document describes the goals, strategic objectives, interventions and the activities captured in the five year plans (2011-2015) for the seventeen (44) local government areas and the State Ministry of Health in Kano State. Together, these culminate into what one will consider as the "Kano State Strategic Health Development Plan (KNSHDP)".

Chapter 2: Situation Analysis

2.1 Background

Historical Background and Geography

Kano State formally came into being on April 1, 1968. It is situated in a semi-arid region located between latitudes 10.30oN to 13oN and longitude 7.40oE and 10.39oE. Kano city is at 472.45 metres above sea level. The state is bordered by Jigawa State in the north-east, Katsina State in the north-west and Kaduna State is on the southern boundary. It has a total land area of 20,760 square kilometres with 1, 754, 200 hectares agricultural and 75,000 hectares forest vegetation and grazing land. The state is noted for its fairly stable climate with relatively minor changes in temperature and humidity[6].

The year is divided into rainy and dry seasons. The dry season lasts from October to May. During the months of December and January the harmattan is at its peak, and the temperature can fall as low as 10oC, but between March-May the mean temperature can go up to 300C - 330C. The rainfall pattern is uni-modal; with an average rainfall of 600mm[7].

Population

Kano State has a 2008 projected population of 10,013,224 (based on the 2006 National Population Census), with an almost equal distribution of male (51%) and female (49%). Urban drift from rural areas within Kano, other states in Nigeria as well as North and West Africa, has provided a steady stream of migrants adding to Kano's growing population. It is therefore a cosmopolitan melting pot of people.

Poverty in the North-West zone, where Kano State is located, is comparatively higher than in the Southern part of the country. Generally, the North West zone has the highest poverty rate of 77% followed by a rate of 70% in North East. These rates are all higher than the rates in the Southern parts of the country. The North also has the worst educational indicators, with literacy levels, school enrolment and retention rates decreasing the further one moves to the northern border of the country. The female literacy rate in the South East is almost three time higher than the rates of 21% in the North East zone and 22% in the North West zone while the male literacy rate of 74% in both the South East and South West zones is 1.7 times the rates in the Northern zones. Illiterate and without economic power, women are excluded from decision making in critical areas of health and education of the household[8].

Language

Although Hausa is the predominant language spoken by both indigenes and non-indigenes in Kano in all forms of businesses and social interactions, English is the official language in government, and to some extent, in business transactions. Other languages spoken in the state are Fulfulde, Yoruba, Ibo, Kanuri, Igbira, mostly by other non-indigene settlers.

Religion

The Religion practised by most people in the State is Islam, but there is a significant population of Christians in the State; most of them are people from other states.

Education

The average literacy rate is 35%, with the male rate put at 37.2% against that of females (32.8%). Life expectancy is 51 years for males and 52.2 years for females. An estimated 76.6% of male children have access to education compared to 31.7% for female. Up to 37.6% have access to portable water supply (that is pipe-bone water) while 75% have access to health services. In Kano State the average school enrolment rate for males is 90% for primary education, 80% for secondary school education and 60% for tertiary education. Female enrolment stands at 40%, 35%, and 20% for primary, secondary and tertiary institutions respectively. This shows a gap of approximately 44.9% between male and female enrolment, which could have significant consequences for women education, equality and access to economic and social facilities in the State and the country in general[6].

Economy

Agriculture is the mainstay of the economy involving at least 75% of the rural population. Important crops produced in the State include cotton, guinea-corn, maize, cowpeas and varieties of vegetables. There are occurrences of solid minerals in the crystalline basement complex routes in the southern parts of the State. These include tin, gold stones, lead, zinc, copper, woalfam and bauxite[2].

There are well over 300 large and medium industrial establishments in Kano spread across Bompai, Sharada and Challawa Industrial Estates. During the past three decades (1960s to 1990), modern manufacturing enterprises involving the processing of basic raw materials such as groundnut milling and other demand based industries like tanning, metal work, confectionery, textile goods and garment-making have been established.

In addition to the formal industrial sector, there are a number of small-scale industrial and commercial activities that make up the Kano Economy.

The Health policy

The health policy in Kano State is strictly based on the Nigerian National Health Policy, put in place since 1986, which is based on the concept and practice of Primary Health Care (PHC). The Primary Health Care system in Nigeria is operated by the Department of Public Health of the Ministry of Health. According to the National Health Policy, the State Government is responsible for secondary health facilities, while the LGAs are responsible for pimary health care facilities. The two are linked through the 2-way referral system[10].

2

2.2 Health Status of the Population

The disease pattern is similar to that of the country with infectious and parasitic disease dominating and is responsible for most of the morbidity and mortality in the State. Non-communicable diseases such as Diabetes Mellitus and Hypertension are increasingly becoming important. Malaria, diarrhoeal diseases, measles and other vaccine preventable diseases, acute respiratory diseases and malnutrition remain leading causes of morbidity and mortality in children in the State. The indicators in table provides a glimpse of the health status of the people of Kano State. The high maternal and child mortality rates reported for the state could easily be attributed to the fact that only 13% of deliveries in Kano were attended to by a skilled birth attendant, only 11% of deliveries in the state take place in a health care facility, only 6% of catchment populations receive required vaccination and more than half of children having not received their immunizations (zero dose). These are interventions that need to be drastically scaled up in the implementation of this plan.

Table 1: Summary of health status indicators for Kano State

INDICATORS	KANO
Total population	9,401,288 (4,947,952 females; 4,453,336 males)
Under 5 years (20% of Total Pop)	1,818,598
Adolescents (10 – 24 years)	2,904,158
Women of child bearing age (15-49 years)	2,077,207
Literacy rate	31% female; 72% men
Households with improved source of drinking water	54%
Households with improved sanitary facilities (not shared)	63%
Households with electricity	50%
Employment status (currently)	47.3% female, 85.3% male
TFR	8.1
Use of FP modern method by married women 15-49	2%
ANC	50%
Skilled attendants at birth	13%
Delivery in HF	11%
Full immunization coverage	6%
Children that have not received any immunization (zero dose)	54%
Stunting in Under 5 children	46%
Wasting in Under 5 children	17%
Diarrhea in children	17.20%
ITN ownership	7%
ITN utilization	3% children, 4% pregnant women
Malaria treatment (any anti-malarial drug)	9% children, 7% pregnant women
Comprehensive knowledge of HIV	22% female, 58% men
Knowledge of TB	69.5% female, 92.2% male

2.3 Health services

Health services in the State are more concentrated in the urban areas as opposed to the rural areas where most of the health problems exist. Eighty nine percent (89%) of all doctors and 73% of nurses in the employment of State Government are located in the metropolis. The state has 1030 public owned primary health care facilities ranging from health posts to primary health care centres. Of these 58% are health posts which provide mostly preventive services with little or no clinical care. This has implications for policy on access to clinical care as the absolute numbers of primary health care facilities may mislead one to think its access to primary health care centres, which provide a good complement of preventive and curative health care services. See annex 1 for details. This number however does not include private health care facilities of which it is estimated that there are 161 of them across the state and the information does not disaggregate them according to the level of care they provide (see annex 2). This may however be an underestimation.

2.4 Key Issues and Challenges

Like in many other states of the Federation, poverty is high in Kano State with 61% of the population living below the poverty line. Life expectancy is 51 years for males and 52.2 years for women. Only 37.6% of the population had access to running water (KSEEDS 2005). Kano has a high dependency ratio compared to other parts of Nigeria; for every individual of economically active age (15-64) there is another household member who is under 15 or over 65 years old, giving a ratio of 1.0 (whereas the figure for Nigeria as a whole is 0.8). With these statistics it is perhaps not surprising that the nutritional picture is bleak. From the NDHS 2003, we learn that the North West Zone has the worst nutritional statistics in Nigeria, with 55% of all under-fives stunted and 42.9% underweight – very much the worst figures in the whole country.

Both health and health status are known to be normally correlated with educational level of individuals in society and educational level of mothers. The scene in Kano does not bode well for health. Kano State has a literacy rate of 35% and the average overall rates for school enrolment stand at 90% for primary education, 80% for secondary education and 60% for tertiary education. Enrolment for females however stands at 40%, 35% and 20% respectively.

It is therefore perhaps unsurprising that health indicators are poor. Infant mortality is around 110 per 1000 live births (KSEEDS 2005). For the North-West Zone as a whole, infant mortality is 114 of which 55 deaths per 1000 are neonatal deaths. Maternal mortality is stated (KSEEDS 2005) as 1700 deaths per 100,000 births. Some authors however put this even higher; a 2003 estimate was 2,420 deaths per 100,000 live births[3]. On top of this, as many as 17,000 per 100,000 are left after childbirth with serious disabilities such as fistula, uterine prolapse, damage to bladder or urethra, pelvic or urinary tract infections, anaemia and infertility.

[1]Adamu Y.M. *et al* , 'Maternal Mortality in Northern Nigeria: a Population-based Study' European Journal of Obstetrics & Gynaecology, Volume 109, no. 2, 15 August 2003

Much of the post-neonatal child mortality is due to communicable diseases, with malaria being a particularly big killer, followed closely by acute respiratory infections. HIV/ AIDS is lower than in other African countries but with a national prevalence of 4.4%, is a significant factor that must reduce life expectancy. Nigeria as a whole has the fourth highest number of TB cases in the world, with an estimated national prevalence of 546 per 100,000 people.

At the same time, non-communicable diseases and injuries represent an increasing burden. Chronic illness such as hypertension and diabetes are examples of conditions that are almost certainly neglected in terms of the care available, and this requires attention. In terms of injuries, Nigeria ranked second on the weighted scale of countries with very high road traffic accident rates (WHO Nigeria publication, 2004).

In order to assess the state of the health services and what might be done, there would seem to be no better place to start than with the SWOT analysis.

Strengths

1. ***Improved infrastructure and equipment in secondary facilities***

Improvements may have been possible in this area, but it is hard to regard the present situation and be complacent. There is poor maintenance culture in the health service, and sadly even if there were, the non-salary component of recurrent funding is so low as to make advisable maintenance schedules a non-starter. The SMOH sees this as a priority to be tackled prior to any increase in secondary level coverage.

2. ***Effective and sound policies to address identified shortcomings in the health sector.***

A strategic plan is written within a given policy framework, and this is not therefore the place to assess SMOH policies. However it can be said that KSEEDS and this plan are written within the same framework of national health policy. The issue is more around whether the arrangements for putting policy into practice are appropriate and affordable.

Weaknesses

3. ***Poor dissemination of organisational objectives and goals to various levels of the Ministry.***

Many aspects of the organisational goals of the SMOH are presently in flux, so it is hard to assess the extent to which dissemination is effective. It is the case however that a review of communication channels will be necessary if, as proposed in this plan, a stewardship approach mirroring that of the Federal MOH is to be developed. It is clear that at the present time, there is a communications gap between the primary and secondary levels of care, and it is crucial that this be changed.

Furthermore, this plan proposes a strategy that hinges largely on organisational changes so in the management of change that must be an integral part of implementation, dissemination of the nature of changes and the encouragement of open discussion of the implications of change, must be nurtured as a priority.

4. ***Weak primary health care system at grassroots level coupled with lack of effective linkage to secondary level.***

We have already seen that the primary care system is indeed weak in terms of coverage. The PPRHAA for 2007 as the earlier exercise in 2005, raised many issues of inadequacy of services, equipment and staffing. Services do not cover the range of essential services even for priority health conditions, and are often open for limited hours daily. These issues are considered further here under Section II Output 2, but of course every part of the plan is an essential plank in changing the current situation. Health sector reform must go hand in hand with improving quality care, ensuring good management, optimising use of resources and so on.

The lack of effective linkage to secondary level is so well-known that evidence is hardly needed. The PPRHAA for 2007 says that "Even though, most of the facilities visited do refer cases to nearby general hospitals, they do not get any feedback after referrals. In addition, Transport arrangements for such referrals are done by patients and their relatives. In a nutshell, protocols for referrals are not in place and referrals are not documented".

5. Inadequate remuneration and drive of personnel

The issue of inadequate remuneration is one that the SMOH alone cannot tackle; the best it can do is work through advocacy to make the case for increased remuneration.

6. Poor orientation of professional and other service providers to meet the needs of patients.

This kind of criticism should not be made lightly when the targets of such criticism are trained health workers who receive inadequate remuneration and still, because they are so few, have to soldier an enormous burden of work. While these problems of course must be addressed directly, motivation and attitudes of health workers can be improved by improvements in communication within the service about what is expected of them, and better team working. This plan will look at the organisational context within which this will be possible.

7. Inadequate resource allocation to the health sector, especially for preventive and promotional purposes

The health sector continues to receive a wholly inadequate allocation as compared to what is needed to offer even a basic minimum standard of health care as defined and agreed in international guidelines.

Internationally it is increasingly recognised that good health is an input to development, as well as the result of development. The 2001 Report of the Commission on Macroeconomics and Health, and a host of publications to be found on the Macroeconomics and Health page of the WHO website, support this view and provide extensive information to make the case.

