HEALTH SECTOR

2019 – 2021 MEDIUM-TERM SECTOR STRATEGY (MTSS)

STATE OF OSUN

AUGUST, 2018

Foreword

Medium Term Sector Strategy (MTSS) represents a process through which strategic policy priorities are determined and aligned with resources allocation, within the context of forecast information on the State's macro-economy and financial outlook. It represents medium term expenditure estimate (3 – 5 years) that are linked to clearly defined sector objectives that are derived from overall State's goal.

It aims at allocating resources towards strategic State's goals and programs within the constraints implied by the overall physical targets over a 3- year program.

The Health Sector like other Sectors, involve an application of activity budgeting with a view to improving strategic prioritization and the efficiency of public expenditures.

It enables effective implementation of State Development Plan (SDP) as regards Health Sector. It also ensures that government expenditure on Health Sector reflects government priorities as articulated SDP; wherein transparency and accountability in government expenditure is guaranteed. However, MTSS facilitates monitoring and evaluation with performance assessment of government expenditures.

Projects and programs elaborated in detail and costed over several years in a Medium Term Sector Strategy (MTSS) are more likely to be feasible and completed successfully than adhoc projects and programs

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Acknowledgements

You may wish to thank key individuals, groups or agencies that have been helpful to you in preparing the MTSS; acknowledge their supports and thank them for the supports.

The Health Sector Planning Team (HSPT) wishes to express profound appreciation to the political heads of the Sector, in persons of the Honorable Commissioner for Health and Special Adviser to Mr. Governor on Health Matters for their unflinching support at ensuring the success of the preparation of the MTSS.

In the same vein, the Team will like to place on record the unparalleled contributions of all the Accounting Officers in the State Health Sector for creating enabling environment for the successful preparation of the document.

It is also very pertinent to recognize the Sector Champion/Expert and Sector Planning Team for their untiring commitment and sacrifice.

The sincere appreciation of the team also goes to the Ministry of Economic Planning, Budget and Development, the various development partners and all other relevant stakeholders.

Finally, and most importantly, the team thanks the Almighty God for the successful completion of the assignment

Table of Acronyms

Acronym	Definition
MTSS	Medium Term Sector Strategy
BCC	Budget Call Circular
MoEPBD	Ministry of Economic Planning Budget and Development
MDAs	Ministries, Departments and Agencies
SPT	State Planning Team
SSHP	State Strategic Health Plan
SODP	State of Osun Development Plan
MTEF	Medium Term Expenditure Framework
SDP	State Development Plan
NEPAD	New Partnership for Africa Development
SDG	Sustainable Development Goals
ERGP	Economic Recovery and Growth Plan
PPP	Public Private Partnership
NGOs	Non-Governmental Organisations
NBS	National Bureau of Statistics
WHO	World Health Organisation
USAID	United State Agency for International Development
UNDP	United Nation Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nation International Children Emergency/Education Fund
EU	European Union
SFH	Society for Family Health
MOH	Ministry of Health
HMB	Hospitals Management Board
O'SACA	Osun State Action Committee on Aids
O'AMBULANCE	Osun State Ambulance
OSPHCDB	Osun State Primary Health Care Development Board
O'HIS	Osun State Health Insurance Scheme
OAUTHC	Obafemi Awolowo University Hospital Complex
LAUTECH	Ladoke Akintola University of Technology

HIV/AIDs	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
CSO	Civil Society Organisation
NHP	National Health Policy

Executive Summary

About 1-page summary of the MTSS document stating (among other things): the key motivations for developing the MTSS; how your sector's MTSS was prepared including stakeholders involvement; number of programmes and outcomes to be pursued in the medium term (2019– 2021); key highlights of the strategies; total costs of the programmes for each of the years 2019 – 2021; how the total costs were brought within the indicative budget ceilings; what plans for monitoring and evaluation?; and a summary of what you see as the critical success factors for the implementation of the MTSS.

The Key Motivations for Developing MTSS are to:

- Enable effective implementation of SDP
- Ensures that government expenditure reflect government priorities as articulated in the SDP (makes budget meaningful)
- Promote transparency and accountability in government expenditure
- Facilitate monitoring and evaluation and performance assessment of government expenditures; ideally any projects not in the MTSS are not admitted into the 2019 -2021 plan.

Preparation of Health Sectors MTSS:
The MTSS was adopted by the State Government of Osun in 2018 wherein all MDAs in the State were divided into 12 Sectors with the Health Sector as one of them. Hitherto, all relevant internal and external stakeholders in the Health Sector participated in the capacity building to formulate MTSS. The process included the following:

- 5 days envisioning of various stakeholders at Royal Park Motel, Iloko-Ijesa
- MDAs and other relevant stakeholders were divided into 12 Sectors and Sector Champions were selected
- 2 Days capacity building on MTSS at Western Sun Hotel, Ede
- A day inauguration and capacity building of SPT at Conference Room, HMB was held
- 3 days capacity building on MTSS at Aurora Event Center, Osogbo
- 3 days workshop for the development of MTSS document for the Health Sector at Leisure Spring Hotel, Osogbo

Number of Programmes and Outcomes to be Pursued in the Medium-term (2019 - 2021):

The Key Highlights of the Strategies:

- Produce medium-term expenditure framework
- Produce annual budgets that are strategic, realistic and forward looking
- Link higher-level State plans, and provides the basis for preparation of annual budget, work plans and cash flow projections
- Gain clear understanding of government policy, priorities and goals as contained in the Osun State Development Plan
- Cost each project and phase them over the medium-term period
- Define outputs and out comes to be delivered to stakeholders in clear measurable terms

Total Costs of The Programmes For Each of the Years (2019 – 2021):

Programme	Proposed Expenditure		
	2019	2020	2021
1.State Health policy	.	.	.
2.1 Disease Control	61,200,000	61,000,000	61,000,000
2.2 Disease prevention	635,000,000	513,750,000	394,750,000
3.1 Human Resource	531,100,000	481,100000	481050000
3.2 Health Infrastructure	2,031,741,770	1,651,663,770	793,309,210
3.3 M&E/HMIS Programme	543,850,000	494,350,000	494,850,000
3.4 Logistics Management and Coordination Programme	917,216,090	917,216,090	917,216,090
4.1 Osun Health Insurance Scheme			
Total Cost	**4,720,107,860**	**4,119,079,860**	**3,142,175,300**
Indicative Budget Ceiling	577,124,224	672,196,455	727,891,251
Indicative Budget Ceiling – Total Cost	-4,142,983,636	-3,446,883,405	-2,414,284,049

How the Total Cost Were Brought Within the Indicative Budget Ceilings:

Plans for Monitoring and Evaluation:

- A Technical Working Group (TWG) for monitoring and evaluation of MTSS implementation plan
- Membership of the TWG will be drawn from all the MDAs that constitute the Health Sector.
- Development of the monitoring and evaluation framework for the plan
- The primary function of TWG amongst others is to conduct monitoring and supervisory visits to stakeholders for performance measurement
- Carry out quarterly and annually review of MTSS performance.
- Conduct an annual stakeholders meeting on MTSS performance

Summary of Success Factors for the Implementation of the MTSS:

- Political Will on the part of Government will enhance implementation of MTSS .
- Unalloyed commitment of relevant stakeholders at ensuring transparency and accountability at all phases of implementation.
- Strict adherence and compliance to the details of MTSS avoiding misappropriation of resources.
- Appointment of Health sector MTSS implementation focal person
- Coordination of all MTSS implementation activities through a collaboration among the various MDAs that made up the Health sector.
- Provision of feedbacks by the Monitoring and evaluation technical working group to the implementers of projects in the MTSS
- MTSS must dovetail into the budget to achieve Health sector goals and objectives
- Increased revenue generation and blocking of leakages will improvement MTSS implementation

Chapter One: Introduction

1.1 Objectives of the MTSS Document

The MTSS is a global best practices for mutual planning that usually span between 3 – 5 years. MTSS is very important in strengthening budget preparation process. Similarly, before MTSS was adopted by the State government of Osun the health sector has a Strategic Health Planning document, a document that has being in use to provide direction and guidance in the strategic implementation of health care services in the State. Recently, the State embarked on the review of the existing SSHP which has the following objectives.

1. Promote an enabling environment for attainment of sector goals
2. Equitably increase coverage with packages of quality essential health care services
3. Strengthen health system for delivery of packages of essential health care services
4. Enhance healthcare financial risk protection

Although the objectives of State Development Plan (SDP) are in tandem with what MTSS is meant to address but with a slight difference. While MTSS represents a process through which strategic sectors priorities are determined and aligned with resource allocation within the context of forecast information on the state macroeconomic and financial outlook, SDP does not take this into account as funding gaps often exist.

The current MTSS for health sector has the following objectives

1.2. SUMMARY OF THE PROCESS USED FOR THE MTSS DEVELOPMENT

The MTSS was adopted by the State government of Osun in 2018 wherein all the MDAs in the State were divided into 12 sectors and health sector was one of them. All relevant internal and external stakeholders in the health sector were invited to participate in the capacity building to formulate MTSS. The process include the following

- 5 days Envisioning of various stakeholders at Royal Park Hotel, Iloko
- MDAs and other relevant stakeholders were divided into 12 sectors and Sector Champions were selected
- A day inauguration and capacity building of sector planning team at Conference room of Hospitals Management Board was held
- 3 days capacity building on MTSS at Aurora Event Centre
- 3 days workshop for the development of MTSS document for the Health Sector.

In the course of the preparation of MTSS, it was discovered that it is high demanding job which require optimum competence and dedication of the SPT members. The SPT members therefore need to be trained in order to do their job to the required standard.

Unfortunately, time given to finish the preparation was not sufficient and the sector team members were not adequately provided for.

It is therefore recommended that the next MTSS preparation should be adequately funded and the Sector Planning Team members be given opportunity to prepare MTSS without any other assignment from their sector during the period of preparation.

1.3 Summary of the sector's Programmes, Outcomes and Related Expenditures

Complete Table 1 below with the programmes your sector plans to implement in the medium term (2019 – 2021), the outcomes of the respective programmes, and the proposed expenditures on the respective programmes. Compare the total cost of all programmes with the indicative budget ceiling issued to your sector as indicated in the Table.

Table 1: Programmes, Expected Outcomes and Proposed Expenditures

Programme	Expected Outcome	Proposed Expenditure		
		2019	2020	2021
1.1.State Health Policy	Availabilty of a State Health policy	-	-	-
2.1 Disease Control	Enhanced quality Health Care Delivery	61,200,000	61,000,000	61,000,000
2.2 Disease prevention	Reduced incidence of diseases	635,000,000	513,750,000	394,750,000
3.1 Human Resource	Improved skill and productivity of health care delivery	531,100,000	481,100000	481050000
3.2 Health Infrastructure	Availability of quality of health infrastructure	2,031,741,770	1,651,663,770	793,309,210
3.3 M&E/HMIS Programme	Enhanced proper planning for health care services	543,850,000	494,350,000	494,850,000
3.4 Logistics Management and Coordination Programme	Availability of drugs and consumables	917,216,090	917,216,090	917,216,090
4.1 Osun Health Insurance Scheme	Reduction in out-of-pocket expenditure			

	Enhanced Universal Health Coverage			
Total Cost		**4,720,107,860**	**4,119,079,860**	**3,142,175,300**
Indicative Budget Ceiling		577,124,224	672,196,455	727,891,251
Indicative Budget Ceiling- Total cost		-4,142,983,636	-3,446,883,405	-2,414,284,049

1.4 Outline of the Structure of the Document

Describe the sequence of chapters, briefs of what each chapter is about and briefly explain the logic of its layout. For example:
This MTSS report is in five chapters as follows:
Chapter One: is introduction. It summarises the key objectives of the MTSS document; the process used for the development of the MTSS; and the sectors programmes, expected outcomes and related expenditures. The chapter ends with an outline of the structure of the MTSS document.

