DELTA STATE
...The Big Heart

Delta State Development Performance

Health Sector Policy Brief, 1991 - 2013

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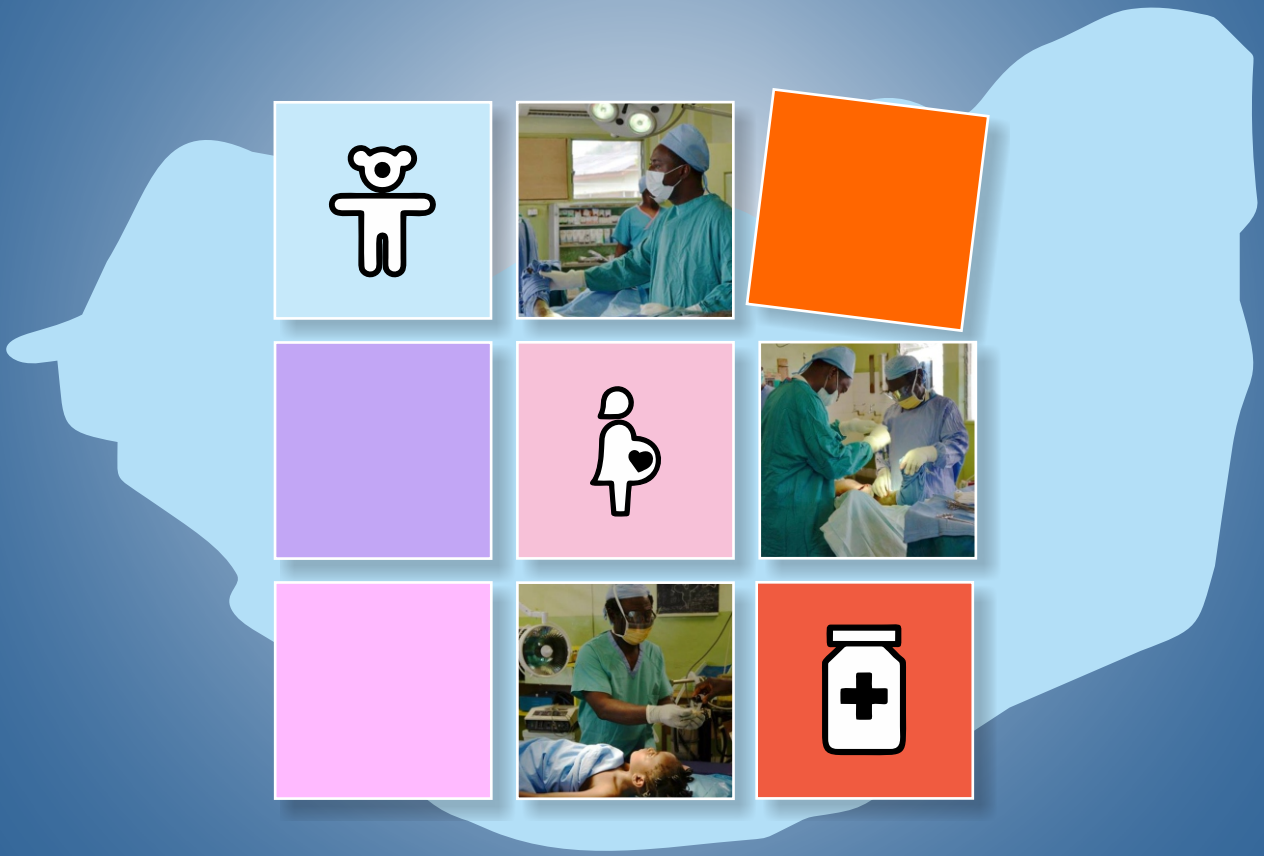

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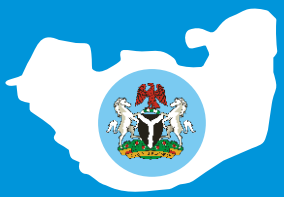

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Delta State

Contents

Foreword

This report, which was prepared by independent consultants with the joint technical assistance of UNDP, UNICEF, WHO and FAO, is the UN's response to the request of the Delta State Government to carry out an assessment of its performance in four key sectors: education, health, agriculture, and water, sanitation and hygeine (WASH).

The analysis of each sector involved a careful examination of the policies and strategies adopted by the government, the governance and regulatory framework put in place, as well as identification of gaps and challenges in performance. It also focuses on sectoral performance using, among other things, the MDG targets and indicators.

The aim of the report is to generate lessons to strengthen the capacity of government for effective stewardship and the development of the State. The policy recommendations presented at the end of each sector appraisal provide the basis for evidence-based policy formulation and implementation, as well as for regulation and legislation which will channel resources towards enhancing the welfare of the people of Delta State. Translating these policy recommendations into action could mean reducing the incidence of disease and providing the people with better access to health care and education. In a nutshell, it means 'human development', which is about people; about expanding their choices to live full creative lives with freedom and dignity. Fundamental to expanding their choices is building human capabilities: the range of things that people can do to attain a long and healthy life, education, a decent standard of living and enjoy political and civil freedoms to participate in the life of one's community.[1]

The report highlights concerted efforts that the state and federal governments, the different communities, civil society organizations, and the private sector have helped to make to expand the opportunities available to people in Delta State. It also points out that while substantial progress has been made in meeting some of the targets, it is still necessary to develop a bolder and focused action plan where significant gaps and disparities exist in order to address the unfinished business of the MDGs and prepare for the Post-2015 Development Agenda.