In Kano this point requires recognition. In KSEEDS, health projects were only allocated 3.06 million Naira while general administration got 3.73 millions and education received 20.53 millions. While no one would contest the importance of education to development, this figure for health speaks of an approach that ignores the importance of health: health in the workforce means higher productivity. Healthy children means that schools are enabled to do their job effectively with children fit to learn, and so on.

Opportunities and Threats

In general, the opportunities identified in KSEEDS remain the same, and this strategic health development plan seeks to capitalise upon them. Thus in one of the priority areas it is acknowledged that community participation and support is a major element of any successful health strategy; this is not only about attracting the contribution of the community to the efforts of the health service, but also about involving communities actively in determining the kind of health service they most need and want, and in actively working to improve their own and their family's health.

New initiatives indeed abound and what this plan does is to provide a strategic context in which their application will make the greatest sense.

The open system for donor support is indeed a reality in Kano, and is considered in this plan to provide the basis for the development over time of a Sector Wide Approach to health (SWAp).

As for the threats, it is hoped that this plan will itself reduce the likelihood of future inconsistencies in programmes and create an atmosphere in which existing policy can be best applied over an extended time period in order to maximise gains.

Increased prevalence of diseases is always a threat, but one upon which the State is actively facing with, for example, its HIV/AIDs strategy. The previous analysis singled out communicable disease. Adequate and detailed epidemiological information is not available, but it is a possibility that the greater threat, requiring greater vigilance, is chronic and non – infectious disease conditions. It is certainly considered among those knowledgeable in the health sector in the State that prevalence of conditions such as hypertension and diabetes are much higher than is recognised and that many go untreated, and this is considered in this plan.

The threat of poor water supply can from the health sector point of view, only be acknowledged. While poor water supply directly affects both health and provision of health care services, it is important to recognise that poor electricity supply is a continual and daily threat to provision of health care in Kano

State, as well as a huge drain on the health care budget since the only alternative is purchase of generator fuel and maintenance of the generators.

Fake and substance drug circulation is indeed a problem. This plan considers the need to improve regulation of pharmacies and patent medicine shops, and also how to encourage retail pharmacy, as there is a lack of registered pharmacies generally in Northern Nigeria, and even few registered Patent Medicine Vendors.

The possibility of significant in-migration may be a threat – but these are really issues beyond the boundaries of the competence and functions of the health sector.

What might be different in a 2009 SWOT analysis?

It would be wrong to leave this discussion without asking about the extent to which the intervening time period since the introduction of the analysis set out above, has changed or might be added to.

In terms of the strengths, it is pertinent to recognise that a major strength for the SMOH is the enthusiasm with which this strategic plan has been developed and the clear commitment there is to its implementation. A significant group of stakeholders have worked together to develop the way forward and they will stay together to ensure that this plan does not, like so many, remain a piece of paper.

Related to this is the recognition within the Ministry that there is considerable scope for increased interaction and cooperation between all health providers and others who are players in the health arena, and this recognition of a hitherto undervalued strength is translated here into strategy.

In terms of weaknesses, there is one weakness that is not actually new but did not receive attention in KSEEDS; that is the observation that it is the most disadvantaged in society who seek – and get – the least share of health care. It is proposed that this must be a priority consideration in health care strategy for Kano State.

A further weakness that is alluded to in point 5 above but demands a more radical analysis than was given in the original SWOT analysis is the separation of the health care system into three levels with organisational divides between them. Of course the fact that primary, secondary and tertiary care is set apart from each other is not new and is well recognised throughout Nigeria as a problem. There are however in various states, current attempts to get around or at least reduce this problem. In Kano, the Primary Health Care Agency Law exists in draft form, and is considered here as an important initiative that will hopefully turn a weakness into – at least – an opportunity. It is hoped that the necessary legislative machinery will turn quickly to bring this legislation onto the statute books.

It is hoped that all who are aware of this plan will assist the health sector in increasing opportunities and eliminating threats, in the pursuit of a healthy society for sustainable development in Kano State.

Overall Strategy for Kano State

The situation analysis reveals a picture in which, while grounds for hope can be discerned, there are nevertheless huge challenges ahead. In this section we attempt to summarise what the greatest of these are and how the strategic plan must work in coordinating activities across the outputs in order to ensure that appropriate sequencing of the work is achieved. Let us first summarise the features that have been identified as the greatest priorities to deal with.

1) There are pressing needs for improving the way that the health system works and the ways in which relationships work between the different parts of the system. All are agreed that a number of reform strategies are of importance here.

2) Improvements to the health care services can only be taken so far on the current health budget, but the state government is requested to give consideration to the arguments produced in this plan demonstrating the severe underfunding of the sector.

3) The consequence of underfunding that is most visible on a daily basis is the lack of recurrent funding for budget lines other than staff salaries, which means that there is negligible funding available for maintenance and repairs, equipment and so on; this makes it almost impossible to run a quality health service and must contribute to reduction in motivation on the part of staff.

4) A less obvious but equally important consequence of underfunding is that the various services that Kano State has declared will be free including MCH services, emergency care and others, often in practice cannot be offered freely and patients end up with a significant bill e.g. for drugs.

5) If there is a single problem that should be singled out as the priority for improving the Kano State health service, it is that of availability of human resources. There is severe under-staffing across the state. This problem is seen as difficult to resolve because of the time it takes to produce extra human resources – as well as the time and investment required in terms of extra buildings and extra training of trainers. The problem has to be addressed in terms of both production and retention of human resources.

6) Of all the health problems suffered by Kano citizens, the most dramatic in terms of mortality and dramatic suffering in families is that of maternal mortality. This was up fronted in KSEEDS and is reiterated here. 2.4% of all mothers are dying. The diagram on the following page shows some of the effects on society when mothers die. KSEEDS did not mention neonatal deaths but for the NW Zone overall, 5.5% of babies die at birth. This is a shocking figure and much of those deaths can be prevented by a safe motherhood policy focusing on safe deliveries. A dramatic upturn in the survival chances for mothers and infants is possible if strategies tried and tested elsewhere can be supported here.

7) Although the data could be improved upon, it is possible to deduce that even out of the available health care in Kano State, a disproportionate amount is being enjoyed by the wealthier in society and the poorest are sadly still getting the smallest share.

Chapter 3: Strategic Health Priorities

This plan discusses eight evidenced-based priority areas identified to improve the performance of the health sector in Kano State, through a holistic approach at the state and LGA levels. They are: leadership and governance, service delivery, human resources for health, health financing, health information system, community participation and ownership, partnerships for health and research for health.

For each of these priority areas, the plan specifies a goal with strategic objectives and corresponding interventions; and the required activities that is expected to contribute to the attainment of the stated objectives and goals as detailed in Appendix. However, the Essential Package of Health Services for Kano State by service delivery mode as listed reflects the priority high impact interventions to be delivered in the state.

Proposed High Impact Services by Levels of Service Delivery

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

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

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

Chapter 4: Resource Requirements

4.1 Human Resources

Adequate human resources has been described as the major challenge of the Kano State health care service delivery system. Whereas in the country as a whole in 2006 there were 28 doctors for every 100,000 population (itself a low figure), in the government services at primary and secondary levels in Kano State there were only 1.78 doctors per 100,000. Nationally there were 170 nurses per 100,000 population, but the number in government services at primary and secondary levels in Kano State works out at only 10.2 per 100,000.

Of course this ignores the doctors and nurses at the tertiary level in the State, but nevertheless this is a shocking picture. If we take the total of all health workers at primary and secondary levels, there are only 80 health workers per 100,000 population in Kano State, and that figure of course includes watchmen, lab staff and so on who do not directly treat patients.

The Ward Minimum Health Package for Nigeria (2006) proposed for a primary care facility at the level of each ward, a staff team of 14 health workers directly providing care headed by a community health worker and including three nurse/midwives and where possible a doctor; this is for a population of 10,000 – 30,000. Kano State will not approach such statistics in many years.

This issue has not been adequately addressed at any level, and it is regrettable that the KSEEDS health projects also did not address human resource constraints at all. There are SMOH plans for a new midwifery school and two extra schools of health technology, but these will only begin to release extra graduates into the system a few years hence. While there are modest plans for human resource development however, the issues around retention of existing staff have barely been addressed. These issues are taken up in Output 5 of this plan.

Table 2: Distribution of health care professional in Kano State

S/N	ZONE	Doctor	Lab Scient/ Tech	Lab Tech/ Assist	Xtray	CHEWs	Pharm	Pharm Tech/ Assist	Nurse/ Midwife	Clinical Assist
1	HMB Hqtr	5	43	-	-	14	5	-	29	-
2	Zone l	18	6	10	7	78	4	23	104	32
3	Zone ll	7	2	10	4	60	2	23	74	26
4	Zone lll	5	3	3	2	16	2	9	74	11
5	Zone lV	6	4	10	5	37	1	18	67	6
6	Zone V	8	2	9	4	45	3	25	67	9
7	Zone Vl	92	31	29	23	127	6	30	427	50
8	Zone Vll	27	14	10	7	18	3	13	159	9
9	Zone Vlll	9	7	6	6	43	1	15	72	8
10	Zone lX	8	6	11	8	82	3	21	106	14
11	Zone X	4	2	8	2	55	1	12	61	6
12	Zone Xl	17	8	10	6	100	2	24	147	52
13	Zone Xll	3	1	9	2	34	1	10	45	19
14	Zone Xlll	3	1	3	1	22	3	12	30	6
15	Zone XlV	7	4	1	3	-	1	4	28	-
TOTAL		219	134	129	80	731	38	239	1,490	240

Based on the WHO recommendation (1994) of 1 doctor to 2060 people, 1 nurse to 980 people, 1 midwife to 600 people and 1 pharmacist to 10,000 people, the disparity between what is required and what is available is shown below:

Table 3: Gap in availability of some health care professionals in Kano State

CADRE OF HEALTH WORKER	NO REQUIRED	NO AVAILABLE	GAP (SHORTFALL)
DOCTOR	4369	219	4150
NURSE	9183	1490	7693
PHARMACIST	900	38	862

It is anticipated that with proper planning and adequate financial commitment, these gaps can be systematically met over a 5-year period.

4.2 Physical & Material Resources

A comprehensive assessment of the status of facilities and equipment and supplies of medical consumables in these facilities in the State is not currently available. Available information from 2006 shows that the state had 1,165 health facilities distributed as shown in the following table

Table 4: Distribution of health facilities by level and ownership in kano state		
Level of health institution	Ownership	Number
Tertiary institution	Public	2
Secondary institution	Public	36
	Private	61
Primary health care institution	Public	970
	Private	96
Total		1,165

There were 970 public and 96 private primary health care facilities in the State, 704 (mostly public) of which were providing routine Immunization services, with a varying schedule and frequency per week.

The existing information for the North West Zone (from the FMOH and World Bank) suggests that the NW has the highest population per secondary facility in Nigeria - in other words is the most poorly served. However the available information for the State puts Kano somewhere in the middle of the league table for Nigeria i.e. somewhere between 120,000 and 200,000 population per hospital facility[4]. It is possible to surmise that the concentration of secondary facilities is skewed heavily in favour of the urban areas and that there are significant parts of the State where secondary care is almost non-existent, but further study will be recommended.

[4] Nation-wide the range is from around 6,000 people per hospital (in the South where there are many private facilities) to 4.9 million per hospital (in Katsina)

For primary care however, Kano actually comes at the bottom of the national league table. Out of a national range of states where primary health care coverage offers one facility to just over 2,000 persons up to others where coverage offers only one facility to around 13,500 persons, Kano comes in the bottom category with only one facility for somewhere between 9,000 and 13,500 persons. KSEEDS contained a proposal that there should be a health facility for any settlement with 500 people. The SMOH four-year plan of 2007 states as an objective the construction of one primary health centre in each political ward in collaboration with LGAs by 2011.

As noted, it is difficult to assess the appropriateness of distribution of facilities. However it is noteworthy that from such maps as have been made available, it is the case that the parts of the State that border with Katsina to the West and Jigawa to the East, have generally very few hospitals – most facilities in these areas are at best primary health centres. Yet Katsina and Jigawa are themselves badly served; Jigawa having primary care provision state-wide that is only marginally better than that for Kano, and Katsina having slightly better PHC provision but the worst secondary care level of provision in Nigeria. Since state borders are open, these considerations also need to be taken into account.

4.3 Financial Resources

Kano State has witnessed a steady increase in allocations to the health sector over the years. In absolute terms, the % of the state budget allocated to the health sector increased from 1.17 billion naira in 2006 to 8.93 billion in 2008. In relative terms, the % allocation increased from 5.5 in 2008, to 7.8 and 8 percentages in 2009 and 2010 respectively. With a population of 9,401,288, in year 2010, the per capita allocation to health is estimated at a mere $6.00. This is a far cry from the recommended $34 per capita by the WHO Commission on Macroeconomics for Health, which is the minimum required to provide individuals with a basic minimum package of healthcare services.