Table 2: Summary of State Level Goals, Sector Level Objectives, Programmes and Outcomes

State Level Goal	Sector Level Objective	Programme	Outcome
Ensure qualitative and functional education and healthy living	Promote an enabling environment for attainment of sector goal	State Health Policy	Availability of a State Health policy document
	Equitable increase coverage with packages of quality essential health care services	Disease control	Enhanced quality Health Care Delivery
		Disease prevention	Reduced incidence of diseases
	Strengthen health system for delivery of package of essential health care services	Human Resource	Improved skill and productivity of health care delivery
		Health Infrastructure	Availability of quality of health infrastructure
		M and E/HMIS Programme	Enhanced proper planning for health care services
		Logistics Management and Coordination Programme	Availability of drugs and consumables
	Enhance Health Care Financial risk protection	Osun Health Insurance Scheme	Reduction in out-of-pocket expenditure
			Enhanced Universal Health Coverage

Chapter Two: The Sector and Policy in the State

2.1 A BRIEF INTRODUCTION OF THE HEALTH SECTOR OF THE STATE

The State Health Sector came into being at the creation of the State on 27th August, 1991 with two (2) Agencies, Ministry of Health and Hospitals Management Board as the Administrative and Supervisory bodies controlling the activities of the Sector.

Since the creation of the State, the two agencies have always entered into partnership with local and international organizations such as WHO, USAID, UNDP, UNFPA, UNICEF, EU, SFH amongst others.

The Health Sector provides Preventive, Curative and Rehabilitative Services across the thirty (30) LGAs and 1 Area Office.

Presently, the Agencies within the health sector have increased from the initial two (2) to Six (6), namely:

== Ministry of Health (MOH);

== Hospitals' Management Board (HMB);

== Osun State Agency for the Control of Aids (O'SACA);

== Osun Ambulance Services (O'AMBULANCE);

== Osun Primary Health Care Development Board (OSPHCDB) ; and

== Osun Health Insurance Scheme (O'HIS)

Furthermore, the number of Health Care facilities have increased as follows:

Number of Primary Health Care facilities	-	876
Number of Secondary Health Care facilities	-	57

Number of Tertiary Health Institutions- 2 (OAUTHC and LAUTECH)

2.2 OVERVIEW OF THE SECTOR'S INSTITUTIONAL STRUCTURE

The Ministry of Health is the Policy making organ in matters relating to the health sector. The Agencies involved in the implementation of these policies are:

- ✓ **Hospitals Management Board (HMB)**

Execute general health policies approved by the State Government through its Secondary Health Care outlets.

- ✓ **Osun State Agency for the Control of Aids (O'SACA)**

Agency responsible for HIV/AIDs control

- ✓ **Osun Ambulance Services (O'AMBULANCE)**

Renders free ambulance services on emergency basis across the State.

- ✓ **Osun Primary Health Care Development Board (OSPHCDB)**

Provides Primary Health Care Services at LGA level.

- ✓ **Osun Health Insurance Scheme (O'HIS)**

The Agency responsible for the provision of universal health coverage through enrolment in the Health Insurance Scheme of the State Government

The above mentioned structures are considered adequate to deliver the expected mandates and outcomes

2.3 SITUATION ANALYSIS

Socioeconomic Context

Osun has a fairly large population. According to the 2006 National Population Census, the population of the state is put at 3,423,535. The state is rich in human and material resources. Historical evidence shows that the Yoruba tradition is one of the earliest and dominant traditions in Nigeria. The people of Osun are predominantly Yoruba. The state is composed of Osun, Ifes, Ijesas and Igbominas. Their language is Yoruba but there are variations in intonation and accent in across the towns and cities(Osun State Government, 2017).

Osun is culturally rich and this can be seen in all spheres of life such as arts, literature, music and other social activities in the state. Similarly, the state is blessed with a highly literate and articulate populace which makes up a strong and productive workforce. Primary school completion rate was 94.7% well above the national average. Furthermore, 94.7% of the young women were literate which will facilitate adoption of safe maternal and child care practices (National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2017).

Seventy four percent of the household in Osun State have access to Electricity (National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2017). Use of solid was 50.1% which is not a safe source of domestic energy for cooking. However, 3.9% and 5.1% of the households use clean energy in the form of Electricity and natural gas respectively.

Access to potable water is cardinal to preventing Communicable Diseases, maintaining sanitation and sound health. Improved source of drinking water such sanitary wells, bore hole and main supply of water was accessible to 88.5% of the households well above the national average of 64.1%. However, only 4.2% of the households with the unimproved sources of water use one form treatment for the domestic source of water. More than a third (38.1%) of the households had none or unimproved sanitary facility.

Access to radio was 68.5% which is the highest for the South-West Geopolitical zone. This is essential for the effective dissemination of health education and services information. Being an agrarian state, agriculture is largely practised both at commercial

and subsistence scales. Other occupations practiced in the state are trading, commercial activities and artisans.

2.3.1 Health Status of the Population

Globally, significant strides have been made in improving maternal and child health outcomes due to investments in MDGs 4 and 5. Preventable child deaths are down by more than half; and maternal mortality is down by almost as much. Despite these global achievements Nigeria has made very little progress in improving RMNCAH + N outcomes. The indicators for RMNCAH +N indicators are as in table 3 below.

Maternal, Newborn and Child Health, Family planning

Maternal Mortality remains persistently high with no significant improvement and is currently 576 per 100, 000 live births (National Population Commission - NPC/Nigeria and ICF International, 2014). The country contributes a disproportionate 14% to the global maternal mortality burden. These maternal deaths account for 32 percent of all deaths among women of reproductive age group (National Health Policy 2016). The high burden of maternal mortality is largely due to suboptimal uptake and quality of ANC, utilization of skilled birth attendance (84.7% source is mics2016), high rates of home deliveries, poor quality of delivery services, limited access to emergency obstetric care services and adverse reproductive behaviours.

Additionally, fertility remains persistently high while use of modern contraceptives has remained low at 22.9% in Osun state above the national average of 13% (National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2017). These are major contributors to the poor maternal health outcomes.

Coverage of high impact cost-effective child survival interventions remain much below the target with wide regional and state variations. Reports show that only 57.3% of babies received pre-lacteal feed in 2013 and exclusive breast feeding rate is 55.3% (National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2017)as against the National target of 50%. Immunization coverage has remained low as only a quarter of children aged 12 – 23 months are fully immunized(National Population Commission - NPC/Nigeria and ICF International, 2014) and the proportion of U5 children who slept under insecticide treated net the night preceding the survey

reduced from 49.8% to 16.6% in 2013 whereas the proportion of children with fever who received appropriate antimalarial drugs reduced from 35.9% in 2008 with 18 points in 2013.

There is inequity in service delivery and uptake which have been attributed to both supply and demand related issues such as mal-distribution of health care workers, poor knowledge and involvement of the community in home based care, high out-of-pocket expenses, inadequate funding, poor commodity logistic supply chain leading to frequent stock outs and lack of information on the skill and population of health workers in specific child-related services. Table 6 below shows the trends in coverage of selected integrated management of child illness services in Nigeria.

Table 1: Key Reproductive, Maternal, Newborn and Child and Adolescent Health Indicators

Coverage measures	**Baseline data (year and source)**	**Most recent (year and source)**	**Differences by region or groups (highest/ lowest)**
Proportion of mothers who received at least 4 ANC visits	14.2 (DHIS)2015	92.2 (MICS 2016)	Urban:68.8/ rural:33.8 (NDHS 2008) Urban:74.5/ rural:38.2 (NDHS 2013) SW: 85.7 /NW:32.8 (MICS 2011)
Proportion of mothers who received TT2+ during pregnancy	50(HMIS 2015)	51(HMIS2016)	SE:77.7 / NW:17.9 (NDHS 2008) SE:82.0 / NE:27.1 (NDHS 2013) SE:84.2/ NW:26.4 (MICSSS 2011)
Proportion of newborns protected against neonatal tetanus at birth	50.8 (MICS 2007) NA	55.2 (MICS 2011) NA	SE:83.5/ NW:23.5 (MICS 2007) SE:87.2 /NW:31.0 (MICS 2011)
Proportion of women who received iron during pregnancy	14.2(HMIS 2015)	20.2 (HMIS 2016)	SW:44.2/ NW:4.8 (NDHS 2008) SW: 42.0/ NW:5.8 (NDHS 2013)
Proportion of pregnant women who slept under an ITN the previous night(in all households)	22.6 MICS 2016		NC&SW:3.4/ SW:7.2 (NDHS 2008) SE:23.2/ NE:13.2 (NDHS 2013) NE:55.5 /SE:12.0 (MICS 2015)
Proportion of pregnant women who received at least 2 doses of IPT in pregnancy	6.5 (NDHS 2008)	14.6 (NDHS 2013)	SS:9.3/ NE:4.0 (NDHS 2008) SE:18.3/ SS:10.1 (NDHS 2013)

		17.4% (MICS 2016)	SS:25.0/NC:10.4 (MIS 2015)
Proportion of HIV+ mothers who received ART prophylaxis	N/A	29% (2015) (End-of-term evaluation of NSP 2010-2015)	

Table 1: Key Reproductive, Maternal, Newborn and Child and Adolescent Health Indicators (Continues)

Coverage measures	Baseline data (year and source)	Most recent (year and source)	Differences by region or groups (highest/ lowest)
Proportion of women delivered by skilled birth attendants	87.1 SMART 2015	84.7% MICS 2016	
Still birth rate	228/1000	396/1000	
Neonatal Mortality rate (per 1000 live births)			
Infant Mortality rate (per 1000 live births)	75/1000	78/1000 MICS 2016	
Under 5 Mortality rate (per 1000 live births)	157/1000	25/1000 MICS 2016	
Exclusive breastfeeding rate	13% (2008) NDHS 22% (MICS, 2011)	55.3% MICS 2016	
Coverage with Penta 3/Immunization coverage		Penta 3 (60%), Fully immunized (43%) MICS 2016	
Maternal mortality ratio (per 100, 000 live births)	545/100,000 live births	576/100,000 live births	
Contraceptive prevalence rate (CPR %)	30.8 SMART 2015	22.9MICS 2016	
Unmet need for family planning	**16.12015**		
Adolescent Birth rate (%)	121/1000	57/1000 MICS	
Total Fertility rate (%)	**5 DHIS 2015**	**4.7 MICS 2016**	

Source of data: NDHS and MICS surveys, 2008, 2013, 2016

Nutrition

In the State of Osun, overall performance in almost all nutritional impact indicators is poor. The State continue to experience rise in incidence of Low birth weight from 12% in 2011 to 15.1% in 2016 when the national average is declining. The wasting rate among U5 children increased as clearly shown in the prevalence of low weight for height which increased from 6.6% in 2011 to 8% in 2016 and the prevalence of slow weight for age which also increased from 11% in 2011 to 18.7% in 2016. Stunting rate rose significantly from 22.2% in 2011 to 23.5% in 2016 making the State the third

largest contributor to poor nutrition indicators in the Southwest. Although some significant progress were made in Exclusive Breastfeeding as the rate rose from 40.7% to 55.3% but this has not reduced both the infant and under five mortality in the State. The State experienced over 80% increase in bottle-feeding within 5 years (from 13% to 23.5%) above the national average of 20.2% at the time when national rate was declining.

