BAUCHI STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Bauchi State Ministry of Health

March 2010

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List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Care
AOP	Annual Operational Plan
ARV	Anti-Retrovirals
ATBU	Abubakar Tafawa Balewa University
ATBUTH	Abubakar Tafawa Balewa University Teaching Hospital
BACATMA	Bauchi State Agency for the Control of AIDS, TB & Malaria
BASEEDS	Bauchi State Economic Empowerment & Development Strategy
BASICS	Basic Support for Institutionalizing Child Survival
BASSHDP	Bauchi State Strategic Health Development Plan
BEOC	Basic Emergency Obstetric Care
BMS	Breast Milk Substitute
CBO	Community Based Organization
CDAs	Community Development Associations
CEDPA	Center for Development & Population Activities
CEOC	Comprehensive Emergency & Obstetric Care
COMPASS	Community Participation for Action in Social Sector
CONTISS	Consolidated Tertiary Institutions Salary Structure
CIET	Community Information for Empowerment and Transparency
CIDA	Canadian International Development Agency
DOTS	Direct Observe Therapy Short course
DPHC/DC	Department of Primary Health Care and Disease Control
DRF	Drug Revolving Fund
EU-PRIME	European Union- Promoting Routine Immunization
FAO	Food and Agriculture Organization
FHI	Family Health International
FGN	Federal Government of Nigeria
FP	Family Planning
FMOH	Federal Ministry of Health
GHAIN	Global HIV/AIDS Initiative Nigeria
HATISS	Harmonized Tertiary Institution Salary Structure
HIV	Human Immuno-deficiency Virus

HMB	Health Management Board
HMIS	Health Management Information System
HRH	Human Resources for Health
HSDP	Health System Development Project
IDRC	International Development Research Centre
IMR	Infant Mortality Rate
IMCI	Integrated Management of Childhood Illness
ITN	Insecticide Treated Net
LGA	Local Government Authority
LLIN	Long Lasting Insecticide Net
MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MMR	Maternal Mortality Rate
MSS	Multi-Stakeholder System for Information and Planning
MTCT	Mother To Child Transmission
M&E	Monitoring and Evaluation
NDHS	National Demographic & Health Survey
NEHSI	Nigerian Evidence-based Health System initiative
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
NPopC	National Population Commission
NSHDP	National Strategic Health Development Plan
OI	Opportunistic Infection
OOP	Out-Of-Pocket
OPV	Oral Polio Vaccine
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PITC	Provider-Initiated Testing & Counseling
PLWH	People Living With HIV
PMTCT	Prevention of Mother To Child Transmission
PPFN	Planned Parenthood Federation of Nigeria
PPP	Public Private Partnership
PRS	Planning Research and Statistics
RH	Reproductive Health
RI	Routine Immunization

SCD	Sickle Cell Disease
SFH	Society for Family Health
SHS	School Health Services
SMOH	State Ministry of Health
SOP	Standard Operating Procedure
SPHCDA	State Primary Health Care Development Agency
SSHDP	State Strategic Health Development Plan
STI	Sexually Transmitted Infections
TAG	Technical Advisory Group
TB	Tuberculosis
TFR	Total Fertility Rate
TSHIP	Targeted States High Impact Project
U5	Under-5
U5MR	Under-5 Mortality Rate
UNICEF	United Nations Children Funds
USAID	United States Agency for International Development
WB	World Bank
WHCMP	Ward Health Care Minimum Package
WHO	World Health Organization

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Foreword

This document is the collective effort of several persons representing a cross section of stakeholders in the state with common interest in promoting the health status of our people. This collective interest was initially expressed by the government health reform agenda, the purpose of which is to reposition the public/private sectors to be more responsible and responsive to the health needs of the citizens.

I am therefore, particularly pleased that a committee was able to articulate this State Strategic Health Development Plan to address the deficiencies identified in the health system and provide a planned approach to its implementation.

It is therefore my believe that this document will motivate all LGAs in the state to develop their specific minimum health care package in line with the local government priorities and resources as a strategy to ensure accelerated health development in their areas.

This in effect is the foundation of the health reform for which we have dedicated ourselves for the benefit of our long suffering populace.

I recommend this document to all the Local Government Areas, all health workers, and the general public and appeal to all institutions and agencies –public or private, national or international to cooperate with the State Government to give full support to the plan and programs collectively so that the goals and objectives of the health sector reform will be realized.

Mallam Isa Yuguda
(Matawallen Bauchi)
Executive Governor, Bauchi State

Executive Summary

Over the years, the health system in Bauchi state has gone through series of constructive transformation with attendant positive impact on the quality of health services. There has been improved performance of the healthcare system in last decade. Various sectors of health services have been upgraded to a level that will enable effective, efficient and equitable delivery of services. International donor collaboration and support towards improved services through collaboration and partnership is worthy of note.

Bauchi State Strategic Health Development Plan (BSSHDP) (2010-2015) intends to reverse the trend of some of the health and development indices of the people of the state. The plan was developed based on the generic framework provided by the national, as a guide to support evidence-based priority interventions that would contribute to achieving the desired targets.