Table 5: Health budget allocation as a % of total state budget allocation in Kano State

YEAR	State Budget Allocation (N)	Allocation to Health Sector	% Allocated to Health Sector
2006	49,991,565,350:00	1,171,530,000:00	2.3
2007	54,344,037,075:00	3,391,704,500:00	6.2
2008	89,365,049,848:00	4,921,028,699:00	5.5
2009	114,891,171,965:00	8,933,176,223:00	7.8
2010	110,619,351,470:00	8,872,909,615:00	8

Table 6: Actual Heal Expenditure as a % of total State Budget

YEAR	State Budget Allocation (N)	Actual Health Expenditure (N)	%
2006	49,991,565,350:00	2,207,138,072:00	4.4
2007	54,344,037,075:00	3,738,813,513:00	6.9
2008	89,365,049,848:00	4,426,343,516:00	5
2009	114,891,171,965:00	4,432,045,327:00	4

Chapter 5: Financial Plan

5.1 Estimated cost of the strategic orientations

The total estimated financial requirement to implement the six –year strategic framework in Kano State is N216,764,597,521 for the period of 2010-2015. This amounts to a cost of N 36,127,432,920.19 annually, an annual per capita cost of N 3,842.82 equivalent to $USD 25.62. The breakdown of the costs according to priority areas are as follows:

Table 8: Cost of the strategic priority areas of the Kano SHDP

Priority Area	Estimated Cost (2010-2015)
Leadership and governance for health	2,167,645,975
Health service delivery	120,678,357,699
Human resources for health	56,546,322,977
Financing for health	25,450,218,007
National health information system	3,251,468,963
Community participation and ownership	2,167,645,975
Partnerships for health	2,167,645,975
Research for health	4,335,291,950
Total	216,764,597,521

5.2 Assessment of the available and projected funds

From table five, the available funding for the year 2010 is 8,872,909,615.00. If we assume this will be sustained, and if we add an annual inflation rate of 12.5% over the period of 2011-2015, the projected funding will be N72,920,164,202.60. However this may be underestimated as it does not include donor funding, LGA allocations to health and private sector contributions are not factored here.

5.3 Determination of the financing gap

The financing gap here is a rough estimate as there was no available data for LGA, donor and private sector contributions to the funding projections for the state. The gap from our analysis above is the difference between the estimated cost of the SHDP and the available/projected funding. This amounts to N216,764,597,521 minus N72,920,164,202.60 = N143,844,433,318.57

5.4 Descriptions of ways of closing the financing gap

In order to close the financing gap identified above, several strategies will be implemented. The state SHDP steering committee, which comprises government, development partners and CSOs will develop a concept note. The major strategies in this concept will include advocacy to government to progressively

increase its allocation to the health sector towards the Abuja target of 15%. Advocacy to donor agencies to increase their funding to the sector in a sustainable manner. The planned country IHP+ compact will help in this regard. Through a joint planning, it is possible to identify funding gaps, which development partners that are members of the steering committee will be able to see immediately, areas of need and make commitments. The ongoing IGR reforms in the state are expected to result in increased government revenue. This is expected to impact on our modest assumption that the funding in 2010 will be sustained. As such in practice, it is hoped that the government allocation will increase progressively.

Chapter 6: Implementation Framework

A special committee which will be made up of all the stakeholders, including development partners will be set up to guide the implementation of the SSHDP throughout the 6 year period. The committee shall be led by the SMoH and implementation will be phased as Phase 1:2010-2011; Phase 2:2012-2013 and Phase 3:2014-2015. Operational plans will be developed annually and a 2 year financing rolling plan will be produced to support the implementation process. Regular meetings will be held to review progress based on the M&E reports and appropriate measures will be taken to keep implementation in focus.

Chapter 7: Monitoring & Evaluation

7.1 Supervision, monitoring and evaluation

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

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Annex 1: Distribution of health care facilities in Kano State

S/N	LGA NAME	GH	SPECIALIST HOSP	CH	CHC	PHC	BHC	MCH	HC	DISP	HP	SCH. CLINIC	TOTAL
		Secondary Health Care Facilities			Primary Health Care Facilities								
1	Ajingi	0	0	0	0	2	0	0	3	5	19	0	29
2	Albasu	0	0	0	0	4	0	0	0	5	25	1	35
3	Bagwai	0	0	0	0	4	2	0	0	3	18	0	27
4	Bebeji	2	0	0	0	1	2	0	0	3	12	0	20
5	Bichi	1	0	0	0	3	0	0	2	1	43	0	50
6	Bunkure	0	0	0	0	1	1	0	0	3	17	0	22
7	D/Kudu	1	0	0	0	1	3	0	0	4	12	0	21
8	D/Tofa	1	1	1	0	4	1	0	2	8	25	2	45
9	Dala	3	0	0	0	0	0	3	6	0	4	0	16
10	Danbatta	1	0	1	0	0	0	0	2	2	27	3	36
11	Doguwa	1	0	0	0	1	0	0	1	8	9	0	20
12	Fagge	1	2	0	0	3	1	2	1	0	2	1	13
13	G/Mallam	0	0	0	0	2	2	0	2	0	12	0	18
14	Gabasawa	0	0	0	1	2	0	1	1	7	18	0	30
15	Garko	0	0	1	0	3	1	1	0	5	7	0	18
16	Gaya	1	0	0	0	2	0	0	4	0	15	0	22
17	Gezawa	1	0	0	0	1	0	0	2	7	8	0	19
18	Gwale	0	0	0	0	3	1	0	10	1	3	2	20
19	Gwarzo	1	0	0	0	2	1	0	0	6	13	0	23
20	Kabo	0	0	1	0	1	0	1	0	6	19	0	28
21	Karaye	0	0	0	1	2	0	0	0	4	13	1	21
22	Kibiya	0	0	0	0	1	4	0	0	0	16	0	21
23	Kiru	0	0	0	1	0	3	0	0	5	20	1	30
24	KMC	1	4	0	0	5	0	1	8	1	0	0	20
25	Kumbotso	0	0	0	1	1	3	0	3	3	15	0	26
26	Kunchi	0	0	0	0	3	2	0	0	2	25	0	32
27	Kura	1	0	0	0	1	0	0	10	2	4	0	18
28	Madobi	0	0	0	1	0	4	0	1	2	12	0	20
29	Makoda	0	0	0	0	3	0	0	1	2	17	1	24

S/N	LGA NAME	GH	SPECIALIST HOSP	CH	CHC	PHC	BHC	MCH	HC	DISP	HP	SCH. CLINIC	TOTAL
		Secondary Health Care Facilities			Primary Health Care Facilities								
30	Minjibir	1	0	0	0	0	4	0	0	6	13	0	24
31	Nasarawa	1	1	0	0	3	1	0	2	2	8	2	20
32	R/Gado	0	0	0	0	0	2	0	0	7	12	0	21
33	Rano	1	0	0	0	0	0	0	2	2	9	1	15
34	Rogo	1	0	1	0	2	5	0	2	5	8	0	24
35	Shanono	0	0	0	1	2	0	0	2	4	12	0	21
36	Sumaila	1	0	0	0	1	6	1	0	14	20	0	43
37	T/Wada	1	0	1	0	1	1	0	8	5	12	2	31
38	Takai	0	0	0	0	2	0	0	0	9	21	0	32
39	Tarauni	1	1	0	0	4	0	0	2	0	4	1	13
40	Tofa	0	0	0	1	1	1	0	0	8	7	0	18
41	Tsanyawa	0	0	0	1	1	6	0	0	0	19	0	27
42	Ungogo	1	1	0	0	0	0	0	8	4	13	0	27
43	Warawa	0	0	0	0	1	1	0	4	10	3	1	20
44	Wudil	1	0	0	0	3	0	0	9	0	6	0	19
	TOTAL	25	10	6	8	77	58	10	98	171	597	19	1079
		2%	1%	1%	1%	7%	5%	1%	9%	16%	55%	2%	100%

Annex 2: Distribution of private health care facilities in Kano State

S/N	LOCAL GOVT	NAME OF FACILITY	TYPE OF FACILITY	ADDRESS	FACILITY NO.	SECTOR
1	NASSARAWA	ABDUL – WAHAB CLINIC	PRIVATE	NO. 102 KAWAJI LAYOUT,	1	U
2	WUDIL	AL-HILAL NURSING HOME	PRIVATE	SABON GARI WUDIL	2	U
3	TARAUNI	ALMU MEMORIAL HOSPITAL	PRIVATE	NO. 1 MAIDUGURI ROAD	3	U
4	NASSARAWA	ALPHA CLINIC AND MATERNITY	PRIVATE	NO. 195 CLUB ROAD, KANO.	4	U
5	WUDIL	AMINA CLINIC	PRIVATE	SABON GARI WUDIL	5	U
6		ASSUMPTA CLINIC	PRIVATE	NO. 106 INIBI AVENUE, KANO.	6	U
7		BIRINI RAYA HOSPITAL	PRIVATE	NO. 1 DAMBATTA WAY	7	U
8		BAMAIYI SAI ALLAH CLINIC & MATERNITY	PRIVATE	NO.35 POLICE STATION ROAD,	8	U
9		CATHARINA HOSPITAL	PRIVATE	NO. 127 SARKIN YAKI ROAD,	9	
10	FAGGE	CONTINENTAL CLINIC	PRIVATE	PLOT. 285 AIRPORT ROAD	10	U
11		CROWN CLINIC	PRIVATE	NO. 381 NAIBAWA QUARTERS	11	U
12		EMOTAN CLINIC	PRIVATE	NO. 2 SANYA OLU/NEW ROAD KANO	12	U
13		FAHMY CLINIC	PRIVATE	NO. 26 DANTATA ROAD , KANO	13	U
14	TAKAI	GASKIYA HOSPITAL AND MATERNITY	PRIVATE	TAKAI TOWN, TAKAI L.G.A.	14	U
15		GODIYA CLINIC	PRIVATE	NO.176 NA'IBAWA QUARTERS	15	U
16	GWALE	HALAL HOSPITAL	PRIVATE	AMINU KANO WAY/GADON KAYA	16	U
17		GREAT SHEPHERDED CLINIC	PRIVATE	SHARADA PHASE 1	17	U
18		IDEAL HOSPITAL	PRIVATE	NO.74 ,EMIR ROAD	18	U
19		IJEOMA CLINIC	PRIVATE	NO.25 AWOLOLWO AVENUE	19	U
20		INTERNATIONAL HOSPITAL	PRIVATE	NO.2A AIRPORT ROAD	20	U
21	GWALE	IVORY CLINIC & MATERNITY	PRIVATE	NO.550 AMINU KANO WAY	21	U
22	UNGOGO	KHADIJAT MEMORIAL HOSPITAL	PRIVATE	PLOT 115 KATSINA ROAD, KANO	22	U
23	UNGOGO	KUNYA HOSPITAL & MATERNITY	PRIVATE	PLOT. 42 KURNA, KANO	23	U
24		KURA SURGERY AND MATERNITY	PRIVATE	NO. 25/26 DALILI QUARTERS	24	
25	FAGGE	LAFIYA SURGERY	PRIVATE	NO.52 AITKEN ROAD	25	U
26		LIFECARE CLNICS AND MATERNITY	PRIVATE	NA'IBWA QUARTERS,KANO.	26	U
27		DIVINE HOPE CLINIC & MATERNITY	PRIVATE	NO. 14 MAHOGANY AVENUE,	27	U
28		MADINA CLINIC & MATERNITY	PRIVATE	NO. 2 SHAGARI QUARTERS	28	U
29	GWALE	MIHIBAN CLINIC AND MATERNITY	PRIVATE	BUK ROAD	29	U
30	FAGGE	MODULAR CLINIC	PRIVATE	NO. 59 NEW ROAD	30	U
31		MOS-METRO HOSPITAL	PRIVATE	NO.6 TUDUN WADA ROAD	31	U
32	FAGGE	NAKOWA CLINIC	PRIVATE	NO. 4 AIRPORT ROAD	32	U
33	TARAUNI	NASARACLINIC	PRIVATE	TARAUNI NEW MARKET ROAD	33	U
34	UNGOGO	RAHAMANIYYA CLINIC AND MATERNITY	PRIVATE	NO.70 KATSINA ROAD KANO	34	U
35	NASSARAWA	SABO CLINIC	PRIVATE	NO. 68E BELLO ROAD	35	U
36		SAHIMA CLINIC AND MATERNITY	PRIVATE	G/ALBASA ROAD	36	U
37	FAGGE	SALAM HOSPITAL	PRIVATE	NO.20 B/HUGHES ROAD,	37	U