This means that 80% more of our children are being bottle fed today than they were five years ago; and are thereby exposed to dangers arising from this practice including increase in the prevalence of diarrhoea and mortality. The State IMR and U5MR were the worst in the South west. The IMR rose from 40 in 2011 to 78 in 2016 and U5MR from 56 to 101 within the same year(National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2017).

Communicable Disease

Communicable diseases continue to pose major challenges to the global community accounting for over 60% of all causes of deaths in 2015*(World Health Organization, 2015).* In Nigeria, communicable diseases (AIDS/HIV, Viral Hepatitis, Malaria, Tuberculosis, Leprosy and neglected tropical diseases (filariasis, onchocerciasis, trachoma, worm infestation, and schistosomiasis), account for 66% of the total burden of morbidity. However, with advances in medicine, most of these diseases are now treatable (HIV, Viral Hepatitis B) and curable (Tuberculosis, Malaria and Viral Hepatitis C and NTDs). The SDG 3, Target 3.3, explicitly seeks to end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases (filariasis, onchocerciasis, trachoma, worm infestation, schistosomiasis, leprosy etc.) and combat hepatitis, waterborne diseases and other communicable diseases by 2030. These diseases have also been listed as priority concerns in the National Health Policy.

Malaria

Malaria remains a major cause of morbidity and mortality in Nigeria, accounting for about 29% and 55% of the cases in Africa and West Africa respectively. In 2016, 26% of the estimated 430, 000 global malaria deaths were reported in Nigeria (World Health Organization, 2016). Malaria is endemic throughout the country with 97% of the estimated 182 million persons at risk, with more deleterious effects on children under five years of age and pregnant women. The disease exerts a huge social and

economic burden on families, communities, resulting in an annual loss of approximately132billion Naira as payments for treatment and prevention as well as lost man -hours.

Over the last decade, the country recorded progress in the fight against malaria. The results of the 2015 Malaria Indicator Survey showed a decline in malaria prevalence from 42% in 2010 to 27%. This is however is marked by wide variation across the states, ranging from 0% in Lagos to 33% in Osun state. The state just distributed almost 3million long lasting insecticidal nets (LLIN) during 2017 replacement campaign with huge support from partners. Population coverage of households with at least one LLIN increased from 25% in 2013(National Population Commission - NPC/Nigeria and ICF International, 2014) to 66% in 2015 ((National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2017)in Osun.)

Tuberculosis

The WHO End TB Strategy, approved by the World Health Assembly in 2014, calls for a 90% reduction in TB deaths and an 80% reduction in the TB incidence rate by 2030 (WHO, 2015)Nigeria and five other countries (India, Indonesia, China, Pakistan and South Africa) account for 60% of the overall 10.4million new TB cases worldwide. In 2015, there were an estimated 480 000 new cases of multidrug-resistant TB (MDR-TB) and an additional 100 000 people with rifampicin-resistant TB (RR-TB) who were also newly eligible for MDR-TB treatment. Nigeria's TB incidence rate stands at 322/100,000, and this accounts for the highest TB burden in Africa. In osun state, incidence rate for new PTB cases is about 66/100000 population while the prevalence rate is about 70/100000 population, mortality rate is put at 4% (source is TBLBU DATA SMOH 2017) Children & male adult population are most at risk. Case detection rate for the estimated population affected with TB remains critically low at only 15%, though success rate among those who were commenced on treatment is impressive at 87%. The high prevalence of HIV increases the risk of TB infections among people living with HIV and therefore the global and National focus on ensuring TB/HIV collaboration to reverse the effects of TB/HIV co-morbidity.

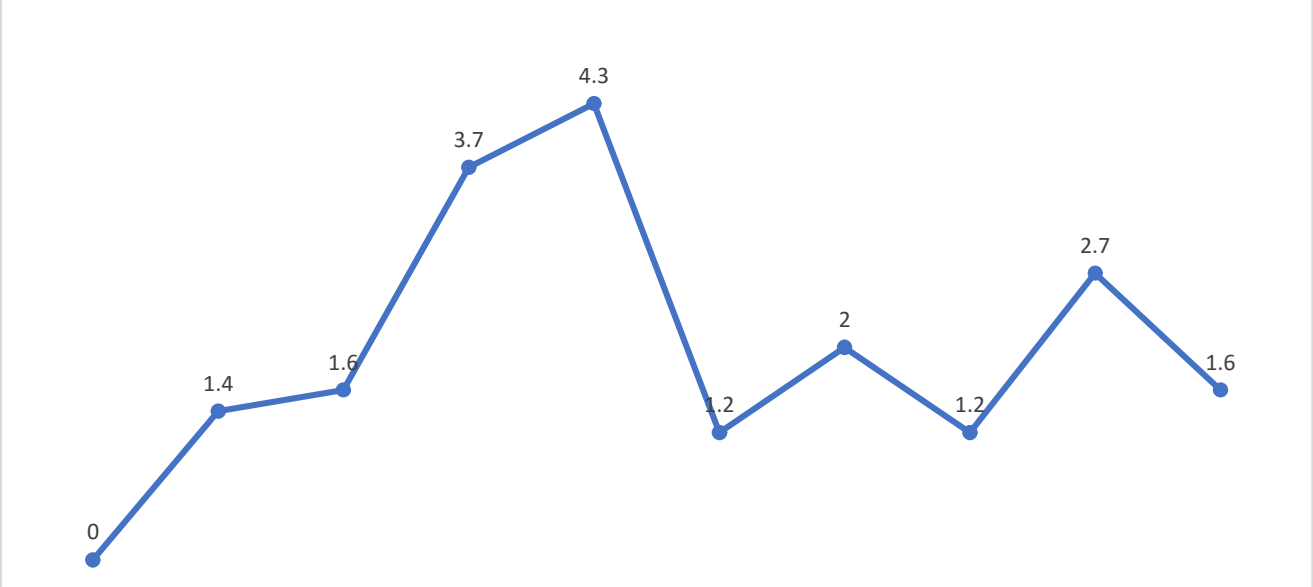
HIV

The pandemic of HIV/ AIDS in Nigeria has continued to constitute serious health and socio economic challenges for more than two decades. Since the first case of AIDS in Nigeria was reported in 1986, the HIV/ AIDS epidemics have continued to evolve,

affecting all population groups and geographic areas of the country. Nigeria has the second largest burden of HIV in the World with about 3.6 million people living with HIV, about 90% as adult and 60% as Women. Nigeria contributed 9% of the people living with HIV, 10% of new HIV infections, and 14% of HIV-related deaths in the world in 2013. The overall National Prevalence currently stands at 3.1%, however several variations exist in Nigeria's epidemic at the sub-national (state) levels and among different population groups.

Osun State has had a fluctuating HIV Prevalence over time with 0% at inception of the HIV Sentinel Survey in 1991. The HIV Prevalence peaked at 4.3% in 2001, declined to 1.2% in 2003, increased to 2% in 2005, declined again to 1.2% in 2008, rose to 2.7% in 2010 but reduced to 1.6% in 2014(FEDERAL MINISTRY OF HEALTH (Nigeria), 2012). The urban prevalence of HIV in the State is higher at 3.4% than the rural at 1.0%.

Figure 2: Osun State HIV Prevalence Trend: 1999-2014

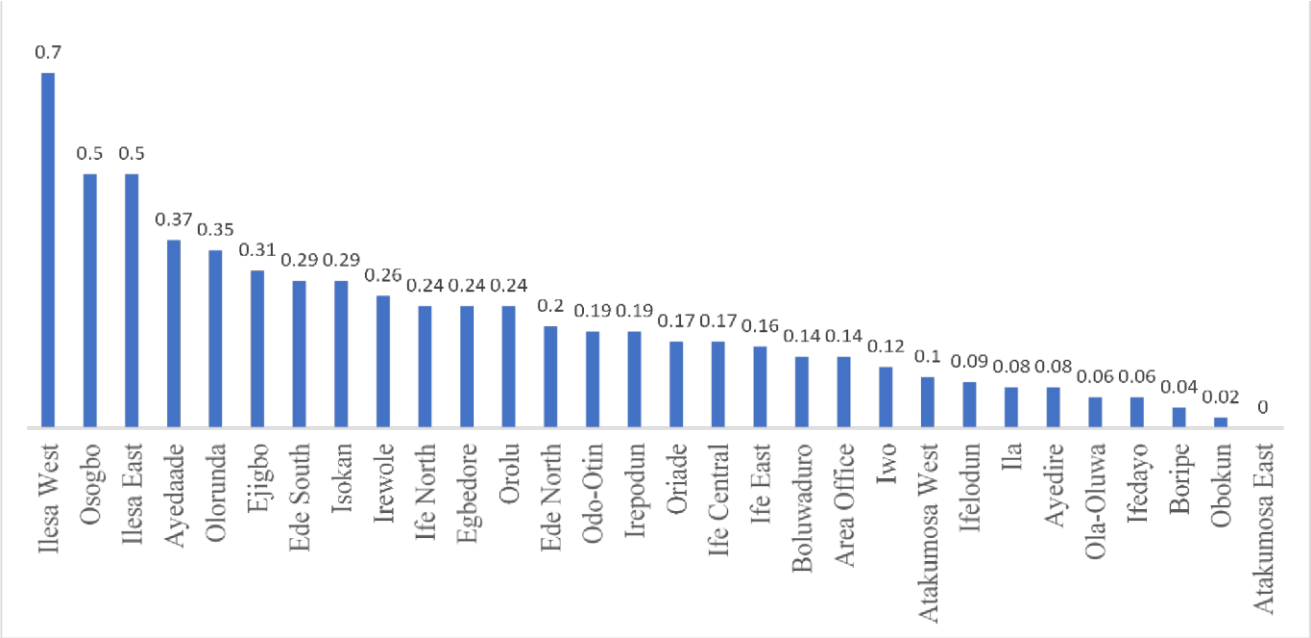


According to Spectrum Estimation, 74, 313 were living with HIV in Osun State by the end of 2015 with a total of 69, 193 adults and 5, 120 children. Estimated New HIV infections was 6, 701 while estimated AIDS deaths-was 4, 025 in 2015. The estimated Cumulative AIDS deaths was 84, 667 by end of 2015

The result of the HIV Counseling and Testing (HCT) Outreaches conducted by the thirty-one (31) Local Agencies for the Control of AIDS (LACAs) showed that Ilesa

West LGA has the highest prevalence of HIV at 0.7% followed by Osogbo LGA and Ilesa East LGA, while Obokun LGA had the lowest at 0.02

Figure 3: Osun State HIV positivity rate by LGA 2015



The drivers of the HIV Epidemic in Osun State are multiple sexual exposure, unprotected sex among youths, ignorance, low risk perception, significant presence of vulnerable population (Uniformed Service Personnel, Transport Workers & Migrant Workers) and significant presence of key population (Female Sex Workers-FSW, Men Sleeping with Men-MSM, People who inject drug-PWID)

According to existing National data, Osun State has a mixed epidemic with a dynamic transmission which is dependent on both activities of key population and the behavioural patterns of the general population. Anecdotal evidences suggest that the Ejigbo-Abidjan transnational migration factor also contributes to the epidemic in the State. This is worthy of note as prevalence amongst pregnant women in Abidjan is 5.2%. This prevalence is well above the national average of 3.4% (FEDERAL MINISTRY OF HEALTH (Nigeria), 2012).