It is our sincere hope that this report will help the Delta State Government build upon its successes and have a self-reflection of the progress made on the MDGs. These have obvious implications on MDG budgeting,

[1]United Nations Development Programme (UNDP). 2003. Human Development Report 2003 *Millennium Development Goals: A Compact among Nations to End Human Poverty,* p. 28. New York: Oxford University Press.

policy directions, more targeted acceleration initiatives, and localization of targets and indicators. Achievement of the MDG targets in Nigeria and even the post-2015 development agenda depend on appropriate and effective policies and public spending by both national and subnational governments. This is particularly true because the state and local governments are closest to the people in terms of providing basic services.

The United Nations System in Nigeria will continue to partner with both states and the federal government to use the analytical evidence of what works – and what doesn't – in local development to shape policy formulation and adjustment, planning and implementation.

Daouda Toure
United Nations Resident Coordinator &
UNDP Resident Representative in Nigeria

Acknowledgments

This report is the outcome of the technical assistance the United Nations Country Team in Nigeria gave to the Delta State Government towards the assessment of the performance of Delta State in four key sectors of development, namely, agriculture, education, health, and water, sanitation and hygiene. The preparation and completion of the report has therefore been done with the collaborative effort and technical lead of the United Nations Country Team.

The Senior Advisor to the Governor on Foreign Ralations wishes to thank the Governor, His Excellency Dr Emmanuel Eweta Uduaghan, for willingly consenting to the independent assessment of the performance of the state by an external body. His political support and the effective participation of all stakeholders in the state have made the exercise a fruitful and reliable one.

Similarly, the Office of the Governor deeply appreciates all the key stakeholders that made the exercise possible. In particular, the technical backstopping provided by the UNCT Technical Team has been outstanding. The Delta State Government, therefore, wishes to express its special thanks to the United Nations Resident Coordinator in Nigeria, Mr Daouda Toure and the UNDP Nigeria Country Director, Mr. Pa lamin Beyai. The same appreciation is due to Jean Cough, UNICEF Representative in Nigeria; Louise L. Setshwaelo, FAO Representative in Nigeria; and Dr Vaz Rui, WHO Representative in Nigeria. The UNCT Technical Team chaired by Colleen Zamba, UNDP Economic Advisor, had on board Grace Arinze-Ononwu, UNDP Associate; George Igelegbai, UNICEF Education Specialist; Ajibade Olokun, UNICEF WASH Specialist; Precious Agbeso, FAO Asso-ciate Professional Officer, and Ogochukwu Chukwujekwu, WHO Health Economist.

We also would like to extend our appreciation to the expanded UNCT Technical Committee that provided comprehensive comments on the draft report. These included Samuel Momanyi, UNICEF Deputy Representative; Atsuko Toda, IFAD Nigeria Representative; Dennis Jobin, UNICEF Chief Planning, Monitoring & Evaluation and Field Coordinator; Rabe Mani, FAO Assistant Representative – Programme; Kwasi Amankwaah, UN Coordination Specialist; Eva Ahlen, UNICEF Chief of Education; Enrique Delamonica, UNICEF Chief of Social Policy; Paul Okunlola, UN-Habitat National Programme Officer; Oluwafunke Ilesanmi, WHO HIV Officer; Mary Stephen, WHO Programme Officer, NCD; and Adeze Molokwu, IOM Programme Assistant.

We are also grateful to the team of independent consultants recruited by the United Nations Country Team to undertake the assessment. Led by Prof. Mike I. Obadan, the team included the following sector

consultants: Prof Joshua Aisiku (Education); Dr Samuel Eremie (Agriculture); Prof Eric Eboh (Agriculture); Dr Klint Nyamuryekung'e (Health); and Prof Lekan Oyebande (WASH).

The secretariat team consisting of Daniel Iruegbukpe, Michael Uwaechie and Ugo Agbaji collated a myriad of documents from the relevant ministries, departments and agencies of Delta State Government for use by the consultants.

Similarly, we like to thank the Commissioners, Advisers, Permanent Secretaries, Directors and staff of the relevant ministries, departments and agencies of the Delta State Government who participated in the various phases of the study, and provided assistance and helpful clarifications on policies, programmes and projects under their purview.

We are further grateful for the participation of all stakeholders across the state at the sensitization and validation workshops. Their contributions reflected in the various perspectives and enriched the diversity and quality of the report. We appreciate Ambassador Shola J. Omoregie and Ambassador Ejeviome Eloho Otobo who led the dialogue with the headquarters of three of the UN agencies in support of the study, as well as with the UN Country Team in Nigeria and the Delta State Government. They also provided guidance to the secretariat and facilitated the interactions between the secretariat and the team of consultants.