S/N	LOCAL GOVT	NAME OF FACILITY	TYPE OF FACILITY	ADDRESS	FACILITY NO.	SECTOR
				S/Gari		
38	NASSARAWA	SANBELL HOSP AND MAT.	PRIVATE	GAMA QUARTERS	38	U
39	GWALE	SAUDA CLINIC	PRIVATE	B8 KABUGA HOUSING ESTATE	39	U
40	NASSARAWA	SAUKI CLINIC	PRIVATE	HADEJIA ROAD, KANO	40	U
41	WUDIL	SAUKI CLINIC	PRIVATE	WUDIL, WUDIL L.G.A. KANO	41	U
42		SHARADA IND. CLINIC	PRIVATE	SHARADA PHASE I	42	U
43	NASSARAWA	SOOMIA HOSPITAL	PRIVATE	NO. 84, TAFAWA BALEWA ROAD	43	U
44	TARAUNI	SUREME CLINIC	PRIVATE	NO. 7B ZOO ROAD	44	U
45	TARAUNI	TAMMY CLINIC AND MATERNITY	PRIVATE	NO. 12, ZOO ROAD, KANO.	45	U
46	NASSARAWA	TIGA CLINIC AND MATERNITY	PRIVATE	NO. 24, BELLO DANDAGO ROAD	46	U
47	DANBATTA	TOPCARE HOSPITAL AND MATERNITY OPP. KAZAURE	PRIVATE	MOTOR PARK, DAMBATTA, KANO.	47	U
48	NASSARAWA	UNIVERSAL CLINIC AND MATERNITY	PRIVATE	NO.33 SARKIN YAKI, KANO	48	U
49	NASSARAWA	VICTORY CLINIC	PRIVATE	NO. 97 KAWAJI LAYOUT, KANO.	49	U
50	TARAUNI	VINTAGE CLINIC	PRIVATE	NO. 2 COURT ROAD, S/GARI	50	U
51	TARAUNI	WALIY HOSPITAL	PRIVATE	COURT ROAD, KANO.	51	U
52	NASSARAWA	WARSHU HOSPITAL	PRIVATE	NO. 1 KAWAJI/ DAKATA	52	U
53	NASSARAWA	ACCCORD SURGERY	PRIVATE	NO. 2 LAMIDO CRESCENT	53	U
54	FAGGE	AMINA SPECIALIST HOSPITAL	PRIVATE	AIRPORT ROAD	54	U
55	FAGGE	AMOOTA SPECIALIST DENTAL CLINIC	PRIVATE	NO. 14 NEW ROAD,	55	U
56		CLASSIC CLINIC	PRIVATE	NO. 1A ABBAS ROAD,	56	U
57	NASSARAWA	COPPER STONE HOSPITAL	PRIVATE	NO. 5 COURT HOUSE CLOSE, OFF MILLER ROAD BOMPAI	57	U
58	TARAUNI	MARHABA HEART & DIAB. CLINIC	PRIVATE	OFF ZOO ROAD	58	U
59	NASSARAWA	PARK HOUSE SPECIALIST CLINIC	PRIVATE	NO. 22A SULTAN ROAD	59	U
60	TARAUNI	PREMIER CLINICS	PRIVATE	NO. 8 FIRST LANE OFF NEW COURT ROAD, HAUSAWA	60	U
61	TARAUNI	SAYAMAY'S SPECIALIST HOSPITAL	PRIVATE	GANDUN ALBASA	61	U
62	TARAUNI	WONDIC SUGERY	PRIVATE	NO. 120 HARUNA SULEIMAN AVENUE, GANDUN ALBASA, KANO.	62	U
63	TARAUNI	CITY DENTAL CLINIC	PRIVATE	NO. 87 ZARIA ROAD KANO	63	U
64	NASSARAWA	CROWN DENTAL CLINIC	PRIVATE	NO. 46 IBRAHIM TAIWO ROAD, KANO.	64	U
65	NASSARAWA	CENTRAL BANK STAFF CLINIC	PRIVATE	CENTRAL BANK STAFF QUARTS HADEJIA ROAD, KANO.	65	U
66	KUMBOTSO	MARIO JOSE ENT. STAFF CLINIC	PRIVATE	PLOT 63, CHALLAWA INDUSTIAL ESTATE, KANO.	66	U
67		7UP COMPANY STAFF CLINIC	PRIVATE	7UP BOTTLING COMPANY	67	U
68	FAGGE	W.J. BUSH & CO. STAFF CLINIC	PRIVATE	NO.168/170 MISSION ROAD	68	U
69	KUMBOTSO	NIG. BOTTLING CO. STAFF CLINIC	PRIVATE	NBC PLANT, CHALLAWA, KANO	69	U
70	FAGGE	EL SHADDAI HOSPITAL	PRIVATE	NO. 8 MAHOGANY AVENUE, NOMANS-LAND, KANO.	70	U
71	TARAUNI	CITY EYE CENTER	PRIVATE	SABO BAKIN ZUWO ROAD, KANO	71	U
72	NASSARAWA	TAFA NURSING HOME	PRIVATE	KWANAR JABA, BRIGADE,	72	U

S/N	LOCAL GOVT	NAME OF FACILITY	TYPE OF FACILITY	ADDRESS	FACILITY NO.	SECTOR
				KANO		
73		TAIMAKO NURSING HOME	PRIVATE	TIGA DAM, TIGA TOWN, KANO.	73	U
74		YAWO SALAM NURSING HOME	PRIVATE	GADAR TAMBURAWA	74	U
75		SEMIRAT MATERNITY HOME	PRIVATE	AUDU UTAI WAY, TUDUN WADA BRIGADE, KANO.	75	U
76		ZAKIRAI MATERNITY HOME	PRIVATE	NO. 171 SARARI QUARTER	76	U
77	KURA	GODIYA NURSING HOME	PRIVATE	CHIROMAWA TOWN, KANO.	77	U
78		RAHAMA NUR & MAT. HOME	PRIVATE	CHIROMAWA TOWN, KANO.	78	U
79	NASSARAWA	MEDICUS CLINIC & DIAG. CENTE	PRIVATE	NO. 19 MAGAJIN RUMFA ROAD, KANO.	79	U
80		OEVENT CLINICAL DIAG. LAB	PRIVATE	NO. 2 SARKIN YAKIN ROAD	80	U
81	FAGGE	ANSAR ORTH. HOSP. & DIAG. CENTER	PRIVATE	OYO STREET, NOMANS LAND, KANO	81	U
82	BUNKURE	HASBUNALLAHU CLINIC & MAT.	PRIVATE	BUNKURE TOWN	82	U
83	GWALE	CITY MEDICAL CLINIC	PRIVATE	SABON TITI AFTER DANDAGO, KANO.	83	U
84	SUMAILA	UMAR MEMORIAL HOSPITAL	PRIVATE	SUMAILA TOWN, KANO.	84	U
85	NASSARAWA	YACHAM CLINIC & MATERNITY	PRIVATE	CHARITY LINE NEW BADAWA LAYOUT , KANO.	85	U
86	NASSARAWA	YASER DENTAL CLINIC	PRIVATE	NO. 1A TUKUR ROAD	86	U
87	FAGGE	BELONWU CHILDREN SPECIALIST CLINIC	PRIVATE	NO. A1 AIRPORT ROAD, KANO.	87	U
88	FAGGE	GRADE MATERNITY & NURSING HOME	PRIVATE	NO.60 CHURCH ROAD	88	U
89		GORDIAL HOSPITAL & MATERNITY	PRIVATE	NO. 377 SARKIN YAKI ROAD	89	U
90	NASSARAWA	TOPCARE MEDICAL CENTER	PRIVATE	118 HADEJIA ROAD, KANO.	90	U
91	UNGOGO	TRINITY HOSPITAL	PRIVATE	NO. 5 BUKAVU BARRACKS, KATSINA ROAD, KANO.	91	U
92	TARAUNI	CITY CONSULTANT CLINIC	PRIVATE	HOTORO/MAIDUGURI ROAD, KANO.	92	U
93		NEW COVENANT CLINIC/SURGERY	PRIVATE	BURMA ROAD, KANO.	93	U
94	TARAUNI	APEX CONSULTANTS HOSPITAL	PRIVATE	PLOT ZOO ROAD, KANO.	94	U
95	TARAUNI	AMEER CLINIC & MATERNITY	PRIVATE	ZOO ROAD/ SHAGARI QUARTERS, KANO.	95	U
96		BALM CLINICS	PRIVATE	AMINU KANO WAY, KANO.	96	U
97	TARAUNI	CRESENT CLINICS	PRIVATE	NO. 12 NEW COURT ROAD, GYADI- GYADI, KANO.	97	U
98	FAGGE	MARYLAND MATERNITY HOME	PRIVATE	GOLD COAST ROAD, SABON-GARI, KANO.	98	U
99	TARAUNI	ABBA CLINIC	PRIVATE	OFF ZOO ROAD, KANO.	99	U
100	TARAUNI	BAREWA CLINICS	PRIVATE	NO. 11 ZARIA ROAD, KANO.	100	U
101	TARAUNI	ACCESS CLINICS	PRIVATE	ZARIA ROAD, KANO.	101	U
102	TARAUNI	EL-MARIAM CLINIC	PRIVATE	NO. 121 HOTORO, OFF NNPC, KANO.	102	U
103		TAIMAKO CLINICS	PRIVATE	K/DANGORA-K/MAIYAKI,KANO.	103	U
104	TARAUNI	AREWA SURGERY	PRIVATE	HOTORO QUARTERS, KANO	104	U
105	WUDIL	GIDAN ALHAZAI HOSPITAL/ MAT	PRIVATE	WUDIL TOWN, WUDIL L.G.A KANO.	105	U
106	FAGGE	GOOD PASTURE CLINIC	PRIVATE	NO. 6 CITTA AVENUE,	106	U

S/N	LOCAL GOVT	NAME OF FACILITY	TYPE OF FACILITY	ADDRESS	FACILITY NO.	SECTOR
				NOMANS LANDS, KANO.		
107		MAI AKOKO CLINIC	PRIVATE	NO. 100 SHARADA MALAM, KANO.	107	U
108	DALA	MIYATTI CLINICS & MATERNITY	PRIVATE	NO. 103 AMINU KANO WAY	108	U
109		HEALTUNE CLINIC	PRIVATE	NO.10 ADAMU DANKURA STREET	109	U
110	NASSARAWA	SULTAN CLINIC	PRIVATE	NO. 104 HADEJIA ROAD, KANO.	110	U
111	FAGGE	UNICARE HOSPITAL	PRIVATE	NO. 8 OFF KATSINA ROAD, VIA PILGRIMS CAMP, KANO.	111	U
112	FAGGE	WHERELSE CLINIC & MATERNITY	PRIVATE	NO. 23 ABEOUKUTA ROAD	112	U
113	NASSARAWA	AL-AHSA CLINIC	PRIVATE	HOTORO QUARTERS, KANO.	113	U
114	UNGOGO	SALAMOTU NURSING HOME	PRIVATE	KURNA ASABE, KANO.	114	U
115	NASSARAWA	HALLMARK CLINIC	PRIVATE	HOTORO QUARTERS,KANO.	115	U
116	TARAUNI	AL-AMEEN MEDICAL CENTER	PRIVATE	HOTORO QUARTERS, KANO.	116	U
117	GWALE	SHUKURA CLINIC & MATERNITY	PRIVATE	SANI MAI NAGGE QUARTERS, KANO.	117	U
118	TARAUNI	FIRST OPT. EYE CLINIC	PRIVATE	ZOO ROAD, KANO.	118	U
119	FAGGE	OMEGA CLINIC	PRIVATE	SANYAOLU STREET	119	U
120	TARAUNI	GENOME CLINICAL DIAG. CENTER	PRIVATE	NO. 42 ZOO ROAD, KANO.	120	U
121	FAGGE	ST. JOHN'S MEMORIAL CLINIC	PRIVATE	NO. 50 YORUBA ROAD,	121	U
122		JEGA NURSING HOME	PRIVATE	SHAGARI QUARTERS, KANO.	122	U
123	D/KUDU	DAWAKI NURSING HOME	PRIVATE	DAWAKIN KUDU TOWN, KANO.	123	U
124		JOY CLINIC	PRIVATE	INUWA WADA AVENUE,	124	U
125	FAGGE	REMEDY QUEST NURSING HOME	PRIVATE	AITKEN ROAD, SABON – GARI, KANO.	125	U
126	GWALE	FATIMA HOSPITAL	PRIVATE	BUK ROAD,	126	U
127		SHAMAT CLINIC	PRIVATE	HADEJIA ROAD	127	U
128		HALIMA MEDICAL CENTER	PRIVATE	MARIRI HOTORO, KANO.	128	U
129	D/KUDU	LAFIYA NURSING & MATERNITY HOME	PRIVATE	MARIRI TOWN KANO.	129	U
130	NASSARAWA	ROYAL CLINICAL DIAGNOSTIC LABOURATORIES	PRIVATE	NO 475 SARKIN YAKI ROAD	130	U
131		ANGEL SPINNING & DYING STAFF CLINIC	PRIVATE	SHARADA PHASE III, KANO.	131	U
132	KUMBOTSO	HAVANA CLINIC	PRIVATE	NO. 17 YADADO ROAD, PANSHEKARA TOWN, KANO.	132	U
133	TARAUNI	MEDICARE SAI ALLAH NURSING HOME	PRIVATE	PLOT 120 GIDAN TSAMIYA, UNGUWA UKU, KANO.	133	U
134	UNGOGO	NAGARI CLASSIC HOSP. & MATERNITY	PRIVATE	DORAYI QUARTERS	134	U
135	TARAUNI	ALFIJIR EYE CENTRER	PRIVATE	TARAUNI QUARTERS , KANO.	135	U
136	TARAUNI	WOMEN & CHILDREN SPECIALIST HOSPITAL	PRIVATE	TAILOR WOOD JUNTION, ZOO ROAD, KANO.	136	U
137	WARAWA	JAMA'ARMU CLINIC	PRIVATE	GARIN DA'U, WARAWA L. G. A., KANO.	137	R
138	NASSARAWA	STANDARD SPECIALIST HOSP.	PRIVATE	LAMIDO ROAD, KANO.	138	U
139	FAGGE	ST. LUKE HOSPITAL	PRIVATE	NOMANS LAND, KANO.	139	U
140	NASSARAWA	SUNNYTEX NURSING & MATERNITY HOME	PRIVATE	NO. 2 BARGERY ROAD /DAKATA POLICE STATION ROAD, KANO.	140	U
141	UNGOGO	BALA DENTAL SERVICES	PRIVATE	KURNA ASABE KANO.	141	U