2.3.2 Overview of the health system

Osun State operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other. Both the private and public sectors provide orthodox health care services in the State. The State Ministry of Health (SMOH) is solely responsible for health policies formulation and implementation. Also, the State Ministry of Health have responsibility for Tertiary and Secondary level health care and technical support to the LGAs. Whereas the LGAs are designated the providers of PHC, they are the weakest link in the health care system as they have the lowest capacity and commitment to health development in the country.

Hospital Management Board (HMB) is responsible for the state hospitals, General Hospitals and the Comprehensive Health Centres which are 57 in number distributed across the local governments. These hospitals render mainly secondary care to the residents. State Primary HealthCare Development Board (SPHCDB) is the agency of government in charge of the 876 Primary Health Facilities (PHFs) distributed across 332 political wards in the 30 Local Government Areas (LGAs) of the state. The Ward Minimum Health Package for Nigeria (National Primary Health care Development Agency, 2008) proposed a primary care facility at the level of each ward that would provide basic emergency obstetric care services.

There are partner involvements in some health programme activities in the state namely:

i. UNICEF- supporting Immunization and Vitamin A distribution
ii. WHO- Supporting Immunization and control epidemics
iii. Global Fund through Catholic Relief Society (CRS)- Supporting LLIN distribution
iv. HFG-USAID- Supporting Healthcare Financing

*2.3.3 **Health services provision and coverage***

Full vaccination coverage was 43%. Utilization of at least any method of family planning by women of children bearing age was 37.4% well above the national prevalence of 13% ((National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2017). The exposure to the family message was 74.5%, highest in the zone. Unmet need of family planning was 10% and lower than the

South West average of 11.3% (National Bureau of Statistics (NBS) and United Nations Children's Fund (UNICEF), 2017).

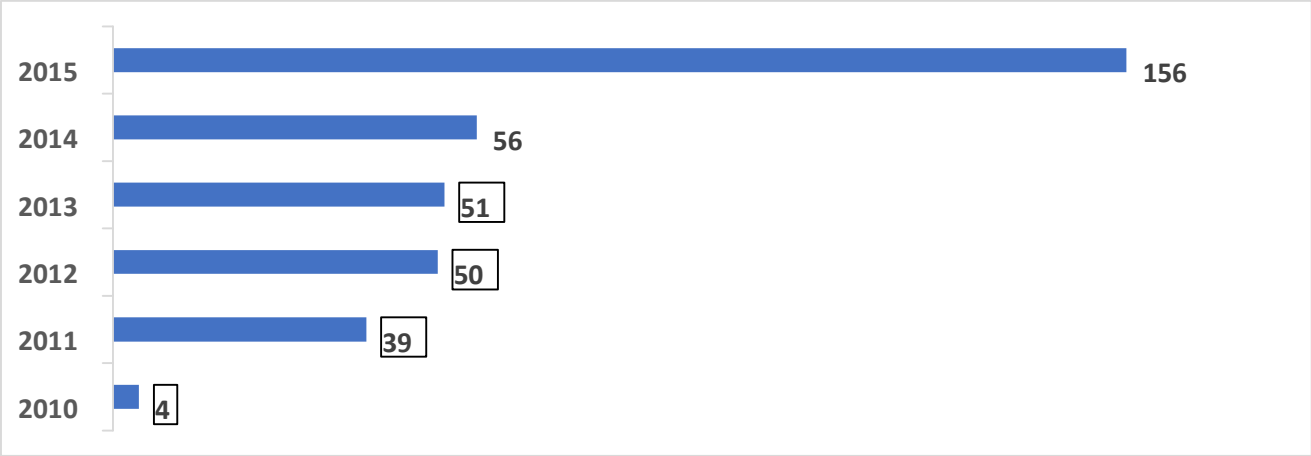
Use of Insecticide Net was high with 41.6% of households sleeping under net the night before interview. Artemisinin Combination Therapy (ACT) treatment was given to only 7.4% children with fever in the previous night. The source of the antimalaria to children with fever was more from private than the public with 45.7% and 30.7% respectively. This underscores the prominent role of private sector involvement in the healthcare delivery in the state. Intermittent Preventive Treatment (IPT) is a public health intervention aimed at treating and preventing malaria episodes in infants (IPTi), children (IPTc), schoolchildren (IPTsc) and pregnant women (IPTp). Only about one in ten (9.5%) of the pregnant women took 3 or more doses of IPT drugs.

Within the continuum of reproductive health care, antenatal care (ANC) provides a platform for important healthcare functions, including health promotion, screening and diagnosis, and disease prevention. ANC coverage by any skill provider was 95.6% among the highest in the country and well above the national average of 65.8%. Delivery by skilled attendant was 84.7%, highest in the south west geopolitical zone and well above national average of 43%.

HTC supported sites in Osun

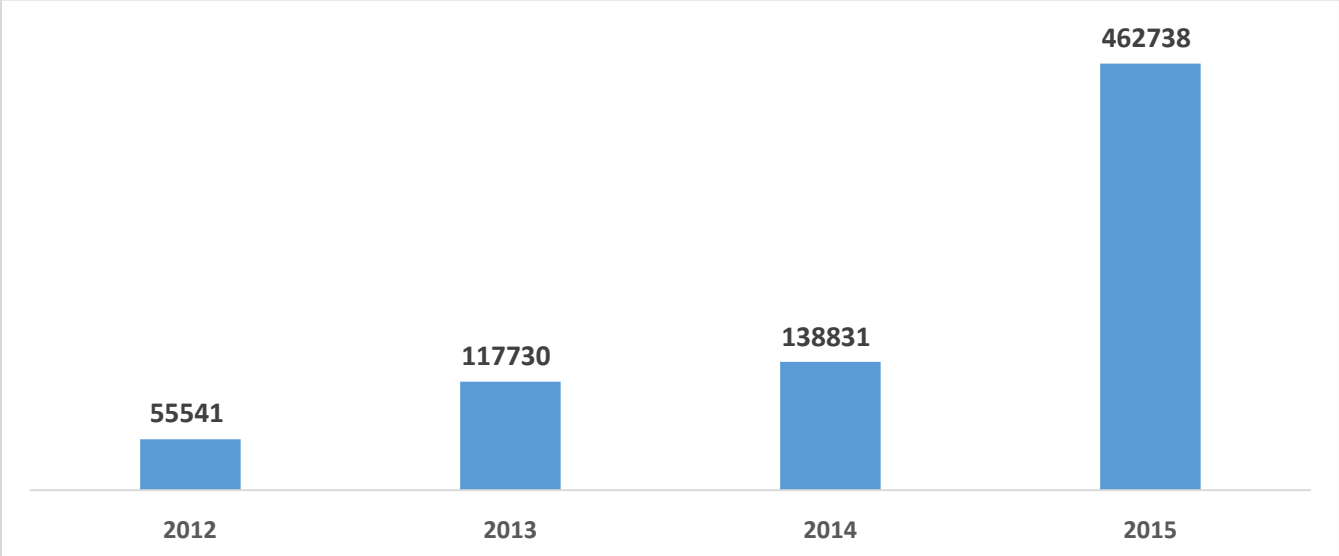
Scale up of HCT services: By December, 2015, HCT service delivery sites had increased to 156 from 4 in 2010 (Figure 4). There is an increase in the number of individuals counselled, tested and received result between 2012 and 2015 and 462, 738 individuals had been counselled, tested and received result by the end of 2015 by the various HCT Sites (Figure 5). The services are provided within health care facilities which are often insufficiently targeting hard to reach communities and most at risk populations. HCT coverage increased from 8.8% in 2007 to 34% in 2012(FEDERAL MINISTRY OF HEALTH (Nigeria), 2012).

Figure 4: HTC supported sites in Osun –State between 2010 and 2015



O-SACA supported MoH to activate fifty (50) Health Facilities for HCT services and LACAs, MDAs and CSOs to carry out community HCT outreaches. MoH Counseled & Tested 22, 825, other MDAs Counseled & Tested 9, 329, LACAs Counseled & Tested 334, 269 while CSO Counseled & Tested 234, 828 through OSACA support

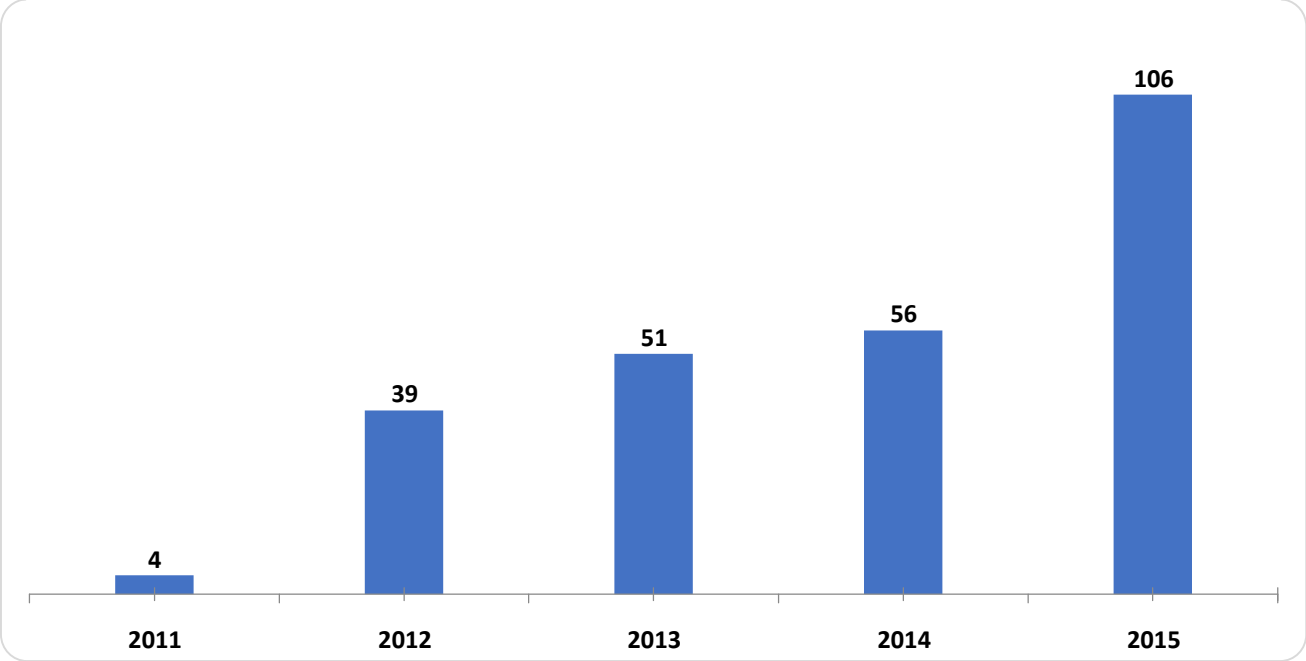
Figure 5: Number of individuals counselled and tested for HIV from HCT Sites (2012-2015)



Delivery of HCT as integrated services in TB clinics, Family Planning clinics and STI clinics is as follows: PEPFAR Funds, IHVN provided support to 14 PMTCT Facilities across 13 Local Government Areas while CCFN provided support to 3 PMTCT Facilities across 4 Local Government Areas in the state. Hygeia Foundation supported by the Global Fund supported PMTCT services in 25 Primary Health Centres (PHCs) across 9 Local Government Areas in the state.