The vision of BASSHDP is to reduce morbidity and mortality due to communicable and non-communicable diseases to the barest minimum; meeting global targets and significantly increasing life expectancy and quality of life of the citizens of Bauchi state. Towards achieving the goals of BASSHDP, a number strategic intervention and activities have been laid out in the implementation framework. These include strengthening leadership and governance, improving health service delivery, provision of skilled and appropriate human resources for health, Health Management Information Systems (HMIS), ensure community involvement in health matters, partnerships, M & E and research.

The end product of this intensive venture is a costed plan developed through participatory approaches that reflect the context and prevailing situations in the state. It is the desire of Bauchi state government that the Health Development Plan 2010- 2015 will serve as the

basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment and mutual accountability among all stakeholders within the health sector.

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

Vision

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

Mission

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

BASSHDP will contribute to the achievement of the overarching goal of the NSHDP to significantly improve the health status of citizens of Bauchi state through the development of a strengthened and sustainable health care delivery system[1].

Targets

Towards the implementation of BASSHDP, the following targets have been set towards performance measurement and re-strategizing the operationalization of this plan. The set targets are:

- *Increase state Immunization Coverage among children aged 0-5 years by 2015;*
- *Reduce Infant Mortality Rate (IMR) from 79/1000 to 35/1000 by 2015;*
- *Reduce U5 Mortality Rate (U5MR) from 104/1000 to 45/1000 by 2015;*
- *Reduce by 30%, Mother-To-Child Transmission (MTCT) of HIV by 2015;*
- *Reduce by 40% the percentage of children 0 – 59 months with diarrhea by 2015;*
- *Reduce incidence of malaria from 11,534/100,000 to 7500/100,000 by 2015;*
- *Reduce level of maternal mortality from 1380/100,000 live births to 450/100,000 live births by 2015;*

[1] NSHDP framework 2009 - 2015

- *Increase by 50% facilities providing BEOC by 2015.*

Chapter 1: Background & Achievements

1.1 Background

Bauchi State was created on the 3rd of February, 1976 out of the defunct North-East region by Late Murtala Ramat Muhammad. It is one of the states in the North – East geo-political zone of Nigeria. The state is bordered to the north by Jigawa, east by Gombe and Yobe states, to the west by Kaduna state and to the South by Plateau and Taraba states.

Bauchi state has a land area of 49,259 Sq Kilometers with a total population of 4,653,066 inhabitants consisting of 2,369,266 males and 2,283,800 females[2]. Bauchi state has twenty LGAs comprising Alkaleri, Bauchi, Bogoro, Dambam, Darazo, Dass, Gamawa, Giade, Ganjuwa, Jama'are, Itas-Gadau, Katagun, Kirfi, Misau, Ningi, Shira , Tafawa Balewa, Toro, Wraji and Zaki[3]. The state has six emirate councils headed by first class Emirs. These are Bauchi, Katagum, Misau, Jama'are, Ningi and Dass. The state is multi-ethnic and multi-religious. The two predominant religions are Islam and Christianity. The major languages spoken in the state are Hausa, Bole and Fulfulde. However, there are over 60 other languages spoken as first languages in all the LGAs. English language is the official language for communication. The predominant pre-occupation of the citizens is subsistence farming.

Bauchi state is among the states with low health indicators, especially for disease conditions targeted for reduction by 2015 under Millennium Development Goals (MDG). More needs to be done in order to achieve set targets under the MDG targets 4, 5 and 6 that deals

Millennium Development Goals.

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equity and empower women
- Reduce Infant mortality
- Improve Maternal health
- Combat HIV/AIDS, malaria and other diseases.
- Ensure environmental sustainability
- Develop global partnership for development

[2] NPopC 2006

[3] www.bauchistategov.org

with child mortality, maternal health and HIV/AIDS, malaria and other diseases. This global initiative to achieve the set targets has added more incentives to the state with the view to strengthening health systems in Bauchi state. The MDGs places emphasis on public health in recognition that improvement in this sector is vital not only in its own right, but also to break the poverty trap of the poor communities[4]

The health system in Bauchi State is based on the National Health Policy which was developed by the FMOH in 1988. This policy recognizes the central role of Primary Health Care as the connerstone for the implementation of health services in all states of the federation[5]. Bauchi state government has undertaken series of steps aimed at reforming the state health system and strengthening its strategic approaches. This reforms also relates to Bauchi State Economic Empowerment and Development Strategies(BASEEDS) which ultimately is aimed at poverty reduction and wealth creation for the entire citizenry of the state[6].

The state has 28 PHC Centers, 1 Comprehensive Health Clinic, 80 Health Clinics, 212 MCH Clinics, 636 Dispensaries, 45 Health Posts and 74 Registered Private Clinics[7].

1.2. Achievements

Over the years, the health system in Bauchi state has gone through series of constructive transformation with attendant positive impact on the quality of health services. There has been improved performance of the healthcare system in last decade. Various sectors of health services have been upgraded to a level that will enable effective, efficient and equitable delivery of services. International donor collaboration and support towards improved services through collaboration and partnership is worthy of note. These include

[4] www.who.int/bulletin/contributors/...
[5] National Health Policy 1988.
[6] Bauchi SEEDS document
[7] BACATMA Annual Report 2009

agencies such as WHO, UNICEF, USAID funded TSHIP, CIET, Immunization BASICS & COMPASS, EU-PRIME, PPFN, CEDPA, SFH, WB and a host of others.