The study benefited greatly from the guidance of Mr. Paul Evuarherhe, the Head of Service, Delta State; Dr. Rukevwe Ugwumba, Special Adviser, Health Monitoring; Mr Tony Obuh, the Permanent Secretary, Government House; and Hon. Oma Djebah, Senior Adviser on Foreign Relations, who provided overall government perspective critical to the assessment. While Sir Paul chaired the Technical Committee comprising the Permanent Secretaries of the Ministries of Health, Water, Education, Agriculture, Environment, and Economic Planning, Mr Obuh, and the entire team of Government House and Protocols gave us unqualified support throughout the exercise.

Finally, the vision and commitment of HE Dr. Emmanuel Uduaghan, the Governor of Delta State, towards improving the living conditions of Deltans was the driving force behind this assessment. His support and readiness to cut through bureaucratic red tape greatly facilitated the work of the consultants in bringing this assessment to fruition. All the contributions are highly appreciated.

Hon. Oma Djebah
Senior Adviser on Foreign Relations, Delta State

Acronyms & Abbreviations

ACT	Artemisinin Combination Therapy
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
ATM	AIDS, Tuberculosis and Malaria
CAFOD	The official Catholic Aid Agency for England and Wales
CBOs	Community-Based Organizations
CCT	Conditional Cash Transfer
CEmOC	Comprehensive Emergency Obstetric Care
CPT	Co-trimoxazole Preventive Therapy
CSOs	Civil Society Organizations
DBS	Dried Blood Spots
DELSUTH	Delta State University Teaching Hospital
DELTASEEDS	Delta State Economic Empowerment and Development Programme
DESOPADEC	Delta State Oil Producing Areas Development Commission
DOTS	Directly Observed Therapy Short Course
DPS	Directorate of Planning and Statistics
DRF	Drug Revolving Fund
EDP	Essential Drugs Project
EID	Early Infant Diagnosis
ELSS	Elongated Life Saving Skills
EmOC	Emergency Obstetric Care
FMC	Federal Medical Centre
FRHS	Free Rural Healthcare Scheme
FU-5HP	Free Under-5 Healthcare Programme
GeneXpert	Nucleic Acid Amplification Technique for Detection of Rifampicin-Resistant TB
HiAP	Health in All Policies
HCT	HIV Counselling and Testing

HIV & AIDS	Human Immunodeficiency virus & Acquired Immunodeficiency Syndrome
HRH	Human Resource for Health
HSRP	Health Sector Reform Programme
IDSR	Integrated Disease Surveillance and Response
IHVN	Institute for Human Virology Nigeria
IMCI	Integrated Management of Childhood Illnesses
IPT	Intermittent Prevention Therapy
IPT	Isonizide Preventive Therapy
ITN	Insecticide Treated Nets
IVM	Integrated Vector Management
LGA	Local Government Authority
LGSC	Local Government Service Commission
LLINs	Long Lasting Insecticide Treated Nets
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDG-CGS	Millennium Development Goals Conditional Grants Scheme
MDGs	Millennium Development Goals
MDR-TB	Multi-drug Resistant Tuberculosis
MICS	Multiple Indicator Cluster Survey
MSS	Midwives Service Scheme
NBS	National Bureau of Statistics
NDHS	National Demographic and Health Survey
NEEDS	National Economic Empowerment and Development Strategy
NGF	Nigeria Governors Forum
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
OSSAP-MDGs	Office of the Senior Special Advisor to the President on MDGs
PCR	Polymerase Chain Reaction

PeTR-GS	Prevention, Education, Training, Treatment & Research – Global Solutions
PHCs	Primary Healthcare Centres
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPM	Private Partnership Mix
PRM	Peer Review Mechanism
Rapid SMS	Rapid Short Message System
RDT	Rapid Diagnostic Test
RHS	Rural Healthcare Scheme
SACA	State Action Committee on HIV & AIDS
SASCP	State AIDS and STI Control Programme
DRS/MOEP	Department of Research and Statistics of the State Ministry of Economic Planning
SHCs	State Healthcare Centres
SHMB	State Health Medical Board
SMEP	State Ministry of Economic Planning
SMoH	State Ministry of Health
SPHCDA	State Primary Health Care Development Agency
SSHDP	State Strategic Health Development Plan
STI	Sexually Transmitted Infections
SURE-P	Subsidy Re-investment and Empowerment Programme
TB	Tuberculosis
THCs	Tertiary Healthcare Centres
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WDC	Ward Development Committee
WHO	World Health Organization
WMHCP	Ward Minimum Healthcare Package

Health Sector Policy Brief

Introduction

This assessment by the United Nations Country Team (UNCT) in Nigeria is a response to the request of Delta State Government to review the performance in education, health, agriculture, water, sanitation and hygiene sectors. The objective of the health sector assessment was to gauge how the sector has contributed to the achievement of the state development goals in general, and the Millennium Development Goals (MDGs) in particular. The assessment commenced on 23 April 2014 by undertaking an extensive documentary review, conducting in-depth discussions with key informants and convening ten stakeholder meetings. Following below is a summary of the health programmes implemented, achievements, challenges, policy recommendations, and a proposal for operationalizing the recommendations.