PMTCT coverage increased from 9.3% in 2007 to 36.2% in 2015, though less than the expected national/ state target of 90% for PMTCT. This was associated with major scale up of PMTCT sites supported by Implementing Partners and with a significant increase in the number of O-SACA supported PMTCT sites as shown in chart below.

Figure 6: Number of PMTCT sites in Osun-State 2011-2015



2.3.4 Implementation of first SSHDP

The first plan was implemented to varying degrees, as evident from the Joint annual and Mid-Term Reviews. The assessment was informed by empirical evidence from the recent related surveys. The review was based on the thematic areas in the first plan (8) and the number of interventions proposed for each intervention. The thematic areas were classed as follows: Target met, close to being met and unmet when indicators were fully (100%), partially (above 50%) and (less than 50%) implemented and how many were not implemented at all(Osun State, 2010).

The review of the first plan has shown that the eight priority areas had a total number of 92 indicators, of which only 22 (23%) of the targets were met while 7 (7%) were close to being met and 39 (35%) of the targets were not met(Osun State, 2010). This shows that within the five-year period of implementing the first plan (2010-2015), less than a quarter of the set targets were met by the state.

Table 2: Summary of the key findings of the review of the first SSHDP performance between 2010-2015(Osun State, 2010).

S/N	PRIORITY AREA	Total No. of Indicators	Targets Met	Targets Close to Being Met	Targets Unmet	Data Not Available

1	Leadership & Governance	20	4	0	1	15
2	Health Service Delivery	46	21	4	12	9
3	Human Resources for Health	13	3	0	6	4
4	Health Financing	9	2	2	5	0
5	Health Information System	8	4	2	2	0
6	Community Participation	6	1	3	2	0
7	Partnership for Health	2	1	0	1	0
8	Research for Health	6	3	0	3	0
	TOTAL	110	39 (35.5)	11 (10.0)	32(29.1)	28 (25.4)

2.3.5 SWOT Analysis (Do a 2 by 2 Table)

The situation analysis was conducted using Strength, Weakness, Opportunity and Threat (SWOT) of the relevant strategic interventions in the state by priority areas

Table 3:

Strengths	**Weaknesses**
• Strong political will for development of state Healthcare and financing policies • Existing guidelines on public procurement, expenditure and financial audit. • Cooperation, understanding, and trust between the public and private sectors. • Availability of the National policies and guidelines booklet to adopt and adapt. • Political backing in term of an enabling law. • Availability of funds for the printing and distribution of the National policies and guidelines booklets. • Readiness and commitment of all health workers to read and make use of the adopted/adapted policies and guidelines. • Active participation by authorities of the ministry of health, Hospital Management Board, Development Partners and other stakeholders.	• Paucity of funds (Recession). • Inadequate Funding. • Inadequate Human resource capacity. • Non-availability of funds. • Non-availability of a local enabling law. • Unenthusiastic, uncommitted health workers due to unmotivated health care work force. • Unwillingness by health workers to make use of the policies and guidelines.

Opportunities	Threats
• Presence of Development partners(Basic Healthcare provision Fund piloted by World bank) • United Nations policies on health i.e UHC • National Health act and on other relevant Health policies Availability of Development partners with capacity to assist. • Relative peace in the state. • Availability of development partners and donor funds for health care services delivery. • If the government can try and pay counterpart funds.	• Favouritism and undue influence on deployment of health personnel • Competition for scarce resources. • Economic down turn in the nation in general. • Occasional communal clashes and political crisis/ mayhem. • Kidnapping and whisking away of health workers and demand for a ransom.

Table 4: SWOT Analysis

Strengths	Weaknesses
• Availability of women of child bearing age 22% of the total population which is 1,065,060 • Availability of policies that support the reduction of maternal morbidity and mortality through the provision of timely, safe, appropriate and effective healthcare services before, during and after child birth. • Free supply of Family Planning commodities and consumables from FMOH. • Airing on radio • Political support of the leaders. • Availability of trained personnel to handle Nutrition activities in all the LGAs • High Communities awareness on EBF • Periodic dissemination of EBF on Media • Availability of health facilities in every Ward to	• In adequate personnel to meet the population of the women of child bearing age. • Ill motivated health workers. • Dwindling resources. • High rate of attrition among trained health workers • Non- compliance with the provisions of BFHI in hospitals and workplaces • Low funding of Nutrition activities restricting training to 3 LGAs • Preponderant of the use of pre-lacteal feeds • Low skill in Lactation management among health workers • Insufficient Maternity leave and poor

promote, protect and support EBF • Establishment of Community structures to support EBF (Community Support Groups) • Positive Policy environment • Availability of tools and data for planning • Trained and competent staffs for quality service delivery • Collaborative activities with other ministries ,religious bodies • The existing structure of the association is a forum to address. • The involvement of global fund support to train the private sector. • The provision of microscopes to 17 health facilities. • Adherence of health workers on the treatment guideline • Training of role model caregivers enhances community involvement. • Participation of community leaders in net distribution campaign promoted cooperation. • Collaboration with other line ministries and CBOs ,and implementing partners	social support • Inadequate knowledge by new staffs and communities that have not been penetrated educationally • Inadequate funding of health by Govt. • Inadequate policy support for good enabling environment • Coverage is still poor. • Inadequate /staff attrition in all the public health facilities • Behavioural attitude of people towards free health programme • Inadequate motivation of workers • Poor funding of community development programme • Inadequate funding of malaria by state. • The partners strictly adhere to their work plan because the programme is majorly donor driven • Lack of budget line for the programme at LGA level.
Opportunities	**Threats**
• Political will & Positive policy environment • Breastfeeding culturally and religiously acceptable • Willing Partners to support EBF in the State • An average community member that is well-informed wants to take care of their health • Availability of Volunteers at community level for	• Incessant industrial actions and Strike action by the health workers. • Unethical promotion of Infant formula in hospitals and market places • Subtle and erroneous display of superiority of bottle-feeding over breastfeeding by advertisers

improved service delivery • Opportunities for service integration at community level. • Commitment of health workers. • Increased awareness of the programme especially during LLIN campaign. • Collaboration with other programmes like NMCHW & immunization,	• Non or poor enforcement of Codes of marketing or Breast milk Substitutes • Traditional and cultural belief • Misconception by the general public about HIV infections • Attrition and retirement of trained staffs • *Inconsistent supply of reagents for the use of microscope* • Misconception of belief on the use on LLINs • Frequent transfer of limited number of staff

2.4 SECTOR POLICY

Since the creation of the State, Health care services especially at the primary and secondary levels have been free for all age groups particularly at the advent of the administration of Ogbeni Rauf Aregbesola in November 2010 who has as part of his six integral action plans; Restoration of healthy living (Action plan number 4) which is executed via free and qualitative health care.

Under this dispensation, Free Consultation by Doctors and other health care providers are free for all categories of patients and basic Laboratory investigations and treatment and management of Obstetric emergencies are free, however, as from year 2015, government raised a committee on health systems reform which upon conclusion recommended inter-alia , drug revolving fund and private public partnerships in healthcare services.

Between the submission of committee report and end of year 2016, the government stuck to its policy of free healthcare, however by the end of 2016, the government directed the ministry of health and hospitals management board to examine and possibly embrace outsourcing of drugs and healthcare commodities in its secondary health facilities whereby the accredited private providers dispense drugs and consumables to the clients and get reimbursed only for the materials covered on the policy of free healthcare.

Recently following the establishment of the Primary healthcare development board, the government directed the ministry of health and her two health related agencies,(HMB, SPHCDB) to explore the possibility of establishing the state health insurance scheme with a view to achieving Universal health coverage using the existing levels of health care delivery system. The state government in an attempt to reduce out of pocket expenditure on health related conditions has also begin the process to kick start the Osun Health Insurance Scheme

(O'HIS)

2.5 Statement of the Sector's Mission, Vision and Core Values

The Core Values

- Accountability
- Equity-driven
- Alignment
- Multi-sectoral collaboration
- Efficiency and effectiveness
- Ethics and respect for human rights
- Industrial harmony
- Teamwork
- Community participation
- Evidence-based measures
- Sustainability
- Transparency
- Quality of care
- Partnership(s)
- People-centred
- Gender-sensitivity

2.6 The Sector's Objectives and Programmes for the MTSS Period

Summarise in Table 3 the objectives, programmes and outcomes deliverables of your sector over the MTSS period (2019 – 2021). These should include Key Performance Indicators (KPIs), baseline and realistic targets of the outcomes. Add rows to the table as necessary!