In the last ten years, Bauchi state government has adopted a number of far reaching measures from which considerable achievements were made. These achievements include

- **De-Centralization of the State Ministry of Health**: For greater efficiency and effectiveness, four agencies were carved out of the SMOH. These are Hospitals Management Board (HMB), State Primary Health Care Development Agency (SPHCDA) Bauchi State Agency for the Control of HIV/AIDS, TB and Malaria (BACATMA) and the State Chapter of the National Health Insurance Scheme (NHIS). Laws establishing these agencies have been passed by the state House of Assembly and are today legal institutions.
- **Prioritization of Health as Development Agenda:** In the last ten years, government has adopted health as a priority development agenda and has matched it with adequate budgetary provision. From 2006 to date, budgetary allocation for heath constitutes more than 10% of the state annual budget. In addition, most of these allocations are matched with concomitant release to the MDAs. This strategy has enabled the state improve healthcare service delivery with the view to attaining, to some degree, the Millennium Development Goals (MDGs) of reducing infant and maternal morbidity and mortality; combating HIV/AIDS and malaria and other diseases.
- **Improved Health Care Service Delivery at Health facilities**: Government has also taken measures to improve service delivery at health facilities through the followings:-
  - Provision of at least one new water supply scheme in every General Hospital in the State including the newly established Teaching Hospital.
  - Provision of at least one new standby Generator as alternative power source, to every General Hospital in the State and a dedicated transformer from public power supply.

- Regular supply, without interruption of Diesel to all the General Hospitals to power the generators.
- Most importantly, as a direct intervention by the state government to reduce infant under five and maternal mortality and morbidity, free maternal care and nutritional services are provided for pregnant women and under-5 children. Under the scheme, consultation, drugs, minor surgery, delivery packs are given to expectant mothers; and all children less than 5 years are provided free medical services. In addition, nutritious food supplements are also provided to malnourished expectant mothers and children less than five years.
- In addition, Government has also approved free medicare to Sickle Cell Diseases (SCD) patients in the state.
- Procured basic medical equipment worth billions of Naira and distributed same to all hospitals and PHCs across the state.
- Recruited over 2,500 different cadre of health workers in the last three years to strengthen human resources for health in the state. Some of these new recruits were posted to PHC at the LGAs. This also includes thirty foreign medical doctors recruited from Egypt.
- Improved the remuneration of all Health workers through the implementation of HATISS IV salary structure and CONTIS for Health Training Institutions.
- Improved the efficiency of the state Drugs Revolving Fund (DRF) scheme through Public-Private Partnership (PPP) with Neimeth Pharmaceutical Company.
- Established Renal Dialysis Centre at the State Specialist/Teaching Hospital to cater for clients with Kidney problems and related complication. The center has since been commissioned and fully operational. The Dialysis center is the biggest so far in the North-East geo-political zone.
- Provided 13 shuttle buses to ease staff movement to and from hospitals in the state.

- Procured 56 state-of-the-art Ambulances which have been distributed to all secondary health facilities and Teaching Hospital in the state.
- In 2009, Bauchi state government expanded and expended its efforts on immunization programme particularly on Polio eradication. This is in addition to supports received from other organizations such as WHO, UNICEF, COMPASS, Immunization BASICS, EU-Prime and NPHCDA. To improve community outreach services, 170 motorcycles were purchased and distributed to all the 20 LGAs in the state to support routine immunization. The result of this collaborative effort was the recording of only a single of case of Wild Polio Virus 3 (WPV3) as at December, 2009.
- The School Health Services (SHS) programme has also been revived in the state. All boarding and day secondary schools and some selected primary schools are provided with basic health services such as environmental sanitation, personal hygiene screening and treatment of common ailments peculiar to the children. Drug and medical devices were distributed to all the schools on termly basis.
- Bauchi state government provides free Anti-retroviral (ARV) drugs to all PLWHs enrolled into the treatment programme. In addition, free drugs are provided for the treatment of Opportunistic Infections (OI) for HIV positive patients in all designated secondary and primary health facilities. Aside all these, Breast Milk Substitute (BMS) are given to mothers who opt in for this option. Mothers are offered infant feeding counseling and opportunity to choose the best option suitable for them. PMTCT services are offered in all secondary and selected PHC centers across the state.
- Over 240,000 Long Lasting Insecticide Nets (LLINs) were been distributed across all the LGAs in the state in 2009. Another batch of 1.8 million LLINs are expected to be distributed in the first quarter of 2010.