S/N	LOCAL GOVT	NAME OF FACILITY	TYPE OF FACILITY	ADDRESS	FACILITY NO.	SECTOR
142	TAKAI	FARIDAT CLINIC	PRIVATE	KACHAKO TOWN	142	R
143	TARAUNI	NASIHA NURSING HOME	PRIVATE	FARAWA,MAIDUGURI ROAD, KANO	143	U
144	GWALE	REAL DIAG. LABOURATORIES	PRIVATE	NO. 482 SANI MAI NAGGE QUARTER, KANO	144	U
145	GARKO	AHIP CLINIC	PRIVATE	GARKO TOWN, KANO.	145	U
146	UNGOGO	AISHA HOSPITAL	PRIVATE	KURNA ASABE QTRS.	146	U
147	TARAUNI	RENO DENTAL CLINIC	PRIVATE	U/UKU, ZARIA ROAD, KANO.	147	U
148	GWALE	ESBEE DENTAL CLINIC	PRIVATE	BUK ROAD, KANO.	148	U
149	NASSARAWA	RELIANCE CLINIC &MAT	PRIVATE	RIMIN KEBE QTRS. KANO.	149	U
150	FAGGE	SUCCESS CLINIC & MAT.	PRIVATE	BURMA ROAD, KANO.	150	U
151	GWALE	UNICARE SKIN CLINIC	PRIVATE	BUK ROAD, KANO.	151	U
152	TARAUNI	UNIVERSAL SPECIALIST HOSPITAL	PRIVATE	ZOO ROAD, KANO.	152	U
153	NASSARAWA	YACHAM CLINIC & NEAT	PRIVATE	BADAWA LAYOUT, KANO.	153	U
154	TARAUNI	EXCELLECE CLINICS	PRIVATE	MAIDUGURI ROAD KANO.	154	U
155	UNGOGO	NI'IMA CLINIC & MAT.	PRIVATE	R/ ZAKI QTRS, KANO.	155	U
156	GWALE	ESBEE DENTAL CLINIC	PRIVATE	OPP. BUK OLD SITE, KANO.	156	U
157	KUMBOTSO	KUNYA HOSPITAL – ANNEX	PRIVATE	PANSHEKARA TOWN	157	U
158	NASSARAWA	FIRST CARE DENTAL CLINIC	PRIVATE	NO. 44 SULTAN ROAD	158	U
159	NASSARAWA	EUNICE MAT. HOME	PRIVATE	BADAWA QTRS, KANO.	159	U
160	GWALE	ALKHAIRI CLINIC & MAT.	PRIVATE	NO. 2060 FLAT NO.2, TAL'UDU, KANO.	160	U
161	NASSARAWA	WATHANI NUR. & MAT. HOME	PRIVATE	T/MURTALA QTRS. KANO.	161	U

Annex 3: Detailed activities in the Kano Strategic Health Development Plan, 2010-2015

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							**2,167,645,975**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		**718,618,086**
		1.1.1	Improved Strategic Planning at State level		Costed Strategic and operational plans produced timed in State and LGAs		**257,817,163**
			1.1.1.1	Support the development of evidence based, costed, and prioritized strategic and operational health plans for the health sector		Swap 84 team members 3 consultants 21 days yearly	246,551,761
			1.1.1.2	Re-orient and strengthen human resources capacities in SMOH and LGAs on policy formulation, planning and implementation of health plans		5 days training 20 particpants twice in a year	9,152,925
			1.1.1.3	Conduct advocacy at State & LGA levels in support of policy development and implementation of agreed plans		PS, 5 directors quarterly	2,112,477
			1.1.1.4	Ensure and support adequate Budgetary provision and prompt releases as at when due for the implementation of the plans		Advocacy to policy makers	-
		1.1.2	Review the Internal Structure of SMOH in order to ensure that it is made consistent with stewardship role				**460,800,924**
			1.1.2.1	Establish Department of Human Resources,SPHCDA,TMB,DPH in the SMOH			225,074,598
			1.1.2.2	Source Technical Assistance to support the definition of functions and development of the new departments		Consultancy, 30 days	69,298,855
			1.1.2.3	Create new Division for the development and support of Public Private Partnership in the SMOH			162,979,434
			1.1.2.4	Establish decision making process on proposed restructuring of SMOH			3,448,037
			1.1.2.5	Seek Government approval when proposal is finalised			-
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2010**		**312,246,339**
		1.2.1	Strengthen regulatory functions of government		Health policy and Health act approved in State		**84,444,962**
			1.2.1.1	Review the existing State health policy and health act		PS, 5 Directors, 2 consultants for 30days	8,077,278

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			1.2.1.2	Support development of public/private partnership policies and plans in State in line with national policy on PPP		PS, 5 Directors, 2 consultants for 30days	8,077,278
			1.2.1.3	Provide technical support on implementation of strategic plans to ensure that the regulatory function of government is strategic and agreed quality standards are set, monitored, and delivered		2 consultants, 14days quarterly	47,955,069
			1.2.1.4	Explore and support arrangements under which state governments may wish to outsource some components of health service delivery to the private sector		Exploration PS, 5 directors, 2 consultants 14 days; support logistcs quarterly	7,724,364
			1.2.1.5	Set up review committees to review and align laws of regulatory bodies: private health institutions registration, other professional bodies etc		5 committees of 5 members 21 days each	6,880,957
			1.2.1.5	Set up committeess to review, align, update and enforce Public Health Acts and Laws		5 pers 21 days	1,376,191
			1.2.1.7	Comply with and streamline roles and responsibilities of regulatory institutions to align with the State Health Bill		5 directors, 2 consultants 21 days	4,353,826
		1.2.2	Rationalizing institutional framework for health care delivery and facilitating decentralization of management		PHC Development Agency established in the State		**227,801,377**
			1.2.2.1	Complete the process aimed at establishing State PHC Development Agency		advocacy PS, 5 directors, infrastructure, furniture, appointments/deployment, trainings	14,547,561
			1.2.2.2	Establish PHC service delivery fund		12 member fund managent committee logistics for quarterly meetings, state and LGAs annual contributions	102,797,550
			1.2.2.3	Establish Traditional Medicine Board		Quarterly logistics	1,955,753
			1.2.2.4	Establish mechanisms to enforce regular conduct of State Council on Health		7 member Committee, secretariat, quarterly logistics; annual conduct	103,806,705
			1.2.2.5	Establish Committee to monitor implementation of resolutions of State Council on Health		Quarterly logistics	4,693,808
	1.3	**To strengthen accountability, transparency and responsiveness of the health system**			**80% of LGAs have an active health sector 'watch dog' by 2015**		**1,136,781,550**

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
		1.3.1	To improve accountability and transparency		Number os PPRHAA campaigns implemented in state per annunm		**1,136,781,550**
			1.3.1.1	Institute facility appraisal mechanisms with community linkages- eg PPRHAA and ISS		Logistics biannually	1,134,336,858
			1.3.1.2	Promote voice and accountability		Advocacy & sensitization	-
			1.3.1.3	Build capacity of health workers on ensuring accountability & transparency			2,444,692
	1.4	**To enhance the performance of the health system in State**			**1. 50% of LGAs updating SHDP annually 2. 50% of LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	**-**
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance		List of priority areas for further analytical work compiled		**-**
			1.4.1.1	Outsource prioritised list of areas for further analytical work to Universities, private sector research firms and research institutes (Refer 8.2.4.1 and 8.2.4.2)			-
			1.4.1.2	Conduct a baseline survey of sectoral information base & review same annually			-
HEALTH SERVICE DELIVERY							-
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**120,678,357,699**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		**116,592,429,604**
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		Proportion of HFs operating within MSP		**116,518,865,444**
			2.1.1.1	Design a strategy to ensure facilities operate within the Minimum Services Package		**Consultancy 30 days**	5,109,185
			2.1.1.2	Implement MSP in State and LGAs		**logistics**	116,513,756,259
			2.1.1.3	Monitor & Supervise the implementation of MSP by all PHC facilities in the State			-
		2.1.2	To strengthen specific communicable and non communicable disease control programmes		Prevalence of communicabe and non communicable diseases in LGA		**34,028,797**
			2.1.2.1	Review the disease pattern in the LGAs using clinical		**Consultancy 21**	

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
				data		**days**	3,616,979
			2.1.2.2	Improve malaria prophylaxis (prevention) (Refer 2.1.1.2)			-
			2.1.2.3	Improve case detection and treatment for TB (Refer 2.1.1.2)			-
			2.1.2.4	Reduce STI/HIV/AIDS transmission (Refer 2.1.1.2)			-
			2.1.2.5	Establish prevention programme for NCDs in all secondary & Primary Health Care facilities			30,411,818
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels		Proportion of HFs using SOPs and guidelines for service delivery		**39,535,363**
			2.1.3.1	Produce and distribute standing orders to PHC facilities.		**Production, logistics for distribution**	10,137,273
			2.1.3.2	Produce and distribute Algorithms & treatment guidelines to all secondary health facilities.		**Production, logistics for distribution**	29,398,091
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		**3,718,056,025**
		2.2.1	To improve geographical equity and access to health services		Number of HFs upgraded/maintained		**2,377,110,378**
			2.2.1.1	Map out all health facilities		**2 consultants, 2 directors 14 days**	2,866,114
			2.2.1.2	Assess repair and equipment needs of all health facilities in state and LGAs		**2 consultants , 3 directors 21 days**	4,545,991
			2.2.1.3	Upgrade/ refurbish and supply equipment for primary and secondary health facilities, and LGA Cold & drug stores based on identified gap		**Repair/upgrade of 3 facilities per quarter**	1,459,767,253
			2.2.1.4	Develop and implement guidelines for outreach & mobile services		**1 consultant, 2 officers 14 days; monthly logistics**	731,515,021
			2.2.1.5	Procure means of transport to assist patients seeking health care in the health facilities			178,415,998
		2.2.2	To ensure availability of drugs and equipment at all levels		Proporion of HFS with Eds and functional equipment at all times		**794,509,600**
			2.2.2.1	Assess the drugs and equipment needs of all facilities taking into consideration using the MSP, Essential Drugs List and catchment population as a guide		**2 consultants, 3 directors 21 days**	4,767,406
			2.2.2.2	Develop and implement a system to ensure procurement and distribution of essential drugs on a sustainable basis		**Forecast**	409,545,813

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			2.2.2.3	Strenghthen the capacity of the State drug management agency		**Needs assessment, rehabiltate, purchase equipment, employ more personnel, train & provide regular support**	285,871,087
			2.2.2.4	Training of pharmacy staff on books of account		**50 participants biannually, 3days**	27,419,295
			2.2.2.5	Establish Drug Revolving Fund scheme in all primary & secondary health facilities			66,905,999
		2.2.3	To establish a system for the maintenance of equipment at all levels				**194,608,069**
			2.2.3.1	Adopt, disseminate and implement the National Health Equipment Policy		2 consultants 14 days	2,424,836
			2.2.3.2	Establish medical equipment and hospital furniture maintenance workshops		quarterly 3 days workshops for 20 participants	18,490,385
			2.2.3.3	Explore public private partnership in maintenance of medical equipment and hospital furniture		logistics	9,731,782
			2.2.3.4	Provide/ review budget lines for preventive maintenance of health facilities and equipment		biannual advocacy PS, 5 directors	62,588,340
			2.2.3.5	Establish School of Biomedical Engineering in the State			101,372,726
		2.2.4	To strengthen referral system		Proportion of HFS with functional referral system		**332,154,966**
			2.2.4.1	Map network linkages for two-way referral systems in line with national standards		**2 consultants, 3 directors 14 days**	325,155,619
			2.2.4.2	Develop/ review and implement transportation, communication and other logistics for referrals		**2consultants, 3 directors 14 days**	3,958,165
			2.2.4.3	Re-orient health workers at all levels on the two-way referral system & monitor implementation			3,041,182
		2.2.5	To foster collaboration with the private sector				**19,673,013**
			2.2.5.1	Map out all categories of private health care providers by operational level and location		**2 consultants 30 days**	5,149,734
			2.2.5.2	Develop guidelines and standards for regulation of the registration and practice of private health care providers		**2 consultants 5 directors 21 days**	5,981,411
			2.2.5.3	Develop and implement a joint performance monitoring mechanism for the private sector		**Development PS, 5 directors 14 days; logistics for**	7,035,458