Key Findings

Achievements

(a) Overall achievements – Generally, Delta State has recorded positive results by implementing health policies and programmes as exemplified by the beneficiaries that were interviewed during the assessment, who expressed satisfaction with the govern-

Fig. 1. : Health Sector Budget Allocations and Disbursements, 2006-2013

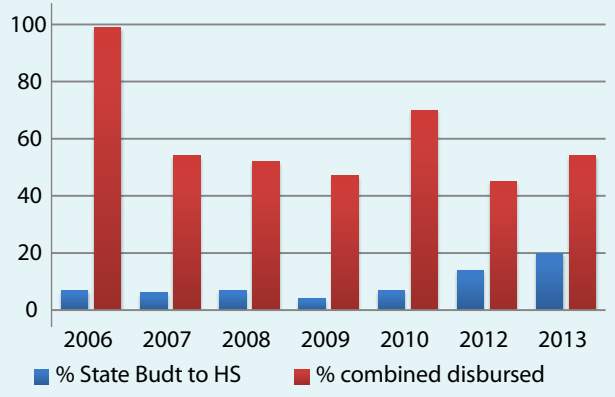
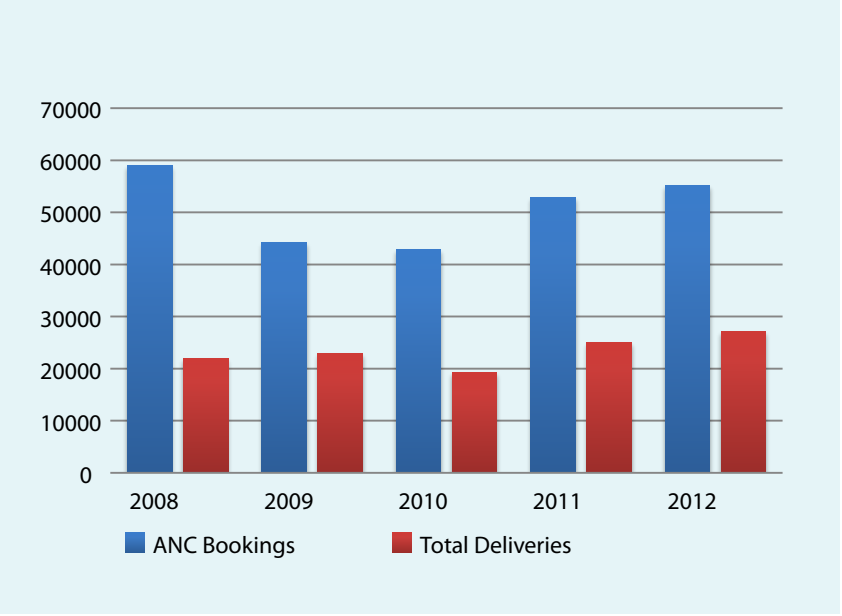


Figure 3. FMHCP - ANC Bookings & Total Deliveries 2008-2012



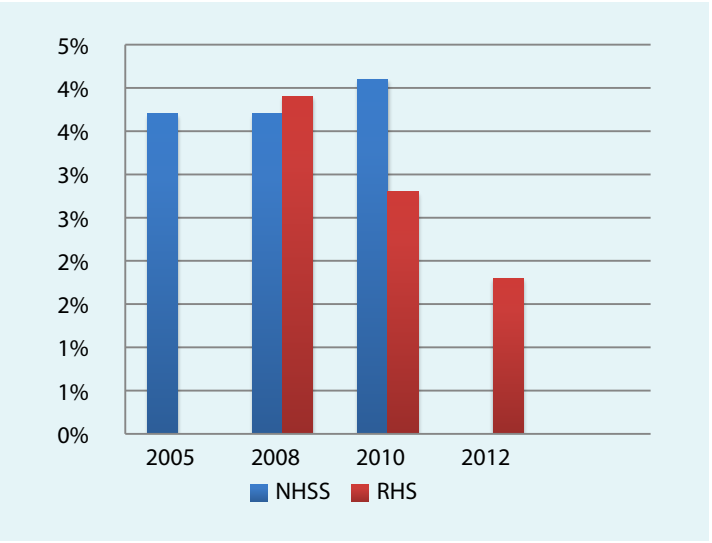
ment health services, a few making suggestions for improvements. Below are some of the achievements:

The sum of N98,547,971,589 was spent on health from 2006 to 2013 by SMOH (N88,857,170,504), DESOPADEC (4,869,238,511) and MDGCGS (N4,816,562,575). The SMOH disbursement constituted 90 per cent, while DESOPADEC and MDG-CGS each constituted 5 per cent of the total expenditure on health for the period 2006-2013.Compared to budget allocation, the disbursements were: SMOH (68 per cent), DESOPADEC (36 per cent) and MDG-CGS (100 per cent). The implication of the low budgetary disbursement to the health sector is that the expected health outcomes would not be achieved.