❖ **Health Infrastructure Development**

- Renovation and upgrading of General Hospitals at T/Balewa, Dambam and Bogoro have been completed and commissioned.
- Four new 110 capacity General Hospitals at Ningi, Azare, Giade and Jama'are have been commissioned.
- Construction of two new additional General Hospitals at Kafin Madaki and Katagum. Work at these two new sites has reached advanced stages. Level of completion is over 85%.
- Renovation of over 60 staff quarters in all the General Hospitals across the state.
- Renovation of Bursali, Boi and Rishi PHC centers as well as Tashan Babiye Comprehensive Health Centre, and Urban Maternity center in Bauchi.
- Renovation of eight additional PHC facilities at Tsangaya (Ningi LGA), Urban Maternity Azare (Katagum LGA), Soro (Ganjuwa LGA) Chinade (Katagum LGA), Hardawa (Misau LGA), Disina (Shira LGA), Dogon Jeji (Jama'are LGA), Futuk (Alkaleri LGA), Guyaba (Kirfi LGA) are also on-going.

❖ **Health Training Institutions**:

- A new school of Health Technology was commissioned in 2008 at Ningi. The objective of this new health institution is to develop a pool of health personnel that would augment the current level of the health work force in the state.
- The state government has also sponsored 43 students (23Females and 20 Males) who are indigenes of the state to undergo studies in Medicine & Surgery in Egypt.
- Approvals have also been obtained from relevant national authorities for the commencement of graduate training in medical sciences at ATBU and the conversion of the Specialist Hospital to a full fledge Teaching Hospital.

Chapter 2: Situation Analysis

The population of the Bauchi state based on the 2006 population census was put at 4,653,066. At population growth rate of 3.4% per annum, it is estimated that by 2010, the total population of the state would have risen to 5,318,893 people. Between 2006 and 2010, the entire population of the state would have increased by 14.0%. An important feature of the population distribution is the almost equal distribution of males and females, at 51.89% and 48.12% respectively.

The population is predominantly young (0-19 yrs) making up to 55.4%. About 7% is 65 years or older. The proportion of the population in each age group declines as age increases; the lowest age group (0-5) has the largest proportion of the population (23%) while the highest age group (75 – 80 years) has the smallest proportion (less than 1 percent)[8]. This scenario is typical of states with high fertility rate. 80% of the entire population in Bauchi state lives in the rural areas while only 16% reside in urban centers[9].

In line with the national health policy[10] of the federal government, Bauchi state regards primary health care as the focal point to achieving improved health for the population. Primary Health Care (PHC) services include health education; adequate nutrition; safe water and sanitation; Reproductive Health(RH) including Family Planning(FP); immunization against the five major infectious diseases; provision of essential drugs; and disease control. It is the mandate of the SPHCDA that every comprehensive health care system should include Maternal and Child Health (MCH) as part of its services.

[8] NDHS 2008
[9] NPopC 2006
[10] Revised National Health Policy 2004

Challenges at the PHC: The major challenges in the implementation of the Ward Minimum Package of Care at the PHC levels include:

- Negative attitude of health care providers.
- General poverty at household and community level.
- Prevalence of high risky behaviors and poor health-seeking behavior due in part to ignorance about causes and consequences of ill-health.
- Acute shortage of health personnel.
- Weak referral system.
- Weak infrastructure.
- Inequity in the distribution of available resources
- Poorly regulated service providers.
- Weak data management system.

Secondary level of Care: Secondary level of care is implemented within the framework of the State Minimum Package of Care which includes provision of services, promotion, prevention and rehabilitation of secondary health facilities. The selection and inclusion of interventions in the state's minimum package of care are based on the following guiding principles: consistency with the state health policy, the state epidemiological profile, equity, and the principle of the continuum of care which takes into account the human life cycle from pre-pregnancy, pregnancy, through birth, infancy and older childhood. Health system is also viewed as critical component of the continuum of care which includes both the home and community.

The ward and state minimum packages are delivered in 3 identified service areas that would create the desired high impacts. These service areas are as follows: -

1. Family and Community Oriented Services;

The interventions within this mode are: Exclusive breastfeeding among children 0-6 months, continued Breastfeeding for children 6-11 months, adequate and safe complementary feeding, supplementary feeding for malnourished children, Oral

Rehydration Therapy (ORT) and Zinc supplementation for diarrhea management, Vitamin A - Treatment for measles, follow up management of Severe Acute Malnutrition etc.

2. Population Oriented Outreaches/Schedulable Services; The interventions within this model of services are - Family Planning, HIV prevention, Ante-natal care, Home based care, Immunization
3. Individual Oriented Clinical Services - Basic Emergency Obstetrics Care (BEOC), Comprehensive Emergency Obstetrics Care (CEOC), strengthening referral services

Staffing: Adequate number, right mix and quality of staff.

2.1 Socio-Economic Context

Bauchi State is among the states where over 80% of its population lives below poverty line of less than $1 a day. 85% of the population are rural with low literacy level and more than 65% classified as very poor[11]. Many economic factors such as underdevelopment, decline in the standards of living, poverty and the general rate of inflation impact upon the health sector. The core economic factors that affect health care delivery in the state include:

a. Level of funding of the health sector particularly at the PHCs.
b. Low availability and distribution of Human Resources for Health (HRH).
c. Low private sector participation in health.
d. Poverty and corruption
e. Income inequality among the population.
f. Total dependency on government to provide all health needs for the entire citizenry.