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
						implementation	
			2.2.5.4	Adapt and implement the national policy on traditional medicine		**5 directors 14 days, logistics for implementation**	1,506,409
			2.2.5.5	Introduce & conduct mandatory annual continuing Medical education for private practitioners			-
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		**121,570,051**
		2.3.1	To strengthen professional regulatory bodies and institutions				**49,316,131**
			2.3.1.1	Build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines		3 days quarterly capacity building for 20 persons	30,752,430
			2.3.1.2	Provide budget lines and funding for professional regulatory bodies		Advocacy PS 5 directors quarterly	3,966,029
			2.3.1.3	Conduct regular monitoring exercises with appropriate documentation and feedback		quarterly logistics	14,597,673
			2.3.1.4	Empower regulators through the provision of necessary security			-
			2.3.1.5	Introduce & conduct mandatory annual management course for all managers in the health sector at State & LGA levels			-
		2.3.2	Develop and institutionalise quality assurance models				**37,972,080**
			2.3.2.1	Introduce SERVICOM to the State & all LGAs		5 directors 21 days	1,745,045
			2.3.2.2	Build institutional capacity and training staff for implementation of SERVICOM guidelines		3 days quarterly capacity building for 20 persons	30,752,430
			2.3.2.3	Develop and implement strategies for monitoring implementation of quality of care		5 directors 7 days, logistic for implementation	5,474,605
			2.3.2.4	Conduct annual retreat for managers in the Health Sector on quality assurance			-
			2.3.2.5				
		2.3.3	Strengthen Health Management and Integrated Supportive Supervision (ISS) mechanisms		Number of ISS vists conducted in LGA		**34,281,840**
			2.3.3.1	Provide budget line and funding for ISS in state		Advocacy PS 5 directors quarterly	3,529,410
			2.3.3.2	Develop capacities of programme managers at all levels in state on the ISS mechanism		3 days quaterly trainings for 20 persons	30,752,430

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			2.3.3.3	Institutionalize comprehensive ISS (Refer 1.3.1.1)		Logistics for quarterly state level and monthly LGA ISS	-
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		**37,575,156**
		2.4.1	To create effective demand for services		Number of BCC activites (by type) conducted		**37,575,156**
			2.4.1.1	Develop, disseminate and implement a State health promotion communication strategy based on the National Health Promotion Policy		2 consultants, 5 directors for 21 days; logistics for dissemination	6,674,380
			2.4.1.2	Provide budget lines and funding for health promotion through Behavioural Change Communication		Advocacy PS 5 directors quarterly	1,705,430
			2.4.1.3	Strengthen programme monitoring and evaluation system		Logistics	29,195,345
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		**208,726,863**
		2.5.1	To improve financial access especially for the vulnerable groups				**208,726,863**
			2.5.1.1	Explore models for financial protection for the vulnerable groups (e.g. Pregnant women, under fives, orphans and the aged) such as exemption schemes vouchers, health cards, pre payment schemes		2 consultants, 5 directors 21 days	5,981,411
			2.5.1.2	Strengthen free MCH programme in State (Refer 2.1.1.2)			-
			2.5.1.3	Adopt and implement the identified financial protection model		logistics	202,745,452
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							**56,546,322,977**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**State and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		**24,695,062**
		3.1.1	To develop and institutionalize the Human Resources Policy framework		State HRH Policy document completed by Dec. 2010		**24,695,062**
			3.1.1.1	Develop State HRH Policy in line with National HRH		5 Directors, 2 consultants 30DAYS	15,283,110

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			3.1.1.2	Formulate/periodic review and Implementation of training and recruitment policy for health personnel		Formulation (5 Directors, 1 consultants 2wks; review @ 2years(same for 1 wk)	3,413,916
			3.1.1.3	Establish HRH forum involving all stakeholders		Formation (2 persX 1 wk); Yrly Meetings for 30 participants and 2 consultants for 3 days	3,978,023
			3.1.1.4	Develop and implement guidelines on retension, task shifting and establish a forum for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks		Guidelines (5 Directors, DD & 1 consultant X 1 wk; Yrly Meetings for 30 participants for 1 day	2,020,014
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		**13,735,225**
		3.2.1	Reappraisal of the the principles of health workforce requirements and recruitment at all levels		Staffing norms implented in State		**13,735,225**
			3.2.1.1	Develop staffing norms based on workload, service availbility and health sector priority		3 Directors, 2 wks	1,975,631
			3.2.1.2	Operationalise the staffing norms			-
			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		HRH coordinating committee inauguration, 10 members; quarterly meeting	11,759,594
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010** **2. 10% of LGAs have functional HRH Units by end 2010**		**55,689,915,296**
		3.3.1	Establishment and strengthening of the HRH Units		List of trainees and implemented training programmes		**55,689,915,296**
			3.3.1.1	Establish training programmes in human resources for health planning and management at all levels		3 day Biannual trainings for 10 directors	34,127,071
			3.3.1.2	Make budgetary provision for employment, training and promotion of Health Care Staff			55,655,788,225

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		**604,299,610**
		3.4.1	To promote the production of adequate number of community health oriented professionals based on national priorities		Improvement on number of community oriented professionals produced in state		**401,912,001**
			3.4.1.1	Improve health training infrastructure in state		Consultancy assessment of infrastructure 21days; renovation/upgrading of 2 institution/ yr	87,722,208
			3.4.1.2	Improve the quality of tutors in state health training institutions		3 day workshop for 20 bi annually, study fellowship 10/ annum	67,124,741
			3.4.1.3	Improving training materials in health training institutions in state		Consultancy, assessment 14 days; supply of materials	38,757,983
			3.4.1.4	Establish an additional School of midwifery in State, as well as Medical School		Depends on approval by Nursing & midwifery council, Medical & Dental Council of Nigeria	201,068,599
			3.4.1.5	Increase number of community health workers and other cadres of supportive programme staff in state		Recruitment, study fellowship for 30/ annum	7,238,470
			3.4.1.6	Increase participation of private sector in public sector HRH training programmes			-
		3.4.2	To strengthen health workforce training capacity and output based on service demand		Training opportunities for health professionals facilitated in state		**202,387,609**
			3.4.2.1	Facilitate accreditation of eligible private sector health facilities to increase training opportunities for internship and post-basic training for all sector health professionals			-
			3.4.2.2	Promote human capital capacity building and continuing professional development (CPD)		3 days quarterly trainings for 100 persons	196,596,833

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			3.4.2.3	Establish coordination with professional regulatory bodies to link sponsorship to bonding of healthcare providers to mitigate migration across states and outside the country		Logistics	5,790,776
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of LGAs have implemented performance management systems by end 2012**		**165,421,319**
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		Equitable distribution of health manpower achieved in State and LGAs		**32,336,848**
			3.5.1.1	Create a database of HRH, develop and provide job descriptions and specifications for all categories of health workers in line with MSP		HRH audit 30 days, 3 Directors, 1 consultant; Developing job description 3 directors 1 wk	10,219,302
			3.5.1.2	Promote mandatory rotation of health workers to underserved rural areas, e. g through NYSC scheme for doctors, pharmacists and appropriate scheme for midwives and nurses			-
			3.5.1.3	Provide budget line and funding for payment of attractive rural allowance for staffs posted to underserved areas		Rural allowance for 500 pers @ 7000	14,074,802
			3.5.1.4	Rationalise health manpower in state and LGAs		Logistics	8,042,744
			3.5.1.5				
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels		System of recognition, reward and saction operational in state and LGAs		**133,084,471**
			3.5.2.1	Institute a sustainable system of recognition, reward and sanctions		Developing system 2 wks, 5 Directors	3,158,673
			3.5.2.2	Establish system to monitor health worker performance, including use of client feedback (exit interviews)		Developing system 3 directors 1 wk; quarterly implementation 7 directors 14 days	104,494,642
			3.5.2.3	Conduct routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics		3 days biannual training for 30 HWs	25,431,156
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		**48,256,464**

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
		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		Health workers and professional groups form part of management teams for health services in state		**48,256,464**
			3.6.1.1	Ensure involvement of health workers and professional groups in management teams, design and monitoring of health services		Logistics, quarterly	9,651,293
			3.6.1.2	Organise annual conference for health workers and regulatory bodies		Logistics, annual	38,605,171
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 and State levels							**25,450,218,007**
	4.1	**To develop and implement health financing strategies at State and Local levels consistent with the National Health Financing Policy**			**50% of LGa have a documented Health Financing Strategy by end 2012**		**1,679,211,988**
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy		Financing system and plan developed for state		**1,679,211,988**
			4.1.1.1	Develop a health financing system for the state		Developing system 5 directors, 1 consultant for 21 days	169,198,613
			4.1.1.2	Set up technical working group for health financing		Inauguration of working group 10 members; quarterly meeting	281,983,038
			4.1.1.3	Develop and implement health financing plan as a component of the State strategic health development plan			-
			4.1.1.4	Monitor the implementation of health financing systems operations	Logistics, annual		1,228,030,337
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		**10,818,201,375**
		4.2.1	To strengthen systems for financial risk health protection		social health protection initiative implemented state-wide		**10,818,201,375**
			4.2.1.1	Explore/ review existing Health insurance schemes (HIS) and innovative social health protection approches		3 directors, 1 consultant 14 days	90,078,719
			4.2.1.2	Develop state-wide HIS		3 directors, 1 consultant 30 days	85,193,066
			4.2.1.3	Implement identified system		Employer contribution; office complex	10,642,929,590
			4.2.1.4	Introduce community contribution scheme			

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
							-
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated State and LGA health funding increased by an average of 5% pa every year until 2015**		**892,239,756**
		4.3.1	To improve financing of the Health Sector		Intensification of effors to get Kano State allocation to health sector increased 15% of state budget		**558,149,331**
			4.3.1.1	Increse the allocation of public resources to the health sector by 15% of total budget in line with Abuja Declaration		Quarterly advocacy meetings PS, 10 directors	351,840,234
			4.3.1.2	Explore other sources of funding for health sector		Consultancy 21 days	206,309,097
		4.3.2	To improve coordination of donor funding mechanisms				**334,090,425**
			4.3.2.1	Explore mechanism for coordinating donor resources with that of government for health development - Common basket funding through options such as joint funding agreements, sector-wide approches (SWAs) and sectional multi donor budget support etc		Quarterly meetings of PS, 5 directors, partners and 1 consultant	334,090,425
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. State, 60% LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		**12,060,564,888**
		4.4.1	To improve Health Budget execution, monitoring and reporting		Number of financial reports produced		**3,126,071,103**
			4.4.1.1	Develop costed, annual operational plans		Planning team 30, 1 consultant 14 days	1,621,464,084
			4.4.1.2	Ensure proper internal recording and accounting of expenditures; and that timely and detailed financial management reports are produced periodically		production of biannual report; biannual training 20 pers 3 days	941,817,400
			4.4.1.3	Promote financial transparency through the development of State Health Accounts (SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets		Annual reviews 30 pers 3 days	562,789,619
		4.4.2	To strengthen financial management skills		Number of owrkshops and seminars held		**8,934,493,785**

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			4.4.2.1	Build capacity of health workers in budgeting, planning, accounting, auditing, monitoring and evaluation	Logistics, annual	biannual training for 30 HWs/ accountants/planners x 3 days	747,624,869
			4.4.2.2	Monitor the process of Planning & budgetting by health managers	Logistics, quarterly		8,186,868,916
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							**3,251,468,963**
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to Federal level by end 2010**		**1,071,607,976**
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points in state		Timely availability of HMIS forms in HFs		**107,063,422**
			5.1.1.1	Assess the requirement of HMIS tools in the state		**2 consultants 14 days**	11,190,841
			5.1.1.2	Formulate a stakeholders committee within HDCC for planning, resource mobilization, production and distribution of HMIS tools		**Inauguration 5 members; quarterly meeting**	16,346,371
			5.1.1.3	Ensure provision of Adequate Budget for Printing and reprinting of standardized HMIS tools		**Advocacy biannual 5 pers**	9,314,177
			5.1.1.4	Ensure timely printing and distribution of adequate quantities of HMIS tools for the state on quarterly basis			-
			5.1.1.5	Strengthen Supervision to ensure appropriate utilization of the distributed HMIS tools in the state		**3 days biannual training for 20 HMIS pers**	70,212,032
		5.1.2	To periodically review of HMIS data collection forms		Annual number of HMIS reviews conducted		**117,937,852**
			5.1.2.1	Conduct bi-annual review of HMIS in state		**20 pers biannual review meetings**	19,390,763
			5.1.2.2	Empower health managers at States and LGAs to create mechanisms to ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools		monthly DSNOs/HMIS meeting 20 pers	98,547,089
		5.1.3	To coordinate data collection from vertical programmes		Data collection and reporting in state harmonised		**66,517,349**
			5.1.3.1	Review guidelines and standards for data collection and reporting in State to ensure linkages in data flow		**21 days consultancy; 2 consultants**	16,101,667