Table 3: Objectives, Programmes and Outcome Deliverables

Sector Objectives	Programme	Outcome Deliverable	KPI	Baseline (e.g. Value of the Outcome in 2017)	Target		
					2019	2020	2021
Promote an enabling environment for attainment of sector goal	State Health Policy	Availabilty of a State Health policy	State health policy document		✓	✓	✓

Equitable increase coverage with packages of quality essential health care services	**Disease control**	Improved quality of health care delivery	IMR, MMR, U5MR, CPR NMR,	78/1000,165/1000,101/1000,22/100,56/1000(MICS 2016)	75/1000,140/1000,95/1000,30/100,50/1000	70/1000,125/1000,85/1000,40/100,46/1000	**60/1000,105**/1000,70/1000,50/100,40/1000
	Disease Prevention	Reduced incidence of diseases	penta 3 coverage, vit A coverage, coverge of essential services	60/100, 63.2/100(MICS 2016)	80/100,70/100	85/100,80/100	90/100,85/100
	Human Resource	Improved Skill and productivity in Health	Necessary skills acquired and productivity				

Strengthen health system for delivery of package of essential health care services		Care Delivery	enhanced				
	Health Infrastructure	Availability Of Quality Health Infrastructure	Quality Health Infrastructure acquired				
	M&E /HMIS Programme	Enhanced Proper Planning for Health Care Services	Availability of reliable data for planning and decision making	86.5% (DHIS 2017)	90%	95%	100%
	Logistics Management and Coordination Programe	Availability of drugs and consumables	Drugs and consumables bought	29.2% (NHF 2016)	30%	40%	50%
Enhance Health Care Financial Risk Protection	**Osun Health Insurance Scheme**	Reduction of Out-of-pocket expenditure	Proportion of population with a form of health financial risk protection				
							s

Table 3b: Objectives, Project and Outcome Deliverables

S/N	Outcome	Project Title	Proposed Expenditure (N'000)			Output	Output KPI	Base Line (e.g. Output Value in 2017)	Output Target			MDA Responsible
			2019	2020	2021				2019	2020	2021	
1	Improved Quality of Health Care Services	Supportive Supervisions for Health	54,600	54,600	54,600	Supportive Supervision carried out	Proportion of Health Facilities visited	n/a	50%	70%	95%	SMOH/SPHCDB
2	Improved Availability & Functionality of Health Infrastructure	Procurement of Medical / Laboratory Equipment / Upgrading of Blood Bank	529,216.09	529,216.09	529,216.09	Availability of Medical / Laboratory Equipment / Upgrading of Blood Bank	Proportion of Medical / Laboratory Equipment / Upgrading of Blood Bank	5%	20%	30%	40%	HMB/SMOH/SPHCDB
3	Reduction in maternal, newborn, infant and U5 mortality	Capacity Building (Seminars, Workshops & Conferences)	470,750	420,750	420,750	Increased skill and capacity building	Proportion of Staff trained	nil	40%	50%	60%	MOH / O'HIS/SPHCDB/HMB

4	Timely, accurate and quality health data for informed decision making	Monitoring and Evaluation Activities/Health Management Information System (HMIS) Activities	180,250	130,250	130,250	1. Quality data available for programme design and implementation. 2. Data tools and ICT utilities available	1. Proportion of HFs reporting timely. 2. Proportion of Health care facilities with data tools and ICT utilities	NA	70%	80%	90%	SMOH/SPHCDB/O'HIS
5		National Immunization Polio Plus Days Activities	12,000	12,000	12,000	Elimination of Polio virus across the state	Proportion of children immunized with OPV	100	100	100	100	SPHCDB
6		Reproductive Health activities involving Post-abortal care, screening for reproductive cancers (Breast, Prostate cancer), Obstetrics fistula prevention and control, Safe Motherhood Day Celebration, Essential new born care, Maternal Perinatal Death Surveillance Response (MPDSR)	6,000	6,000	6,000	Increased access to ANC, Labour, Puerperium and Post abortal Care, Cancer Screening	% coverage of various services	NA	60	70	85	MOH/ SPHCDB
7		Female Genital Mutilation/cutting Reduction Activities	5,000	5,000	5,000	Reduction in Female Genital Mutilation/cutting	% of female genital mutilation/cutting recorded	76.3	50	40	30	SPHCDB
8		Maternal Newborn and Child Health Week	50,000	50,000	50,000	MNCHW conducted	% Coverage of various services &interventions	2 Rounds	2 Rounds	2 Rounds	2 Rounds	SPHCDB
9		Immunization service across all LCDAs	5,000	5,000	100,000	Regular Immunization Services in all health facilities in the state	Proportion of health facilities with regular immunization services	43	70	90	95	SPHCDB
10		Maintenance of existing cold chain	1,000	1,000	1,000	Cold chain regularly maintained	Functionality of CC equipment	NA	NA	NA	NA	SPHCDB
11		Quarterly Meeting of State Advisory Committee on NTDs	600	600	600	Meetings conducted	Proportion of planned meetings conducted	NA	NA	NA	NA	SPHCDB
12		Activities for Control of non-communicable diseases (Diabetes, Cancer screening & mental health)	6,000	6,000	6,000	Number of the populace reached with NCDs screening services	Early detection rate of NCDs	NA	NA	NA	NA	SPHCDB
13	Improved Quality of Health	HIV/AIDS Testing Services	1,000	1,000	1,000	More pregnant women tested	proportion for pregnant women tested for HIV	30%	40%	50%	60%	MoH/SASCP
14	Improved Waste	Health care waste				More HCWs trained on	Proportion of HCWs	34%	55%	60%	60%	MoH/SAS

	Management	management activities	400	300	300	waste management	trained					CP
15	Improved Quality of Care	Health Research Activities	20,350	20,350	20,300	Research on HIV/AIDS	Reported Research on HIV/AIDS	NA	NA	NA	NA	MOH
16	1. Improved Availability & Functionality of Health Infrastructure 2. Reduced incidence and impact of public health emergencies	National /State Council on Health Meetings	10,000	10,000	10,000	National /State Council on Health Meetings conducted	Number of National /State Council on Health Meetings conducted	National -1 State - 0	National - 1 State - 1	National -1 State - 1	National -1 State - 1	MOH
17	Improved Availability & Functionality of Health Infrastructure	Development of State Strategic Health Plan	20,000	20,000	20,000	Availability of SHDP	Proportion of SHDP implemented	10%	30%	35%	40%	MOH
18	Improved Availability & Functionality of Health Infrastructure	Renovation and Upgrading of Buildings	723,267.21	418,267.21	263,267.21	Dilapidated health care facilities renovated.	Proportion of dilapidated Health facilities renovated.	N/A	30%	40%	50%	SMOH/SPHCDB
19	Improved Quality of Data/documentation of patients	Printing of Hospitals Cards/Forms	6,000	6,000	6,000	Availability of Hospital Cards	Proportion of Health Facilities with Hospital Cards/Forms	5%	10%	15%	20%	HMB
20		Family planning Services	4,000	4,000	4,000	More people, especially woman accessing modern contraceptives	Contraceptive prevalence rate	22	28	35	40	MOH/SPHCDB
21		Last Mile Distribution (LMD) of FP commodities	5,000	5,000	5,000	Increase the contraceptives in all the service delivery points (SDPs)	% of SDPs with contraceptives	15%	30	45	70	SPHCDB
22		Health Promotion and Education (including Production of BCC materials and community mobilization)	15,000	15,000	15,000	1. Increased awareness on various health intervention 2. Improved knowledge of NTDs prevention including chemotherapy	1. Proportion of population with increased awareness on targeted health intervention. 2. Prop. of the populace with appropriate knowledge on NTDs prevention	NA	40%	60%	70%	SPHCDB
23		Baby Friendly Hospital Initiatives and promotion of EBF	2,100	2,000	2,000	1. Increase the proportion of children 0-6months exclusively breastfed to 70%. 2. Proportion of HF that are BFHI compliant increased by 40%	55.3	60	64	67	70	SPHCDB

24		Micronutrient Deficiency Control Activities among pregnant mothers, adolescent girls	1,200	1,000	1,000	1. Pregnant mothers supplemented with iron folate. 2. Adolescent girls supplemented with iron folate	1. Proportion of pregnant mothers supplemented with Iron folate. 2. Proportion of Pregnant and Adolescent girls supplemented with Iron folate.	36	50	65	80	SPHCDB
25		Distribution of PC-NTD Drugs (Microfilaria diseases)	19,400	19400	19,400	Reach all eligible populace with PCT-NTDs drugs	% of people reached	65	70	75	80	SPHCDB/ MOH
26		Prevention of Diet related non communicable diseases among adult population (Hypertension, Heart Diseases)	550	1,500	1,500	Reduction in the incidence of DR-NCDs	% of adult population with DR-NCDs	19	18	17	15	SPHCDB
27		Quarterly State Data Review Meetings	3000	3500	4000	Meetings conducted	Proportion of planned meetings held	100%	100%	100%	100%	MOH
28		Refund of Medical expenses	15000	15000	15000	Refunds made	Proportion of medical expenses of patients refunded	NA	40%	50%	60%	MOH
29		Development & Equiping of Health Institution Libraries	19254.56	19254.56	120000	Libraries equipped	Proportion of libraries equipped	NA	40%	50%	60%	MOH
30	Availability and accessibility of quality medicines,vaccines and other health commodities	Procurement of Drugs/Medication / Consumables	382,000	382,000	382,000	Availability of Drugs/Medication / Consumables in Health Facilities	Proportion of Health Facilities with Drugs/Medication / Consumables	40%	60%	80%	90%	SMOH/SP HCDB
31	Increased quality and quantity of Human Resource for Health	Accreditation/Re-accreditation of Hospitals/Internship Programs/Health Institutions & Programs / Health Care Providers	22,000	22,000	22,000	Accredited /Re-accredited Hospitals/Internship Programs/Health Institutions & Programs / Health Care Providers	Proportion of Internship Programs Accredited	50%	70%	90%	100%	HMB/SM OH
32	Improved Availability & Functionality of Health Infrastructure	Procurement/Refurbishm ent of Motor Vehicles	473,042	283,042	252,042	Vehicles Refurbished/ Procured	Proportion of Vehicles available for MDAs/Health Facilities use	nil	45%	50%	55%	HMB/SM OH/ O'HIS/SPH CDB
33	Improved Availability & Functionality of Health Infrastructure	Advocacy Activities for Health & Nutrition	480,000	340,000	250,000	Available of health infrastructure	Proportion of health facilities with basic health infrastructure	Nil	10%	20%	25%	MOH / Sphcdb

34		Medical Mission Activities	45000	45000	45000	Medical missions conducted	Proportion of planned Medical missions conducted	NA	50%	60%	70%	MOH
35	Enhanced operational effectiveness	Procurement of Office Equipment and Furniture	141,178	107,100	81,000	Availability of Office Equipment	Proportion of Agencies/MDAs with equipped offices	30%	40%	50%	55%	MOH / O'HIS/ SPHCDB
36		Establishment of community based health and nutrition intervention centres linked to SDGs/MCH facilities	8,000	8,000	8,000	Proportion of SDGs/MCH facilities with community based H&N intervention centres	Proportion of SDGs/ MCH facilities with community based health and nutrition intervention centres	NA	NA	NA	NA	SPHCDB
37		Routine distribution of Net	2000	3000	3000	Increase net ownership	Proportion of Households with at least one LLINs	47%	60%	80%	100%	MOH
38		Celebration of World Malaria Day Activities	2500	3000	3500	Increased awareness	Proportion of the population aware	NA	50%	60%	70%	MOH
39		Annual World TB Day celebration	750	750	750	Increased awareness	Proportion of the population aware	NA	30%	40%	60%	MOH
40	Improved Availability & Functionality of Health Infrastructure	Construction of New Buildings	653,000	629,000	555,000	New Buildings Constructed	Proportion of MDAs with New Buildings constructed	nil	30%	60%	90%	MOH / O'HIS/SPH CDB
41		Establishment of youth friendly centers (Adolescent sexual reproductive health)	10,000	10,000	10,000	Youths, especially adolescent girls have access to RH services	% of centres offering youth friendly services	5	20	30	40	MOH/SPH CDB
42		Establishment of blended complementary food centre	5,000	250	250	Blended Complementary foods plant established and functional	Availability of blended foods from the plant					SPHCDB
43		Consultancy Services-Software Application and Deployment for Health	300,000	300,000	300,000	Improved Data collection	Percentage increase in Enrolment	NIL	15%	20%	30%	O'HIS
44		Internship for Graduate Nurses	10000	10000	10000	Increase human resource for health	Proportion of graduate nurses completing internship	NA	20%	30%	60%	SMOH/H MB
	Total		**4,701,008**	**3,905,730**	**3,726,325**							

Chapter Three: The Development of Sector Strategy

3.1 Outline Major Strategic Challenges

Describe here the main challenges raised and considered during the strategy session. Some of the challenges would have been revealed by your review of high level policy documents and situation analysis of your sector. Current challenges in the sector which you will need to develop strategies to resolve; some of them would have been mentioned in Section 2.3 above.