[11] UNDP Human Development Report 2005

2.2 Health Status

According to a Directory of Health facilities in Bauchi state, recent compiled by BASPHCDA in collaboration with CIET[12], there are 1,002 primary health care facilities at the Local Government (LGA) level, which include basic health centres, comprehensive health centres, maternity centres and dispensaries. The state has 22 secondary health-care facilities and of recent a tertiary health facility – Abubakar Tafawa Balewa University Teaching Hospital (ATBUTH). A Federal Medical Center owned by the Federal Government is also located in the state at Azare. In addition to all these, there exist 74 registered private health facilities and several mission hospitals/clinics in the state.

The State Ministry of Health provides overall direction for the organization of health services in the state while also having the responsibility for health manpower development and organization; and implementation of secondary health care. The State acting through the ministry of health also provides technical assistance to the local governments as regards primary health care and disease control. The Local Government on the other hand organizes and implements primary health care activities at the grassroots level and also has the responsibility of funding and coordinating service delivery at local level.

Health Indicators

A lot of the initiative of the state has been geared towards improving the health status of the population. However, existent cultural and religious barriers are the main bane of many of the poor health indices in the state. A sizeable proportion of the population still live below the poverty line while access to qualitative health care services in rural areas is still far from ideal.

[12] Directory of Health facilities in Bauchi State, 2009, Bauchi State Primary Health Care Development Agency, CIET

Table 1: summary of Health &Social Indices of Bauchi State based on NDHS Report 2008

S/No	Indicators	Estimates
1.	Projected Total Population (2010)	5,143,998
	Males	2,361,449
	Females	2,533,115
2.	Children Under 5 years	996,210
3.	Adolescents (10 – 24 years)	1,519,923
4.	Women of Child bearing age	1,067,285
	Social Services	
5.	Literacy rate	
	Male	52%
	Female	13%
6.	Households with improved source of drinking water	36%
7.	Households with improved sanitary facilities (not shared)	22%
8.	Households with electricity	18%
9.	Employment status	
	Males	95.7%
	Females	59.1%
	FP/RH	
10.	Total Fertility Rate (TFR)	8.1
11.	Married women 15- 49 years using any modern method of FP	2%
	Maternal Health	
12.	Women age 15-49, who are mothers or pregnant with first child	51%
13.	Women who received ANC from skilled providers	44%
14.	Women who delivered in a health facility	13%
15.	Mothers assisted during delivery by skilled providers	16%
	Child Health	
16.	Immunization coverage	1%
17.	Children that have never received any immunization	27%
18.	Stunting in under-5 children	51%

Table 2: Summary of Health & Social Indices of Bauchi State (2)

S/No	Indicators	Estimates
19.	Wasting in under-5 children	13%
20.	Diarrhoea in children under-5	32%
21.	Fever in children under-5	36.4%
	Malaria	
21.	Households with at least one ITN	7%
22.	Households that slept under an ITN a night before	
	Children under-5	4%
	Pregnant Women 15-49 years	8%
23.	Pregnant women that received IPT for malaria during ANC visit	1%
	HIV/TB	
24.	Knowledge about HIV prevention among women	24%
25.	Knowledge of MTCT of HIV among women	19%
26.	Knowledge of Tuberculosis (TB)	
	Males	90.7%
	Females	70.3%

According to the recently released report, the Maternal Mortality Ratio (MMR) in Nigeria in the last seven years was estimated at 545 maternal deaths per 100,000 live births[13]. Over the years MMR has not improved in Bauchi state. The situation worsened from 1,350/100,000 live birth in 2003 to 1380/100,000 in 2006[14]. At one of her public presentations, the Special Adviser to the Governor of Bauchi state, Hajia Hajara Yakubu Wanka disclosed that over 60,000 women die of pregnancy related causes in Bauchi state annually and Nigeria accounts for 10% of the total maternal deaths in the world[15].

[13] NDHS 2008
[14] UNFPA 2006
[15] Summit on child/maternal mortality organized by Bauchi state MDG, Hajara Yakubu Wanka, 2009

A recent population based, state wide study conducted by CIET for the State Ministry of Health and the State Primary Health Care Development Agency, indicated a worsening situation of maternal health and care[16]. The study indicated that .some 70% men and 50% women did not know a single danger sign during pregnancy. Some 9% of women in the age group 14-50 years had some form of female genital mutilation. Among women reported to have a pregnancy during last three years prior to survey, 68% continued their routine heavy work throughout during their last pregnancy. Although two third (67%) of these women registered themselves at a health facility, only 40% had at least four ANC visits, while only 20% gave birth under the care of a skilled health provider. Some 21% women developed some complication during their last pregnancy or child birth. Symptoms of pre-eclampsia or eclampsia (10%) and Sepsis (6%) were the main complications reported. The survey recorded 124 maternal deaths during the period of two years prior to survey against 7287 live births reported among the same households during three year period prior to survey, This gives a crude MMR estimate of 2550/100,000 live births. Gender stratified focus groups organized under the same study discussed this evidence with the community members who attributed distance to the health facility, lack of appropriate transport and attitude of health workers as the major factors for low utilization of health facilities especially for delivery. The groups considered media especially radio and health workers as their major source of information on pregnancy and child birth.