Maternal Health – Free Maternal Healthcare Programme Results

A total of 254,254 ANC bookings, 116 deliveries, 13,594 C/S were recorded for 2008 – 2012. Antenatal bookings remained constant over the period. The postnatal care visits peaked in 2009 before declining to in 2011 and 2012. Caesarean Section rates increased steadily from 10 per cent in 2008 to 13 per cent in 2012.

Figure 5. HIV Prevalence among Women Comparing NHSS and RHS, 2005-2012

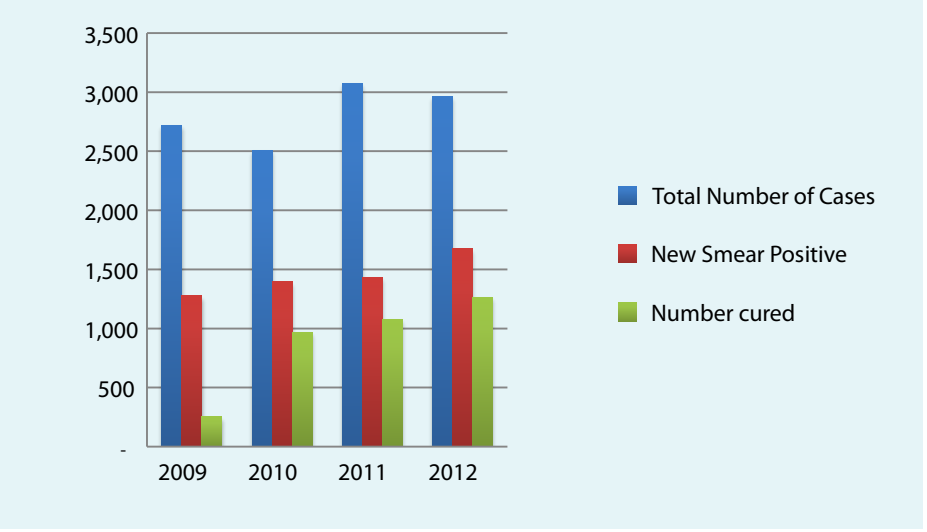


The Under-5 Healthcare Programme (U-5HCP),which is offered in Secondary Health Facilities free to the patients, has recorded an increase in the number of patients over the four-year period. A total of 1,018,270 patients both out-patient and those on admission were registered over the period from 2010-2013. The majority of the patients were attended as out-patients.

The Rural Healthcare Scheme (RHS) was initiated in 2008 and designed to operate as an outreach service to rural communities. A total of 97,678 patients were attended to for the period from 2008 – 2012. The number of communities visited was 443, number of operations conducted was 6,421 including General Surgery (1,444), Obstetric and Gynaecological (360), Ophthalmic (2,562), and Dental (2,055). Some 4,165 children aged 0-11 months were immunized. A total of 44,263 men and women accessed HIV Counselling and Testing services over the five-year period, ranging between 6,811 in 2010 to 10,503 in 2011, depicting a stable number accessing the services over the years. The HIV prevalence recorded was 3.4 per cent (2008), 2.9 per cent (2009), 2.5 per cent (2010), 2.6 per cent (2011), and 2.9 per cent (2012).

The HIV&AIDS programme has made remarkable progress having a total of 637 counselling and testing centres, providing services to 104,800 patients in 2013 alone. Prevention of Mother- to-Child Transmission of HIV services were scaled up between 2013

Figure 6. TB Programme Performance, 2009-2012



and Mid-2014. In 2013, a total of 47,015 pregnant women were counselled, tested and given their results, which is a coverage of about 23 per cent. Antiretroviral therapy (ART) services were offered in a total of 94 sites throughout the state. By December 2013 a total of 14,236 patients were on ART which translates to a coverage of about 25 per cent.

The Malaria Control programme's achievements include distributing Long Lasting Insecticide Nets (LLINs) such that 65 per cent of households had at least one, 47 percent persons of all ages had access to ITN, while 43 per cent of children under-5 slept under ITN the night prior to survey that was conducted in 2013. The same survey also revealed that 34 per cent of the children under five with fever got tested and received Artemisinin Combination Therapy (ACT) within 24 hours.

Progress made towards achieving the MDGs – This was assessed according to the agreed indicators as follows:

Infant mortality rate increased from 48/1,000 live births (2003) to 68/1,000 live births (2006), declined to 32.3/1,000 live births (2011) and rising slightly to 37/1,000 live births in 2012. The national 1990 baseline value and 2015 target are 91/1,000 live births and 30.6/1,000 live births respectively.