1. MTSS is a highly demanding job requiring optimum competence and dedication of the SPT members
2. Time Constraint: the time allotted for the preparation of the MTSS was insufficient
3. The Sector Team Members (STM) were not adequately provided for
4. Paucity of Fund
5. Gross inadequacy of relevant Health professionals
6. Inadequate capacity building
7. Inadequate provision of medical equipment
8. Inadequate data collection.

3.2 Resource Constraints

Complete tables 4 and 5 with the historical budget data of your sector. Discuss the results in the tables. Were all the budgeted funds released? If not, what has been the impact on your sector? The balance between capital and recurrent expenditure; what proportion of the approved expenditure is recurrent (Personnel + Overhead) and what proportion is Capital? Is the proportion healthy; if not, what does the Sector plan to do better in future?

Table 4: Summary of 2017 Budget Data

Item	Approved Budget (N'000) in 2017	Amount Released (N'000) in 2017	Actual Expenditure (N'000) in 2017	Amount Released as % of Approved	Actual Expenditure as % of Releases
Personnel	6,831,773,950.00	3,405,227,581.00	3,405,227,581.00	50%	100%
Overhead	266,649,070.00	96,716,743.00	96,716,743.00	36%	100%
Capital	2,431,108,700.00	463,425,593.00	463,425,593.00	19%	100%
Total	**9,529,531,720.00**	**3,965,369,917.00**	**3,965,369,917.00**	-	-

Table 5: Summary of 2018 Budget Data

Item	Approved Budget (N'000) in 2018	Amount Released (N'000) in 2018 (Up to March)	Actual Expenditure (N'000) in 2018	Amount Released as % of Approved	Actual Expenditure as % of Releases
Personnel	7,896,578,710.00	460,537,368.00	460,537,368.00	6%	100%
Overhead	313,572,060.00	28,921,454.00	28,921,454.00	9%	100%
Capital	2,632,404,663.00	-	-	0%	-
Total	**10,842,555,433.00**	**489,458,822.00**	**489,458,822.00**	**-**	**-**

3.3 Projects Prioritisation

Complete Table 6 with the results of your projects prioritization and described how you have prioritized your projects; what criteria were used, how was the scoring done, etc.? Also explain why the prioritization was necessary and how you plan to use the results of your prioritization exercise.

Criterion 1: Evidence that the existing projects are indeed ongoing

Mark	Does the project correspond to an ongoing or existing project?
4	Abundant and convincing evidence that the project is ongoing or existing (e.g. ExCo's approval; con award; details of contractor(s); detailed project work plan with deliverables, milestones and targets engineering designs; cost revisions/contract variations; implementation progress report; etc.)
3	Sufficient and convincing evidence that the project is ongoing or existing
2	Some evidence or moderate evidence that project is ongoing or existing
1	No substantial evidence that project is ongoing or existing

Criterion 2: Clarity of current justification for the project

Mark	How well can the sector account for the level of funds currently allocated to that project?
4	Very Well – All cost components can be clearly identified and a strong argument presented for all co
3	Well – The cost components can be clearly identified, although not all can be fully justified as neces
2	Moderately – Some but not all of the cost components can be identified, with limited justification
1	Not at all – The cost components can be neither identified nor can these be justified.

Criterion 3: Current impact of the project.

Mark	What are the tangible positive impacts of the project?
4	Abundant and convincing evidence of substantial positive impact from existing commitment
3	Sufficient and convincing evidence of moderate positive impact
2	Some evidence of moderate positive impact
1	No substantial evidence of positive impact

Criterion 4: Likelihood of completion in 2019 – 2021 timeframe

Mark	How well can the Sector justify that the current budget commitment and planned future spendi complete the project, and run the project post completion? This should be based on the contrac and the data collected.

4	All evidence suggests that the project will be completed with the budgeted funds and that future r costs have been fully taken into account
3	Sector can show that the project is likely to be completed with budgeted funds and future running been adequately considered
2	Sector can show that budgeted funds will allow for substantial progress but not completion and fu running costs can be identified
1	Not at all – allocated funds will not allow for substantial progress nor can future running costs be a identified

Criterion 5: Relation to the sector's objectives

Mark	How critical is this project to the achievement of the sector's objectives?
4	Vital – Objectives cannot be achieved otherwise.
3	Important – This project will make a substantial and measurable contribution to achieving the objec
2	Moderately – This project will make some contribution to achieving the objectives.
1	Limited – the project will make no significant contribution to achieving the objectives.

- Once the SPT has completed the review of existing budget commitments, it may decide that some ongoing projects have performed so poorly that they should be discontinued.
- The SPT should clearly list any ongoing project that have been discontinued and justify why this is the case.

Table 6: Summary of Projects Review and Prioritisation (Ongoing, Existing & New Projects)

Project Name	Budgeted Expenditure in 2018 (N'000)	Criterion 1	Criterion 2	Criterion 3	Criter 4
Supportive Supervisions for Health		4	4	4	3
Procurement of Medical / Laboratory Equipment / Upgrading of Blood Bank		4	4	4	2
Capacity Building (Seminars, Workshops & Conferences)		4	4	4	2
Monitoring and Evaluation Activities/Health Management Information System (HMIS) Activities		4	4	4	2
National Immunization Polio Plus Days Activities		4	4	4	2
Reproductive Health activities involving Post-abortal care, screening for reproductive cancers (Breast, Prostate cancer), Obstetrics fistula prevention and controsl, Safe Motherhood Day Celebration, Essential new born care,		4	4	4	2

Maternal Perinatal Death Surveillance Response (MPDSR)					
Female Genital Mutilation/cutting Reduction Activities		4	4	4	2
Maternal Newborn and Child Health Week		4	4	4	3
Immunization service across all LCDAs		4	4	4	2
Maintenance of existing cold chain		4	4	4	2
Quarterly Meeting of State Advisory Committee on NTDs		4	4	4	2
Activities for Control of non-communicable diseases (Diabetes, Cancer screening & mental health)		4	4	4	2
HIV/AIDS Testing Services		4	4	4	2
Health care waste management activities		4	4	4	2
Health Research Activities		4	4	4	2
National /State Council on Health Meetings		4	4	4	2
Development of State Strategic Health Plan		4	4	4	2
Renovation and Upgrading of Buildings		4	4	4	2
Printing of Hospitals Cards/Forms		4	4	3	2
Family planning Services		4	4	4	2
Last Mile Distribution (LMD) of FP commodities		4	4	4	2
Health Promotion and Education (including Production of BCC materials and community mobilization)		4	4	4	2
Baby Friendly Hospital Initiatives and promotion of EBF		4	4	4	2
Micronutrient Deficiency Control Activities among pregnant mothers, adolescent girls		4	4	4	2
Distribution of PC-NTD Drugs (Microfilaria diseases)		4	4	4	2
Prevention of Diet related non communicable diseases among adult population (Hypertension, Heart Diseases)		4	4	4	2
Quarterly State Data Review Meetings		4	4	4	2
Refund of Medical expenses		4	4	4	2
Development & Equiping of Health Institution Libraries		4	4	4	2
Procurement of Drugs/Medication / Consumables		3	4	4	1
Accreditation/Re-accreditation of Hospitals/Internship Programs/Health Institutions & Programs / Health Care Providers		4	4	3	2
Procurement/Refurbishment of Motor Vehicles		4	4	3	2
Advocacy Activities for Health & Nutrition		4	4	3	2
Medical Mission Activities		4	4	3	2

Procurement of Office Equipment and Furniture		4	4	3	2
Establishment of community based health and nutrition intervention centres linked to SDGs/MCH facilities		3	4	3	2
Routine distribution of Net		4	3	3	2
Celebration of World Malaria Day Activities		4	4	2	2
Annual World TB Day celebration		4	4	2	2
Construction of New Buildings		0	0	0	0
Establishment of youth friendly centers (Adolescent sexual reproductive health)		0	0	0	0

3.4 Personnel and Overhead Costs: Existing and Projections

Complete Table 7 with the approved 2018 budgeted figures (approved and actual) for your sector's personnel and overhead; as well as what you project the figures to be for each of the MTSS years of 2019 – 2021. Justify your projections for personnel and overhead.

Table 7: Personnel and Overhead Costs: Existing and Projected

Expenditure Head	2018 (N'000)		Projections (N'000)		
	Approved	Actual (By March)	2019	2020	2021
Personnel Cost	7,896,578.71	460,537,368	7,896,578.71	7,896,578.71	7,896,578.71
Overhead Cost	313,572.06	28,921,454	313,572.06	313,572.06	313,572.06
Total Cost (N)	**8,210,150,770**	**489,458,822**	**8,210,150,770**	**8,210,150,770**	**8,210,150,770**

3.5 Contributions from our Partners

Describe here what is known about the likely activities of partners in the sector. This could include donors, Development Partners, NGOs, private agencies, religious organisations, etc. This could include formal understandings of shared responsibilities between government and the private sector in a PPP agreement. Complete table 8 for all applicable grants and donor funding (or any adapted variant of the table). If the donor fund is in foreign currency, convert it to Naira using the exchange rate provided by MoEPBD.

Table 8: Grants and Donor Funding

Source / Description of Grant	Amount Expected (N'000)			Counterpart Funding Requirements (N'000)		
	2019	2020	2021	2019	2020	2021
SOML P&R	306,000-	612,000-	-612,000	-	-	-
BHCPF						

3.6 Cross-Cutting Issues

Briefly describe here how you have treated the cross-cutting issues in your sector; e.g. gender, social inclusion, sustainability and cross-sectors issues (e.g. Projects which cut across more than one sector).