Infant Mortality Rate (IMR) has also not feared better in the state. This has increased from 98/1000 live births in 1990 to 132/1000 live births in 2006. With the expected population of over 5 million people by 2010, only 36% have access to improved drinking water sources and 22% with improved sanitary facilities[17].

[16] Social Audit on Maternal Outcomes in Bauchi State; SMoH, BASPHCDA, CIET 2009/10
[17] NDHS 2008

2.3 Health Service Provision & Utilization

Bauchi state government has invested in past years on provision of health care services. However, the great investments made in provision of health care services have not translated to qualitative access to care especially in the rural areas. The state has one of the lowest ante-natal attendance and hospital deliveries compared to national and global indices. It is estimated that only 15 out of 100 pregnant women that registered for ANC actually deliver in the health care settings, whether public or private[18],[19]. This has been attributed to inadequate number of skilled health providers, low morale and poor utilization of services, poor quality of care, uneven access to emergency obstetric care, weak community support, limited male involvement, out of stock syndrome of drugs and commodities; limited access to health facilities; negative cultural beliefs, poverty and low literacy levels. Maternal and child health issues are presenting new challenges, treatment regimes are changing, new schemes are being introduced, thus the need for the health sector to re-strategize its programming for increased relevance and greater impact to galvanize the process of health provision, promotion, prevention and rehabilitation in the State.

Routine Immunization (RI) services are provided in only 40% of the functional health facilities. Immunization services are not provided on daily basis, in most cases once a week. Immunization coverage in Bauchi state has dropped over the years; from less than 9% in 2006 to the recently reported 1% in 2008[20].

Family Planning services are provided in selected facilities in COMPASS and UNFPA supported LGAs. Even then, there was always erratic supply of Family Planning commodities which further discouraged clients from patronizing these facilities.

Majority of the PHC facilities in the state are dispensaries which are not capable of providing maternal and child health services.

[18] NARHS 2007
[19] NDHS 2008
[20] NDHS 2008

2.4 Key Issues & Challenges

A major concern of the state is how to fast track health development particularly in the rural communities of the state without jeopardizing quality. In this regard, the state had enjoyed tremendous support from development partners including World Bank (HSDP II) WHO, UNICEF, UNFPA, CIDA, CIET, GAVI, TSHIP, PPFN, FHI/GHAIN, ActionAID International, SFH and a host of others. The various collaborative efforts ushered in an era of many health initiatives and a climate of continuous improvement in service delivery. Each of this bilateral or multilaterals has contributed to key success factors in their areas of interest. However, the sustainability status of some of these initiatives remains a big challenge. Some of the key issues and challenges are list under the sub-heads below:

Leadership and Governance

- Poorly defined roles and responsibilities of the different actors within the health sector which results in duplication of efforts.
- Weak coordination capacity of the SMOH.
- Absence of an independent Watch-dog for all health and health-related issues in the state.
- Weak health commodity supply chain management systems.
- Inadequate public transparency and accountability.
- Weak regulatory control mechanism of private, traditional, spiritual and even religious health service providers in the State,
- Weak capacity of the state to set standards and ensure compliance in Procurement processes.

Health Care Delivery

- Low number of pregnant women availing themselves of ANC services in either public or private health facilities.

- Attitude and behavior of the rural population towards orthodox health care systems.
- Inadequate number of skilled health care providers,
- Uneven access to Emergency Obstetric & Neonatal Care (EONC),
- Poor access to health facilities, some of which are over located hundred kilometers away.
- Weak community support,
- Non-availability of essential medical supplies and commodities
- Poor commitment to establish a system of procurement for health commodities that is dynamic and effective.
- Fragmented disease control programs many of which are running vertical programs.
- Public – Private Partnership is weak,
- Inadequate Standard Operating Procedures (SOP) and treatment protocols for use by health personnel.
- Implementation of NPHCDA approved Ward Health Care Minimum Package (WHCMP) is limited due to inadequacies in training and re-training.
- Poor attitude of health care providers.
- Weak emergency preparedness and response to epidemics.

Health Financing

- Inadequate release of allocated funds
- Poor resource management in the health sector.
- Low level of internally generated revenue.
- Poor mobilization of community resources for health care.
- Poor coordination of partner funding streams.
- Limited coverage of NHIS services.

State Health Information Management Systems

- Inadequate number of NHIMS data collection tools at health facilities.
- Use of different data collection tools by multiple actors, especially development partners.
- Need to redefine some indicators to account for missing data and generate standard international indicators to monitor health care service delivery
- The existing data collection system did not capture activities of the private and traditional health providers.
- Delays in reporting (Lack of Stationery and transport/communication means)
- Poor data collation, supervision and analysis at the health facility level including missing data and reports
- Lack of timely dissemination and prompt feedback mechanisms by the LGAs, SMOH and its Agencies
- Service based indicators refer to around 1/3 of population: thus the actual situation in the communities could be better off, could be worse off

Community Participation & Ownership

- The level of community participation and ownership in health programs is very weak partly due to their non-involvement in the conceptualization and planning of community based activities.
- Inadequate feedback to the communities.