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			5.1.3.2	Strengthen Health Data Consultative Committee State levels in collaboration with partners and other government agencies to streamline and strengthen data collection systems		**Quarterly meetings for 20 pers**	50,415,682
		5.1.4	To build capacity of health workers for data management		Number of HMIS staff recruited; number of HMIS trainings conducted		**151,684,590**
			5.1.4.1	Identify existing health information personnel in state and determine the gap		Review 1 director 2 deputy directors 14days	3,501,786
			5.1.4.2	Prepare proposal for the recruitment of health information personnel to fill the identified gaps			45,640
			5.1.4.3	Develop and implement a sustainable system of comprehensive training and retraining of service provider on data collection tools, analysis and utilization of data for action in health programining and policy formulation on a quarterly basis		TNA/ development of training plan (2 consultants 21 days); TOT 10 pers; quarterly trainings for 20 pers	115,276,619
			5.1.4.4	Establish adequate monitoring systems at State levels to ensure data quality		Logistics (monthly)	32,860,546
		5.1.5	To provide a legal framework for activities of the State HMIS programme		HMIS activities guided by state HMIS policy		**483,501,071**
			5.1.5.1	Adapt/ Develop and implement a state HMIS policy in line with national policy		**Development 2 consultants, 5 directors 3 wks**	10,645,057
			5.1.5.2	Provide guidelines for implementing the HMIS policy (Ref 5.1.5.1)			-
			5.1.5.3	Conduct 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		**Advocacy logistics for PS and 5 directors biannually**	472,856,014
		5.1.6	To improve coverage of data collection		Proportion of public and private facilities reporting timely and complete data		**69,393,583**
			5.1.6.1	Strengthen strategies for timely and complete collection of data from all public and private health facilities; and the community (Ref 5.1.1.5)		Logistics (monthly)	32,860,546
			5.1.6.2	Strengthen community based data collection system in the state		Logistics (monthly)	32,860,546
			5.1.6.3	Strengthen relationship between ministry of Health and National Population Commission to strengthen vital statistics of birth and death registration both at state and LGAs		Annual meetings for 15 pers	3,672,492
		5.1.7	Instituting routine supervision strategy for data collection at state and LGAs		Complete and timely data collection and reporting in state and LGAs		**75,510,109**

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			5.1.7.1	Create budget line and realistic budget for supervision of data collection at state and LGAs		Advocacy logistics for PS and 5 directors (quarterly)	23,557,436
			5.1.7.2	Facilitate timely release of fund for routine supervision of data collection		Advocacy logistic for HDCC (20 pers) quarterly	51,496,277
			5.1.7.3	Develop a schedule for routine supervision of data collection at the state and LGA level			456,396
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**		**112,821,206**
		5.2.1	To strengthen the use of information technology in HIS		Proportion of LGA with functional DHIS		**91,352,317**
			5.2.1.1	Install Internet Service at the state HQ and zonal Health Offices (5)			-
			5.2.1.2	Strengthen DHIS in state and LGAs		Computer systems (laptops 18); biannual training for 20 HMIS pers	87,299,516
			5.2.1.3	Explore use of GSM for data transfer		Installation, training for 20 HMIS pers	4,052,801
		5.2.2	To provide HMIS Minimum Package at the different levels (SMOH, LGA) of data management		% of LGAs with functional HIS minimum package		**21,468,890**
			5.2.2.1	Define HIS minimum package in state		consultancy 14 days days	10,734,445
			5.2.2.2	Provide/Repair non functional computers and power supply set to all the LGAs as part of basic Infrastructures for data storage, analysis and transmission system			-
			5.2.2.3	Establish and implement a sustainable system of preventive maintenance of HMIS equipment in state and LGAs		consultancy 14 days	10,734,445
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**		**569,418,487**
		5.3.1	To strengthen the Hospital Information System				**317,487,638**
			5.3.1.1	Establish and strengthen patient information systems as well as systems for mapping disease		3days Annual training for 30 record staff; logistics	43,649,758

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
Priority Area						
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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			5.3.1.2	Build capacity of health workers in Computing skills		Annual training	273,837,880
		5.3.2	To strengthen the Disease Surveillance System		No.of LGAs that reported diseases timely		**251,930,849**
			5.3.2.1	Ensure regular reporting of notifiable diseases by all health facilities is carried out		Logistics (monthly)	32,860,546
			5.3.2.2	Strengthen community based surveillance to strengthen disease Surveillance System in State and LGAs (Ref 5.1.6.2)		Reorientation, advocacy & sensitization, logistics	-
			5.3.2.3	Regularly provide logistics for diseases surveillance systems	Annual supply of adequate quantity		219,070,304
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		**28,990,304**
		5.4.1	To establish monitoring protocol for HMIS programme implementation at all levels in line with stated activities and expected outputs		Monitoring protocol for HIS in place		**28,990,304**
			5.4.1.1	Ensure availability of logistics materials (vehicles or motorcycles) and use of HMIS field monitoring instruments at all levels (Ref 5.3.2.1)		Supply	-
			5.4.1.2	Develop/adapt, produce and distribute HIS Quality Assurance (QA) manual (Handbook)		2 consultants 14days	28,990,304
			5.4.1.3	Support LGAs to hold monthly HIS review meeting (5.1.2.2)		Technical support, monthly	-
			5.4.1.4	Develop and implement schedule for bi-annual review meeting at state level (Ref 5.1.2.1)			-
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of LGAs have Units capable of analysing health information by end 2012 2. States disseminate available results regularly**		**1,468,630,990**
		5.5.1	To institutionalize data analysis and dissemination at all levels		Data used to inform decision and programming in State and LGAs		**1,468,630,990**
			5.5.1.1	Establish a functional Database across the state		Consultancy 14 days	1,331,712,051
			5.5.1.2	Develop human capacity for Data analysis (Ref 5.1.4.3)		Training 14 days	-
			5.5.1.3	Produce periodic health bulletin and annual reports		printing	136,918,940
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**2,167,645,975**

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
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	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		**597,330,555**
		6.1.1	Providing an enabling policy framework for community participation				**517,811,740**
			6.1.1.1	Strengthen state community mobilization team		monthly logistics	282,161,768
			6.1.1.2	Reorientate community development committees and community based institutions (CBOs, CDAs, VOs, Interfaith, etc.)		Quarterly logistics, training/ meetings	235,649,973
		6.1.2	Providing an enabling implementation framework and environment for community participation				**79,518,815**
			6.1.2.1	Identify already existing bodies in the community i.e. Red cross society, TBAs, Youths clubs, JNI, private clinics, pharmaceutical stores and patent drugs vendors.		5 directors, 1 consultant 21 days	34,764,823
			6.1.2.2	Develop tools and approach for community participation in planning, management, monitoring and evaluation of health facility and health related activities.		2 consultants 21 days; printing and distribution	44,753,991
	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		**1,362,289,359**
		6.2.1	Building capacity within communities to 'own' their health services				**1,362,289,359**
			6.2.1.1	Empower communities with health knowledge and capacity in management, implementation, as well as basic interpretation of health data		3 day quarterly Capacity building for 50 persons	534,226,280
			6.2.1.2	Define key roles and functions of community stakeholders and structures		5 directors 14 days	10,002,468
			6.2.1.3	Develop, upgrade or modify existing participatory tools for mobilising communities in planning and management		2 consultants 3 directors 14 days	30,024,420
			6.2.1.4	Identify and map out of key community stakeholders and resources with community assessment of capacity needs		2 consultants 3 directors 14 days	30,024,420
			6.2.1.5	Re-orient community development committees and community-based health care providers on their roles and responsibilities		3 day biannual capacity building for 50 persons	267,113,140
			6.2.1.6	Provide budget line and funding for community level activities		advocacy 5 directors quarterly	20,629,018
			6.2.1.7	Organize community dialogue between communities and government structures		logistics	235,134,806

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			6.2.1.8	Organize information, education and communication (IEC) activities and media to enlighten and empower communities for positive action		logistics for production of tools and airing of jingles/ programmes	235,134,806
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		**51,664,048**
		6.3.1	Restructuring and strengthening the interface between the community and the health services delivery points				**51,664,048**
			6.3.1.1	Review and assess the level of linkages of the existing health delivery structures with the community		2 consultants 14 days	391,891
			6.3.1.2	Support community stakeholders to develop guidelines for strengthening the community-health services linkage		1 consultant 2 directors 14 days	4,245,195
			6.3.1.3	Promote community participation in health development using health delivery structures		logistics	47,026,961
	6.4	**To increase state capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		**125,906,567**
		6.4.1	Developing/ Implementing multisectoral policies and actions that facilitate community involvement in health development				**125,906,567**
			6.4.1.1	Conduct advocacy to community gatekeepers to increase their awareness on community participation and health promotion		quarterly advocacy by 10 directors	31,852,645
			6.4.1.2	Organize community health development programmes		logistics, quarterly	47,026,961
			6.4.1.3	Provide support to various levels to link health with other sectors using the health promotion guidelines		logistics, quarterly	47,026,961
	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**		**30,455,446**
		6.5.1	To develop and implement systematic measurement of community involvement				**30,455,446**
			6.5.1.1	Develop/adapt models that will be used to establish simple mechanisms to support communities to measure impact and document lessons learnt and best practices from specific community-level approaches, methods and initiatives		2 consultants 3 directors 14 days	30,455,446

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
Priority Area						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**2,167,645,975**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. SMOH has an active HPCC with Donor Partners that meets at least quarterly by end 2010 2. SMOH has an active PPP forum that meets quarterly by end 2011**		**2,167,645,975**
		7.1.1	To promote Public Private Partnerships (PPP)		PPP initiatives in state implemented inline with national PPP policy		**285,083,356**
			7.1.1.1	Develop strategies for implementing PPP initiatives in line with state PPP policy		4 Persons level 14 for 30 days	21,429,633
			7.1.1.2	Establish PPP desk in DPRS at state level to promote, oversee and monitor PPP initiatives		2 Persons GL 12 and 10X 2wks; logistics	99,303,034
			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)		Quarterly meetings for 30 pers; Logistics (monthly)	164,350,689
			7.1.1.4	Explore mechanism for motivating private sector to set up health facilities in rural and under-served areas (Refer 7.1.1.3)			-
			7.1.1.5	Establish joint monitoring visits by public and private care providers with adequate feedback (Refer ISS)			-
		7.1.2	To institutionalize a framework for coordination of Development Partners		Partners support in state coordinated inline state framework and guidelines		**121,696,079**
			7.1.2.1	Develop a framework and guidelines for the harmonization and aligment of development partners support		2 pers GL12 2 wks	5,081,754
			7.1.2.2	Establish the Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners		Inauguration 5 members; quarterly meeting	37,734,499
			7.1.2.3	Strengthen Mechanism for coordination of partner resource in State		Logistics (monthly)	78,879,825
		7.1.3	To facilitate inter-sectoral collaboration		Intersectoral Ministerial forum meeting on quarterly basis		**208,904,240**
			7.1.3.1	Establish intersectoral Ministerial forum at DPRS state level to facilitate inter sectoral collaboration		Quarterly meetings for 30 pers; Logistics (monthly)	208,904,240

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			7.1.3.2	Conduct Quarterly Meetings (Refer 7.1.3.1)			-
		7.1.4	To engage professional groups		All professional groups involved in Planning and Implementation of health activities in the State		**111,499,035**
			7.1.4.1	Identify Professional Groups in the State		1 Director, 2 pers GL12 3wks; logistics	40,459,458
			7.1.4.2	Engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes (Refer 7.1.3.1)			-
			7.1.4.3	Support professioal bodies in their continuing education activities to enhance the skills of health professionals			-
			7.1.4.4	Strengthen collaboration b/w govt. and professional groups to advocate for increased coverage of essential interventions, particularly increased funding		Advocacy biannually, 10 pers	71,039,578
			7.1.4.5	Promote effective communication to faciltate relationship b/w professional groups and SMOH (Refer 7.1.3.1)			-
		7.1.5	To engage with communities		Numbers of Jingles aired on Radio and TV weekly, and Instructional materials on health of communities distributed		**827,842,568**
			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		52 weeks of TV and radio Jingles at N15,000 per jingle; 5000 copies of instructional materials x LGAs	54,339,435
			7.1.5.2	Organize quarterly sensitization meetings between senior SMOH officials and community leadership		Quarterly meetings for 30 pers	119,939,956
			7.1.5.3	Produce and distribute information packages for community (Refer 7.1.4.5)			-
			7.1.5.4	Develop and disseminate Health charter at all levels		500 copies 44 LGAs and State level	39,439,913
			7.1.5.5	Build Capacity of community to prevent and manage Priority Health conditions through BCC, social marketing Public awareness, education and communication (IEC)		5 days TOT for 20 then step down trainings (3days) for 50 pers quarterly	614,123,264
		7.1.6	To engage with traditional health practitioners		Traditional medcine practioners' body established and their practices improved		**612,620,698**