Under-5 mortality rates were 102 per 1,000 live births (2003), 54.4 per 1,000 live births (2006), 108 per 1,000 live births (2011),

Figure 5. IMR/1,000LB Trends, 2006-2012

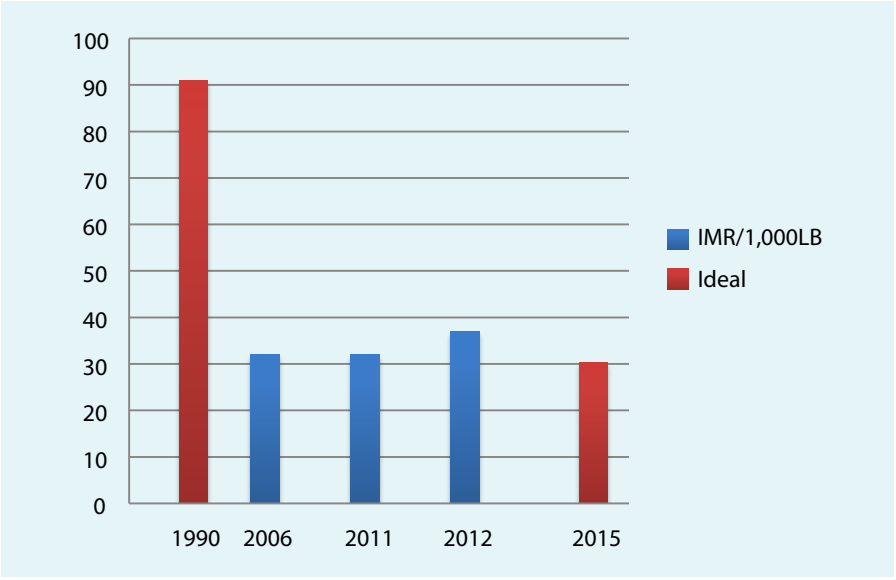


Figure 6: U-5 Mortality Rate/1,00LB Trends

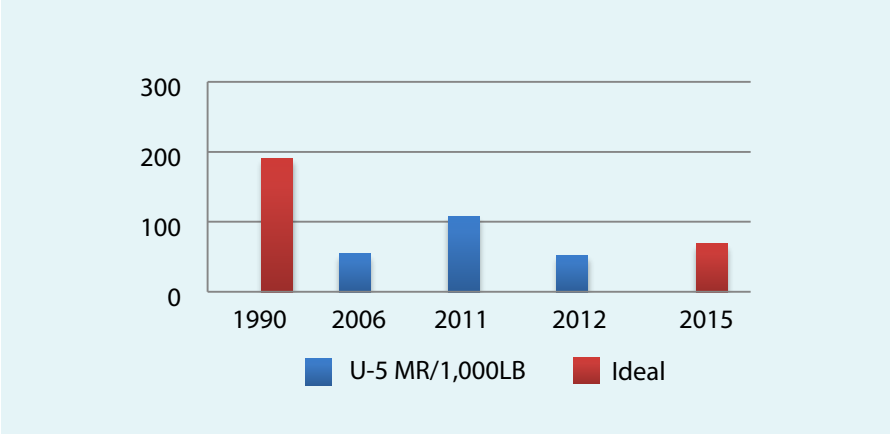
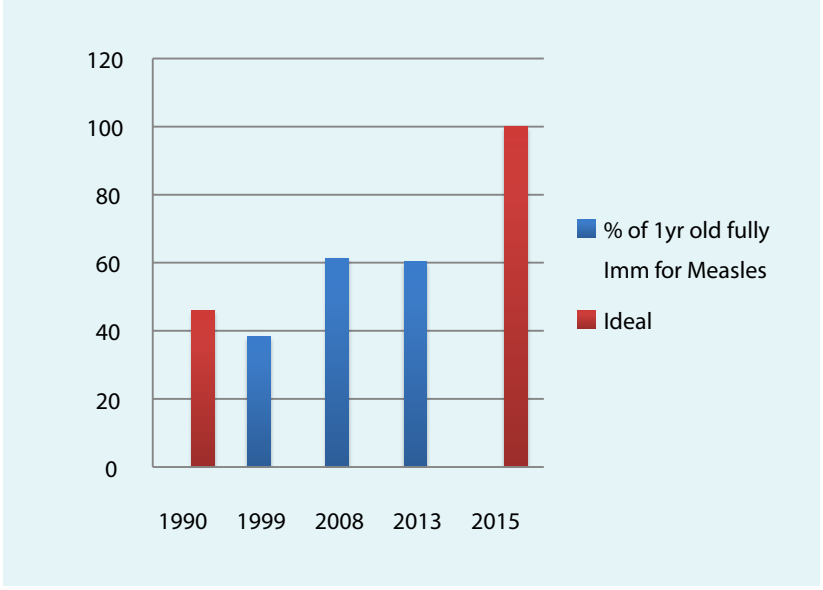


Figure 7: Percentage of One-Year-Olds Fully Immunized Against Measles



declining to 52/1,000 live births (2012). The national 1990 baseline value and 2015 target are 191/1,000 live births and 63.7/1,000 live births, respectively.

The percentage of one-year-olds fully immunized against measles was 38.5 per cent, 61.3 per cent, 57.6 per cent and 60.4 per cent in 1999, 2008, 2012 and 2013, respectively. The national 1990 baseline value and 2015 target are 46 per cent and 100 per cent, respectively.

According to the data provided by the SMOH, maternal mortality rate has progressively declined in the last ten years; from 456 per 100,000 live births in 2005 to 188 per 100,000 live births in 2013, indicating that the 2015 target of 250 per 100,000 live births has already been achieved.