Partnership for Health

- Weak mechanism for development of Public-Private Partnership (PPP).
- Non-Governmental Organizations and Community Based Organizations operates parallel programs with due recourse to state plans and programs.

- Development partners not willing to allow the state government drive their processes.
- Non-existent Public-Private Partnership Policy in the State.

Research for Health

- Weak capacity for research in the State Ministry of Health, its Agencies and LGAs.
- Findings from research work conducted by development partners are not shared with the state.
- Limited authentic documentation and publication of research findings that gives feedback for planning purposes.

Chapter 3: Strategic Health Priorities

3.1 Strategic orientations

The strategic priorities are based on the eight evidence-based identified priority areas which were adopted by the state. The end product of this exercise would be a costed plan developed through participatory approaches that reflect the context and prevailing situations in the state. It is the desire of Bauchi state government that the Health Development Plan 2010- 2015 will serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment and mutual accountability. The eight identified priority areas are:

- **Leadership & Governance for Health**
- **Health Care Delivery**
- **Human Resources for Health (HRH)**
- **Health Financing**
- **Health Information System**
- **Community Participation & Ownership**
- **Partnerships for health**
- **Research for health**

For each of these priority areas, a unifying goal is developed with strategic objectives and recommended interventions from which actionable activities could be extracted for implementation. The state priority High Impact Services are summarized in the Table below;

Table 4: Priority High Impact Services

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

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

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

Chapter 4: Resources Requirements

4.1 Human resources

Human Resources for Health (HRH) comprise of trained health personnel in the public and private sector (doctors, nurses/midwives, pharmacists, relevant technicians, public health officers, community health workers, etc), untrained informal health workers including community – based health care providers e.g. herbalists, traditional birth attendants, and volunteers, who play complementary roles in health care delivery. HRH can be categorized into the professional and administrative health staff. While the former are those who have a level of training related to providing care for those who are ill or taking action to prevent the occurrence of illness, the latter are those that provide administrative/technical support for the work of the former. On the basis of this, we can differentiate between HRH in the public as opposed to the private and HRH in orthodox health care as opposed to HRH in traditional "unorthodox" care.

The management of public sector Human Resources for Health in the state is the responsibility of the two tiers of Government – state & LGA. However, the following are key factors affecting performance of health personnel in the state: -

- Absence of well articulated state plan for Human Resource for Health.
- Inadequacies in the number of Human Resource for Health management.
- Recurrent industrial disputes.
- Inter- and intra- professional conflicts.
- Poor educational training facilities.
- Migration of skilled health workers from the public to the private sectors, NGOs and international partner agencies.
- Inequitable distribution of the limited number of health workers in favor of urban areas.
- Lack of enabling health policy environment.

- Ineffective coordination, supervision and various categories of health workers existed in the different health sectors of Bauchi state. A survey of health manpower showed that there are about fifteen groups of different health workers within the public health sector[21]. Table 2 below makes a comparative assessment of the state HRH in 2006[22] and latest findings by the SMOH.

Table 4: State HRH Workforce in 2009

S/No	Human Resources	Counts	
		2006[23]	**2009[24]**
1.	Medical Doctors	110	230
2.	Nurses/Midwives	530	519
3.	Pharmacists	73	14
4.	Lab. Scientists	7	32
5.	Lab. Technicians	NA	47
6.	Community Health Officers (CHO)	84	108
7.	Community Health Extension Workers (CHEWS)	440	782
8.	Nutritionists / Dieticians	NA	8
9.	Environmental Health Officers (EHO)	NA	200
10.	Environmental Health Assistants/Technicians	NA	251
11.	Hospital Attendants	NA	3500
12.	Radiographers	1	2
13.	Health Record Officers	1	24
14.	Physiotherapist	4	2
15.	Dentists	5	4

[21] SMOH 2009
[22] National Human Resources for Health Policy 2006
[23] Nigeria Health Review 2007
[24] SMOH Bauchi

NA: Not Available
JCHEW Cadre not included
LGA Health personnel not included

In order to address these challenges, Bauchi state shall adopt

- A comprehensive policy on Human Resource for Health (HRH).
- The capacity of the state health training institutions to produce quality health professionals will be strengthened by ensuring that all schools are accredited.
- Training and re-training of all cadres of staff such as doctors, nurses/midwives, public health/environmental health, pharmacist, laboratory technicians/scientists, radiologist, community health workers etc will be expanded.
- The national midwives service scheme and community midwifery program has been adopted by the State.
- The ongoing practice of placing medical students studying in any university in the country on basic salary GL 05 – 07 will be sustained and expanded to include other relevant health cadres.
- Additional incentives will be provided to health workers posted to rural areas.
- Human resource for health unit will be established and strengthened at the State and LGA levels.

4.2 Physical/Materials.

Even with the right mix of human resource in the health sector, health workers require basic infrastructure for efficiency in service delivery. However, the following challenges are evident.