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			7.1.6.1	Strengthen traditional medicine practitioners board and regulate their practice		Guidelines for registration and practice PS, 3 Directors, 1 consultant X 3wks; monhly logistics	106,212,218
			7.1.6.2	Organise research activities to gain more insignt and understanding of traditional health practice			-
			7.1.6.3	Provide traditional Health Practitioners with additional skills to improve their practices of proven value e.g referal system		Capacity building for 3 days for 20 pers biannually	174,061,482
			7.1.6.4	Train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system		Capacity building for 3 days for 20 pers biannually	166,173,499
			7.1.6.5	Work with traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene, immunisation and family planning		Capacity building for 3 days for 20 pers biannually	166,173,499
			7.1.6.6	Discourage unregistered traditional health practitioners from advertising themselves and making false claims in the public media (Refer 7.1.6.1)			-
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							**4,335,291,950**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		**2,328,151,298**
		8.1.1	To develop Health Research Policy at State level and health research strategies at State and LGA levels		Presence of authenticated State health Research Policy 2010		**99,681,777**
			8.1.1.1	Develop State health research policy		PS, 5 Directors, 2 consultants for 30days	59,827,190
			8.1.1.2	Develop health research strategies		5 Directors, 1 consultants 14 days	16,833,563
			8.1.1.3	Establish Health research steering committees		Inauguration 7 members; quarterly meeting	23,021,025
		8.1.2	To establish and or strengthen mechanisms for health research at State and LGA levels		Number of functiona research units in State		**328,300,414**

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			8.1.2.1	Strengthen research unit at state and create unit in LGAs		State(monthly logistics); establishment in 44 LGAs	84,501,504
			8.1.2.2	Strenthen DPRS at State level, and establish DPRS at LGAs		Monthly logistics for SMOH; establishment in 44 LGAs; 3 days biannual trainings for 20 pers	237,763,088
			8.1.2.3	Ensure coordinated implementation of the Essential National Health Research (ENHR) guidelines		Adopting, printing and distribution of guidelines	6,035,822
		8.1.3	To institutionalize processes for setting health research agenda and priorities		Availability of Guidelines; understanding and implementation of the Guidelines by all principal actors		**1,752,512,901**
			8.1.3.1	Establish/ strengthen functional institutional structures for research		research grants for 20 per institution (4 instituitons)/ annum	1,738,316,649
			8.1.3.2	Develop and implement guidelines for collaborative health research agenda		2 consultants 14 days	14,196,253
		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		Health research forum established; Budgetary allocation by stakeholders for reasearch		**91,058,763**
			8.1.4.1	Establish a forum of health research officers at state and LGAs		Inauguration of working group 20 members; quarterly meeting	65,091,653
			8.1.4.2	Organize annual convening of multi-stakeholders forum to identify research priorities and harmonize research efforts		Annual meetings for 50 pers	25,967,110
			8.1.4.3	All stakeholders to provide budget line and funding for research proposals and implementation			-
		8.1.5	To mobilise adequate financial resources to support health research at State and LGAs levels		% of SMOH and LGA budgets released for research		**35,453,241**
			8.1.5.1	Allocate at least 2% of health budget for health research at State and LGA levels		Advocacy biannually, 10 pers	15,944,327
			8.1.5.2	Explore other sources of funding for research		PS, 5 directors, 1 consultants 14 days	19,508,914

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
		8.1.6	To establish ethical standards and practise codes for health research at State and LGA levels		State ethical board and regulatory standards and guidelines established		**21,144,202**
			8.1.6.1	Establish State ethical board/Institutional review board		Inauguaration of 10 members; quarterly meetings for 10	8,711,098
			8.1.6.2	Establish ethical standards and guidelines		10 pers, 1 consultnat for 2 wks	12,433,105
			8.1.6.3	Strengthen monitoring & evaluation system to regulate research & use of research findings at State and LGAs			-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at State and LGA levels**			**SMOH has an active forum with local health institutions and research agencies by end 2011**		**1,352,778,783**
		8.2.1	To strengthen identified health research institutions at State level		Number of institutions receiving technical support from SMOH		**121,704,244**
			8.2.1.1	Identify and strengthen identified health research institutions for collaboration		Logistics	3,862,926
			8.2.1.2	Conduct periodic capacity assessment of health research organizations and institutions		5 Directors, 1 consultants 14 days yearly	63,518,923
			8.2.1.3	Implement measures to address identified research capacity gaps and weaknesses		Forecast	54,322,395
		8.2.2	To create a critical mass of health researchers at all levels		Number of research grants and scholarship awards for PHD		**415,451,299**
			8.2.2.1	Develop appropriate training interventions for research, based on the identified needs at all level		PS, 5 directors 2 weeks	13,175,855
			8.2.2.2	Provide competitive research grants for prospective researchers while motivating increased PhD training in health in tertiary institutions through award of PhD studentship scholarships		10 Phd grants/ annum	217,289,581
			8.2.2.3	Provide on the job training for heath personnel for reasearch		Capacity building for 3 days for 50 pers biannually	184,985,863
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels		Number of reseaches translated into policies		**72,603,813**
			8.2.3.1	Develop mechanisms for translating research findings into policies		biannual reviews for PS, 5 Directors and 1 consultant for 2 days	28,550,250

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			8.2.3.2	Establish close liaison and linkages between research users (e.g. policy makers, development partners) and researchers		Annual researchers and users forum 50 pers 2 days	44,053,563
		8.2.4	To undertake research on identified critical priority areas		Number of researches conducted by focused areas		**743,019,427**
			8.2.4.1	Conduct needs assessment to identify required health research gaps at all levels		2 consultants, 3officers GL 12 14 days	18,720,823
			8.2.4.2	Conduct research in focused areas		research grants for 2 focused research/ annum	724,298,604
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. State has a Health Research Unit by end 2010 2. State Health Research Units manage an accessible repository by end 2012**		**434,579,162**
		8.3.1	To develop strategies for getting research findings into strategies and practices		No of research finding gone into programmes and policies		**434,579,162**
			8.3.1.1	Establish a mechanism for "getting research into programmes and policies at all levels; & instituting bi-annual Health research policy fora at all levels (Refer 8.2.3.1 and 8.2.3.2)			-
			8.3.1.2	Introduce annual summit on health research	Annual	Annual	434,579,162
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		Number of researches by SMOH and LGAs		
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**Health research in state conducted in line with national communication strategy by end 2012**		**219,782,707**
		8.4.1	To create a framework for sharing research knowledge and its applications		Number of annual health conferences, seminars and workshops		**117,909,376**
			8.4.1.1	Develop a framework for sharing research knowledge at all levels		5 directors 2wks	9,119,726
			8.4.1.2	Convene annual health conferences, seminars and workshops at State levels on key thematic areas (financing, human resources, MDGs, health research, etc)		3days annual conference etc for 100	108,789,650
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				**101,873,330**
			8.4.2.1	Identify persons with ability to develop policy briefs		3 directors 3 days	568,099

KANO STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
Priority Area							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**Total Estimated Cost (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
			8.4.2.2	Develop the capacity of researchers, and identified persons to effectively produce policy briefs targetted at informing policy makers as well as the broad scienctific and non scientific audiences		3 days biannual capacity building for 20 pers	89,233,588
			8.4.2.3	Establish a scientific journal & simple bulletin for publishing and dissemination of results of Health systems research			12,071,643
							216,764,597,521

Annex 4: Results/M&E Matrix for Kano Strategic Health Development Plan

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

KANO 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**
	published and disseminated annually					
4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD	10	25	50%
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	TBD	50	75	100%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report	TBD	10	25	50%
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	75%
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD	25	50	75%
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report	TBD	2	4	6
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	TBD	???	???	???
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	2%	10%	15%	20%
	26. Number of new users of modern contraceptive methods	NDHS/HMIS	0.2 - 27.5%	2 - 30%	5 - 50%	10 - 75%

KANO 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**
	(male/female)					
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	TBD	2 - 30%	5 - 50%	10 - 75%
	28. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10 - 45%	20 - 75%	100%
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	20 - 40%	30 - 60%	40 - 75%
	30. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy)	NDHS/MICS	2.9 - 65.0%	2.0 - 40%	1.0 - 30%	0.5 - 20%
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	12.3 - 96.3%	25 - 100%	50 - 100%	75 - 100%
	32. Proportion of births attended by skilled health personnel	HMIS	4.7 - 98%	25 -100	50 -100%	75 - 100%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	TBD	10 - 40%	25 - 50%	40 - 75%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	0.1 - 5.6%	1.0 - 10%	5.0 - 20%	10 - 30 %
	35. Case fertility rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	10 - 60%	7 - 40%	5 - 25%
	36. Perinatal mortality rate**	HMIS	37 - 53/1000LBs	25 - 45/1000LBs	15 - 30/1000LBs	10 - 20/1000 LBs
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD	??	??	??
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	0.5 - 22.4%	10 - 40%	25 - 60%	50 - 75%
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline			??
	40. Number of interventions performed to repair an obstetric fistula	HMIS	No Baseline			??
	41. Proportion of women screened for cervical cancer	HMIS				
	42. % of newborn with infection receiving treatment	MICS	No Baseline	10 -25%	25 -50%	50 - 75%
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	0 - 57.4%	10 - 65%	20 - 75%	40 - 80%
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	6.00%	20%	30%	40%

KANO 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**
	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	12.4 - 63.5%	8.0 - 50%	5.0 - 35%	2.0 - 15%
	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	2.0 - 49.9%	25 - 60%	40 - 75%	60 - 90%
	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	TBD	???	???	???
	51. HIV prevalence rate among adults 15 years and above	NDHS				
	52. HIV prevalence in pregnant women	NARHS	2.20%	1.20%	1%	0.50%
	53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS		???	???	???
	54.Condom use at last high risk sex	NDHS/MICS				
	55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	6 - 61.6%	20 - 75%	40 - 90%	60 - 100%
	56. Prevalence of tuberculosis	NARHS	1.5 - 6.9%*	1.0 - 4.0	0.5 - 3%	0.1 - 2*
	57.Death rates associated with tuberculosis	NMIS				
	58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	TBD	30%	40%	50%
Output 6. Improved quality of Health care services	59. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	25 - 50%	50 - 75%	75 - 100%
	60. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	25 - 50%	50 - 75%	75 - 100%
	61. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20 - 40%	50 - 75%	75 - 100%
	62. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10 - 25%	25 - 50%	50 - 75%

KANO 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**
	63. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	25 - 40%	40 - 75%	75 - 100%
	64. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	10 - 25%	25 - 40%	40 - 75%
	65. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD	10 - 45%	30 - 75%	50 - 90%
Output 7. Increased demand for health services	66. Proportion of the population utilizing essential services package	MICS	TBD	25 - 50%	50 -75%	75 - 100%
	67. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	25 - 50%	50 - 75%	75 - 100%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	68. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20 - 40%	30 - 60%	50 - 75%
	69. Retention rate of HRH	HR survey Report	TBD	???	???	???
	70. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	10 - 30%	30 - 50%	50 - 75%
	71. Stock (and density) of HRH	HR survey Report	TBD	1 CHW:4000 pop; 1 Nurse or MW:8000 pop; 1 Dr & Dentist:8000 pop; 1 Pharmacist: 20,000 pop;	1 CHW:3000 pop; 1 Nurse or MW:6000 pop; 1 Dr & Dentist:7000 pop; 1 Pharmacist: 15,000 pop;	1 CHW:2000 pop; 1 Nurse or MW:4000 pop; 1 Dr & Dentist:5000 pop; 1 Pharmacist: 10,000 pop;
	72. Distribution of HRH by geographical location	MICS	TBD	???	???	???
	73. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD	10 - 20%	25 - 50%	50 - 75%
	74. % of LGAs implementing performance-based managment systems	HR survey Report	TBD	25 - 30%	30 - 50%	50 - 80%
	75. % of staff satisfied with	HR survey Report	TBD	10 - 25%	25 - 50%	50 - 75%

KANO 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**
	the performance based management system					
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	76. % LGAs making availabile consistent flow of HRH information	NHMIS	0 - 100%	25 - 100%	50 - 100%	100%
	77. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	78. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	79. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	80. Medical doctor density per 10,000 population	MICS	1:40000	1:30000	1:20000	1:10000
	81. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	82. HRH database mechanism in place at LGA level	HRH Database	TBD	50 - 75%	75 - 100%	100%
Output 10: Strengthened capacity of training institutions to scale up the production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	83. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	10 -25%	25 - 50%	50 - 75%
	84. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	50 - 90%	30 - 75%	10 - 50%

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

KANO 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**
	dissemination					
	98. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	99. % of LGA plans using the HMIS data	NHMIS Report	TBD	40%	75%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	100. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	25%	50%	75%
	101. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	102. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	103. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	104. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	105. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	106. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	107. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	25%	50%	75%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role of government for research and knowledge management systems	108. % of LGAs partnering with researchers	Research Reports	TBD	10%	25%	50%
	109. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%

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