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The proportion of births attended by skilled birth attendants was 49.1 per cent, 61.5 per cent 73.2 per cent, and 59.8 per cent in 1999, 2008, 2012 and 2013, respectively. The national 1990 baseline value and 2015 target are 45 per cent and 100 per cent, respectively.

Contraceptive prevalence rates were 18.7 per cent, 26.6 per cent, 16 per cent and 28.7 per cent in 1999, 2008, 2012 and 2013, respectively.

Antenatal care coverage of four or more visits was 74.6 per cent and 72.5 per cent in 2012 and 2013, respectively.

HIV prevalence among pregnant women aged 15-24 years was 2.8 per cent, 2.3 per cent, 2.8 per cent, and 2.3 per cent in 2009, 2010, 2011 and 2012, showing a stabilization in the rate at which new HIV infections are being acquired.

As derived from the new sputum positive cases, the TB prevalence values were: 33/100,000 in 2009, 33/100,000 in 2010, 28/100,000 in 2011 and 29/100,000 in 2012. Indicators 4.1- Infant mortality rate will likely be achieved by 2015, while the target for indicator 4.2 Under-5 mortality rate, and indicator 5.1 maternal mortality rate, may already have been achieved.

Targets for indicators 4.3: Percentage of one-year-olds fully immunized against measles, 5.2: Proportion of births attended by skilled birth attendants; 5.3: contraceptive prevalence rate; 5.5: antenatal care coverage of four or more visits; 6.1: prevalence of HIV among pregnant women aged 15-24 years are all levelling down or showing slow improvement over time. More concerted and targeted effort will be required to begin to register positive trends.

For the rest of the targets, there is no adequate data to enable trend analysis and drawing of any conclusions.

Challenges

The major challenges militating against the timely achievement of health outcomes in Delta State are:

- The weak health system characterized by inadequate numbers and mal-distribution of the health workforce, inadequate equipment and weak system for their repair and maintenance, inadequate health financing, a dysfunctional referral system for patients from the PHC facilities to the secondary and tertiary facilities, inadequate logistics for conducting regular supervision and a dearth of reliable, timely and accurate information for planning, monitoring and evaluating health programmes.
- The socio-cultural practices that negatively influence health seeking behaviour, contribute to the low utilization of reproductive and maternal health services by women, especially in the PHC facilities.
- The social stigma related to HIV&AIDS that is forcing people living with HIV&-AIDS from disclosing their sero-status and preventing people from seeking HIV&-AIDS services;
- Inadequate community involvement and participation without which health service ownership and sustainability become uncertain;
- Inadequate collaboration between the government and the private healthcare providers.

- Poverty, ignorance, peace and security issues, gender, food security, nutrition, and the environment all contribute to poor health.

Observations and Policy Recommendations

The observations and recommendations are as follows:

1. The assessment has revealed that patients are bypassing the Primary Health Care (PHC) facilities because of cost and perception of quality, to seek maternal and child health services in Secondary Facilities, thereby overstretching their capacities. It is recommended that the State Ministry of Health, the State Ministry of Local Government Authority and Local Government Chairmen should collaboratively explore modalities for providing free Reproductive, Maternal and Child Health services in all PHCs.
2. The Rural Healthcare Scheme (RHS) is delivered largely as an isolated outreach service to the communities with weak linkages with the surrounding health facilities. As a result, there is no continuity of these services to the target communities between the RHS visits. It is recommended, therefore, that the delivery of the Rural Healthcare Scheme should be redesigned. For accessible communities, the services under the scheme should be delivered in designated static health facilities where regular outreach services could serve as practical, on-the-job training for health workers in these facilities. Inaccessible riverine communities should benefit from the services under the Scheme using appropriate transport and service delivery methods to reach them.
3. Delta State has done well in investing in health improvement and evidence points to the reduction of the infant and Under-5 mortality rates. Data on maternal mortality rate from the different sources show disparity, although the SMOH service data show a steady decline. It is recommended that the State Health Medical Board (SHMB), the State Primary Health Care Development Agency (SPHCDA) and the Local Government Authority (LGA) Health Departments should expand the Midwives Service Scheme (MSS) to cover all the LGAs.
4. Diagnostic capacities for HIV&AIDS and Multi-drug Resistant TB are very inadequate in Delta State. It is recommended that the SMOH should conduct an assessment of selected secondary health facilities with a view to strengthening their laboratories, including the establishment of Polymerase Chain Reaction (PCR) and GeneXpert testing capacity.
5. It has been revealed that the health manpower is inadequate to deliver the needed services while maintaining their quality. Additionally, staff motivation is affected negatively by the irregular and delayed payment of sala-

ries for PHC based and LGA staff, security concerns in some PHC facilities, and inadequate work tools and overwork. It is recommended that the SMOH should collaborate with the State Local Government Authority to develop, cost and implement a Human Resource for Health (HRH) Plan; the embargo on staff employment should be waved to allow for filling of the staff gaps based on a workload analysis in the PHCs and Secondary Health Facilities.