3.7 Outline of Key Strategies

Complete Table 9 to describe the main strategies and core activities of your sector's MTSS. This is the Logframe discussed previously. The table could be completed in Excel format, copied and inserted in the report. The instructions for completing the Table are as follows:

- **Column 1: Add the outcomes developed for each programme (As in Tables 2 and 3 above).**
- **Column 2: Add all projects that will be implemented in relation to the respective programmes; i.e. projects that will be implemented in order to deliver the expected outcomes. If the number of projects or activities is more than the number of rows provided in the Logframe Table, add more rows.**
- **Columns 3 – 5: Record the proposed expenditure for each project. The proposed expenditure will be derived through costing of the projects.**
- **Column 6: Indicate the output expected from each project. An output is what you expect to get from spending money on a particular project. For example, if the project is "Construct a block of six classrooms at Aiyegun School"; then the output to be expected after the project has been executed is "A block of six classrooms constructed at Aiyegun School".**
- **Column 7: Output KPI is how would we know whether or not the specified output is delivered.**
- **Column 8: The value of the output during the base year; e.g. 2017 (the baseline value).**
- **Columns 9 – 11: The quantities of the output that will be delivered in each of the MTSS year (2019 – 2021).**
- **Column 12: Specify the MDA in your sector that is responsible for implementing the project and delivering the associated output**

- Table 9: Summary of Projects' expenditures and output measures

S/N	Outcome	Project Title	Proposed Expenditure (N'000)			Output	Output KPI	Base Line (e.g. Output Value in 2017)	Output Target			MDA Responsible
			2019	2020	2021				2019	2020	2021	
1	Improved Quality of Health Care Services	Supportive Supervisions for Health	54,600	54,600	54,600	Supportive Supervision carried out	Proportion of Health Facilities visited	n/a	50%	70%	95%	SMOH/SPHCDB
2	Improved Availability & Functionality of Health Infrastructure	Procurement of Medical / Laboratory Equipment / Upgrading of Blood Bank	529,216.09	529,216.09	529,216.09	Availability of Medical / Laboratory Equipment / Upgrading of Blood Bank	Proportion of Medical / Laboratory Equipment / Upgrading of Blood Bank	5%	20%	30%	40%	HMB/SMOH/SPHCDB
3	Reduction in maternal, newborn, infant and U5 mortality	Capacity Building (Seminars, Workshops & Conferences)	470,750	420,750	420,750	Increased skill and capacity building	Proportion of Staff trained	nil	40%	50%	60%	MOH / O'HIS/SPHCDB/HMB
4	Timely, accurate and quality health data for informed decision making	Monitoring and Evaluation Activities/Health Management Information System (HMIS) Activities	180,250	130,250	130,250	1. Quality data available for programme design and implementation. 2. Data tools and ICT utilities available	1. Proportion of HFs reporting timely. 2. Proportion of Health care facilities with data tools and ICT utilities	NA	70%	80%	90%	SMOH/SPHCDB/O'HIS
5		National Immunization Polio Plus Days Activities	12,000	12,000	12,000	Elimination of Polio virus across the state	Proportion of children immunized with OPV	100	100	100	100	SPHCDB

6		Reproductive Health activities involving Post-abortal care, screening for reproductive cancers (Breast, Prostate cancer), Obstetrics fistula prevention and control, Safe Motherhood Day Celebration, Essential new born care, Maternal Perinatal Death Surveillance Response (MPDSR)	6,000	6,000	6,000	Increased access to ANC, Labour, Puerperium and Post abortal Care, Cancer Screening	% coverage of various services	NA	60	70	85	MOH/ SPHCDB
7		Female Genital Mutilation/cutting Reduction Activities	5,000	5,000	5,000	Reduction in Female Genital Mutilation/cutting	% of female genital mutilation/cutting recorded	76.3	50	40	30	SPHCDB
8		Maternal Newborn and Child Health Week	50,000	50,000	50,000	MNCHW conducted	% Coverage of various services &interventions	2 Rounds	2 Rounds	2 Rounds	2 Rounds	SPHCDB
9		Immunization service across all LCDAs	5,000	5,000	100,000	Regular Immunization Services in all health facilities in the state	Proportion of health facilities with regular immunization services	43	70	90	95	SPHCDB
10		Maintenance of existing cold chain	1,000	1,000	1,000	Cold chain regularly maintained	Functionality of CC equipment	NA	NA	NA	NA	SPHCDB
11		Quarterly Meeting of State Advisory Committee on NTDs	600	600	600	Meetings conducted	Proportion of planned meetings conducted	NA	NA	NA	NA	SPHCDB
12		Activities for Control of non-communicable diseases (Diabetes, Cancer screening & mental health)	6,000	6,000	6,000	Number of the populace reached with NCDs screening services	Early detection rate of NCDs	NA	NA	NA	NA	SPHCDB
13	Improved Quality of Health	HIV/AIDS Testing Services	1,000	1,000	1,000	More pregnant women tested	proportion for pregnant women tested for HIV	30%	40%	50%	60%	MoH/SASCP
14	Improved Waste Management	Health care waste management activities	400	300	300	More HCWs trained on waste management	Proportion of HCWs trained	34%	55%	60%	60%	MoH/SASCP
15	Improved Quality of Care	Health Research Activities	20,350	20,350	20,300	Research on HIV/AIDS	Reported Research on HIV/AIDS	NA	NA	NA	NA	MOH

16	1. Improved Availability & Functionality of Health Infrastructure 2. Reduced incidence and impact of public health emergencies	National /State Council on Health Meetings	10,000	10,000	10,000	National /State Council on Health Meetings conducted	Number of National /State Council on Health Meetings conducted	National -1 State - 0	National - 1 State - 1	National -1 State - 1	National -1 State - 1	MOH
17	Improved Availability & Functionality of Health Infrastructure	Development of State Strategic Health Plan	20,000	20,000	20,000	Availability of SHDP	Proportion of SHDP implemented	10%	30%	35%	40%	MOH
18	Improved Availability & Functionality of Health Infrastructure	Renovation and Upgrading of Buildings	723,267.21	418,267.21	263,267.21	Dilapidated health care facilities renovated.	Proportion of dilapidated Health facilities renovated.	N/A	30%	40%	50%	SMOH/SPHCDB
19	Improved Quality of Data/documentation of patients	Printing of Hospitals Cards/Forms	6,000	6,000	6,000	Availability of Hospital Cards	Proportion of Health Facilities with Hospital Cards/Forms	5%	10%	15%	20%	HMB
20		Family planning Services	4,000	4,000	4,000	More people, especially woman accessing modern contraceptives	Contraceptive prevalence rate	22	28	35	40	MOH/SPHCDB
21		Last Mile Distribution (LMD) of FP commodities	5,000	5,000	5,000	Increase the contraceptives in all the service delivery points (SDPs)	% of SDPs with contraceptives	15%	30	45	70	SPHCDB
22		Health Promotion and Education (including Production of BCC materials and community mobilization)	15,000	15,000	15,000	1. Increased awareness on various health intervention 2. Improved knowledge of NTDs prevention including chemotherapy	1. Proportion of population with increased awareness on targeted health intervention. 2. Prop. of the populace with appropriate knowledge on NTDs prevention	NA	40%	60%	70%	SPHCDB
23		Baby Friendly Hospital Initiatives and promotion of EBF	2,100	2,000	2,000	1. Increase the proportion of children 0-6months exclusively breastfed to 70%. 2. Proportion of HF that are BFHI compliant increased by 40%	55.3	60	64	67	70	SPHCDB

24		Micronutrient Deficiency Control Activities among pregnant mothers, adolescent girls	1,200	1,000	1,000	1. Pregnant mothers supplemented with iron folate. 2. Adolescent girls supplemented with iron folate	1. Proportion of pregnant mothers supplemented with Iron folate. 2. Proportion of Pregnant and Adolescent girls supplemented with Iron folate.	36	50	65	80	SPHCDB
25		Distribution of PC-NTD Drugs (Microfilaria diseases)	19,400	19400	19,400	Reach all eligible populace with PCT-NTDs drugs	% of people reached	65	70	75	80	SPHCDB/ MOH
26		Prevention of Diet related non communicable diseases among adult population (Hypertension, Heart Diseases)	550	1,500	1,500	Reduction in the incidence of DR-NCDs	% of adult population with DR-NCDs	19	18	17	15	SPHCDB
27		Quarterly State Data Review Meetings	3000	3500	4000	Meetings conducted	Proportion of planned meetings held	100%	100%	100%	100%	MOH
28		Refund of Medical expenses	15000	15000	15000	Refunds made	Proportion of medical expenses of patients refunded	NA	40%	50%	60%	MOH
29		Development & Equiping of Health Institution Libraries	19254.56	19254.56	120000	Libraries equipped	Proportion of libraries equipped	NA	40%	50%	60%	MOH
30	Availability and accessibility of quality medicines,vaccines and other health commodities	Procurement of Drugs/Medication / Consumables	382,000	382,000	382,000	Availability of Drugs/Medication / Consumables in Health Facilities	Proportion of Health Facilities with Drugs/Medication / Consumables	40%	60%	80%	90%	SMOH/SP HCDB
31	Increased quality and quantity of Human Resource for Health	Accreditation/Re-accreditation of Hospitals/Internship Programs/Health Institutions & Programs / Health Care Providers	22,000	22,000	22,000	Accredited /Re-accredited Hospitals/Internship Programs/Health Institutions & Programs / Health Care Providers	Proportion of Internship Programs Accredited	50%	70%	90%	100%	HMB/SM OH
32	Improved Availability & Functionality of Health Infrastructure	Procurement/Refurbishment of Motor Vehicles	473,042	283,042	252,042	Vehicles Refurbished/ Procured	Proportion of Vehicles available for MDAs/Health Facilities use	nil	45%	50%	55%	HMB/SM OH/ O'HIS/SPH CDB
33	Improved Availability & Functionality of Health Infrastructure	Advocacy Activities for Health & Nutrition	480,000	340,000	250,000	reduction in out of pocket expenses on health	Increase Enrolment	Nil	10%	20%	25%	MOH / O'HIS

34		Medical Mission Activities	45000	45000	45000	Medical missions conducted	Proportion of planned Medical missions conducted	NA	50%	60%	70%	MOH
35	Enhanced operational effectiveness	Procurement of Office Equipment and Furniture	141,178	107,100	81,000	Availability of Office Equipment	Proportion of Agencies/MDAs with equipped offices	30%	40%	50%	55%	MOH / O'HIS/ SPHCDB
36		Establishment of community based health and nutrition intervention centres linked to SDGs/MCH facilities	8,000	8,000	8,000	Proportion of SDGs/MCH facilities with community based H&N intervention centres	Proportion of SDGs/ MCH facilities with community based health and nutrition intervention centres	NA	NA	NA	NA	SPHCDB
37		Routine distribution of Net	2000	3000	3000	Increase net ownership	Proportion of Households with at least one LLINs	47%	60%	80%	100%	MOH
38		Celebration of World Malaria Day Activities	2500	3000	3500	Increased awareness	Proportion of the population aware	NA	50%	60%	70%	MOH
39		Annual World TB Day celebration	750	750	750	Increased awareness	Proportion of the population aware	NA	30%	40%	60%	MOH
40	Improved Availability & Functionality of Health Infrastructure	Construction of New Buildings	653,000	629,000	555,000	New Buildings Constructed	Proportion of MDAs with New Buildings constructed	nil	30%	60%	90%	MOH / O'HIS/SPH CDB
41		Establishment of youth friendly centers (Adolescent sexual reproductive health)	10,000	10,000	10,000	Youths, especially adolescent girls have access to RH services	% of centres offering youth friendly services	5	20	30	40	MOH/SPH CDB
42		Establishment of blended complementary food centre	5,000	250	250	Blended Complementary foods plant established and functional	Availability of blended foods from the plant					SPHCDB
43		Consultancy Services-Software Application and Deployment for Health	300,000	300,000	300,000	Improved Data collection	Percentage increase in Enrolment	NIL	15%	20%	30%	O'HIS
44		Internship for Graduate Nurses	10000	10000	10000	Increase human resource for health	Proportion of graduate nurses completing internship	NA	20%	30%	60%	SMOH/H MB
	Total		**4,701,008**	**3,905,730**	**3,726,325**							

3.8 Justification