6. Except for immunization, TB, malaria and HIV services, other health services are provided through payment of user fees by the patient in the PHC facility. It is recommended that the SMOH should establish a mechanism that provides financial protection for all its citizenry, especially the poor, by replacing all out-of-pocket payments for health services by a pre-payment me-chanism.
7. The proportion of the State budget that is allocated to health over the years has been far below the prescribed 15 per cent of the total budget while the proportion of approved health budget that is ultimately released has been low. It is recommended that Delta State should maintain its budgetary allocation to the health sector above the 15 per cent target and increase the disbursement rate of the approved health budget.
8. In addition to SMOH, the Directorate of MDGs, the Local Government Commission, the Delta State Oil Producing Areas Development Commission (DESOPADEC), International Agencies, and individuals are financing health services in Delta State. It becomes very difficult for the SMOH to determine the total health expenditure. It is recommended that Delta State should seek the support of the UN to institutionalize a State Health Account.
9. The State Drug Revolving Fund (DRF) is functioning well in ensuring the distribution of affordable, efficacious and high quality medicines and health supplies; however, most of the PHC facilities are not patronizing the DRF for reasons that were not well clarified. There is little or no assurance of the safety and quality of the medicines that are purchased from elsewhere. It is recommended that the SMOH should quickly prepare to adapt the new National Drug Distribution System in order to ensure the safety and effectiveness of the medicines delivered by all health facilities including PHC Centres and private-owned facilities.
10. There is a dearth of data to monitor and evaluate health programmes' outcomes and impact, except for the Household and Housing Surveys (HHS) conducted by the Department of Research and Statistics of MOEP. It is recommended that the Delta State Government should embark on strengthening the Department of

Research and Statistics (SMEP), the Population Commission and the Department of Planning and Statistics (DPS) of the SMOH to collaborate in conducting household and other population surveys; The RapidSMS technology applied by the Population Commission in reporting of child births be expanded to include child and maternal deaths; this will generate the needed Vital Statistics as well as enable timely responses to the causes of maternal child mortality.

11. The SMOH, using nationally developed guidelines, undertook a highly participatory exercise to develop the SSHDP 2010-2015. The expected Annual Operational Plans (AOPs) were not consistently developed except in the first year. The health budget is not linked to the SSHDP Priority Areas; consequently, the SSHDP has not been systematically implemented. It is recommended that the SMOH should institute a Monitoring and Evaluation Team to organize a participatory review of the SSHDP performance and generate lessons that will inform the development of the next plan, beyond 2015.
12. There are 281 out of 725 (39 per cent) Primary and 182 out of 244 (75 per cent) Secondary Health Facilities belonging to the Private Sector. However, except for the Programme on Immunization, the SMOH has not adequately engaged the private health service providers in expanding service delivery access. It is recommended that the SMOH should formalize arrangements for collaboration with Private Health Service Providers by signing of memoranda for health service delivery.
13. The HIV&AIDS, TB and Malaria Programmes are enjoying substantial donor support to implement activities including provision of medicines, supplies, and reagents. There is very little funding from donors for operations. It is recommended that the SMOH should create a budget line for each programme and gradually increase its budgetary allocation in order to alleviate the inadequate funding for operations and to ensure sustainability of these important programmes.

Operationalizing the Recommendations

In order to move forward in implementing the above recommendations, it is recommended that the SMOH with technical support of the UN should organize a workshop lasting three days. The participants of the workshop should include: (i) Representatives from the key State Ministries and Departments, (ii) LGA Chairmen, (iv) Civil Society Organizations (NGOs, CBOs, Professional Associations), (v) Organized Private Sector, (vi) Federal Ministry of Health, (vii) NPHCDA, and (viii) Development Partners. The proposed objectives of the workshop are: (i) To present

and discuss the findings and policy recommendations contained in this report; (ii) Develop a road-map with a timeframe, budget, responsible and collaborating technical partners responsible for implementing each recommendation; (iii) Discuss and agree on how the required funding for implementing the recommendations will be mobilized; (iv) Agree on a Monitoring and Evaluation Framework with Indicators to track progress in the implementation of the recommendations; and (v) Appoint a team that will be responsible for monitoring the implementation progress, and the modalities for involving all the stakeholders.

Conclusion

1. The SSHDP 2010-2015 has not been systematically implemented. The implication of this is that when its lifespan expires in 2015, there will be patchy lessons learnt to inform the development of a subsequent State Strategic Plan. The full implementation of the SSHDP was expected to have strengthened the health system and Primary Health Care.
2. There is a serious shortage of the Human Resource for Health (HRH) in Delta State. Due to the importance of HRH, all the other inputs into the health system will only have limited effectiveness without addressing it.
3. Health financing is another important health system's building block. The proportion of state budget allocated to the health sector remains far below the target set in the Abuja Declaration of 2001 and the disbursement rate is still inadequate and needs to increase.
4. Partnerships, including intersectoral collaboration and Public/Private Partnership have not been adequately exploited for better achievement of health outcomes.
5. There is an abundance of service delivery data, which is mostly in the output domain. This data is quite useful especially for service quality improvement. For programme performance tracking, however, outcome and impact data are also needed. The lack of such data specifically for Delta State has posed a constraint in assessing the impact of the investments made over the period, and hampers the determination of progress made towards achieving the MDGs