- Most of these health facilities are dilapidated requiring rehabilitation.
- Health facilities that are functioning lack basic equipments such as those required for Basic Emergency obstetric Care etc.

The State Government is committed to properly equipping all the health facilities in the State to provide basic health services to generality of the people.

4.3 Financial.

Over the years, the health sector has witnessed increased budgetary allocation. However funds release is not commiserate with the amounts allocated. The financing of health care at the state and LGAs remain difficult and often contentious. Abuja declaration recommends at least 15% of annual budgetary allocation should be set aside for health care financing[25]. This has remained a daunting task to accomplish. Most public health finances are in the form of direct Out-Of-Pocket (OOP) payments. Given the limited resources, the state government is implementing free Ante-Natal Care (ANC) program for pregnant women and U5 children as well as providing nutritional supplements for malnourished kids.

Year	*State Budget*	*SMOH Budget*	*Proportion of SMOH budget to State*	*Actual Release*
2006	59,931,854,092	3,823,323,529	6.38%	2,328,042,608
2007	79,308,013,000	6,037,173,575	7.62%	4,118,800,794
2008	95,670,326,424	10,943,046,530	11.44%	7,336,980346
2009	80,421,989,524	11,861,173,266	14.75%	7,277,291,937

[25] Abuja Declaration on Sustainable Health Financing, 2005

The proportion of the State budget allocated to the health sector has consistently increased from 6.38% in 2006 to almost 15% in 2009. ***This remarkable achievement which is indicative of increased Leadership commitment to providing health services in the state needs to be sustained.***

Table 5: Trend in Bauchi state health financing 2006 – 2009[26]

In partnership with the NHIS, community health insurance scheme is currently being piloted in rural communities in the state. Thus, in meeting the target set in BASSHDP (2010 – 2015) and the health-related MDGs, adequate funding system is required that would be equitable, efficient and sustainable.

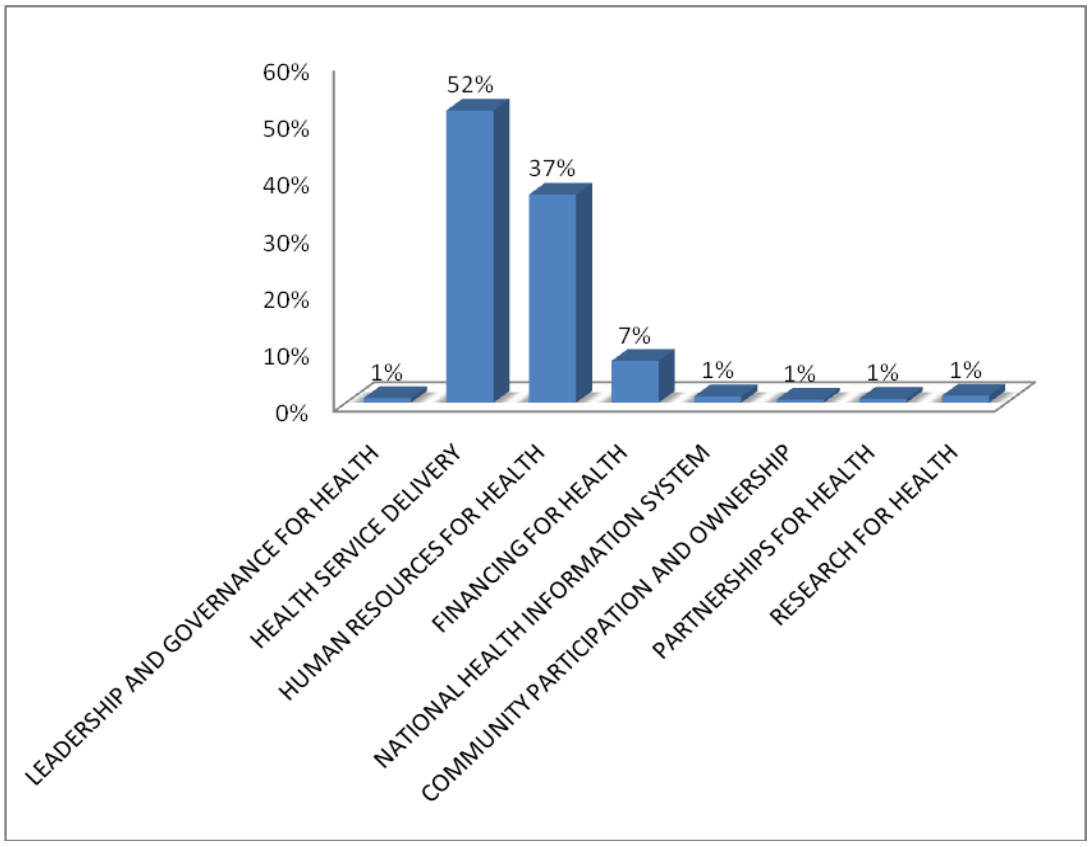
[26] Bauchi State Ministry of Health, Draft Medium-Term Sector Strategy Report 2009

Chapter 5: Financing Plan

5.1 Estimated Cost of Strategic Plan

The total cost of implementing the State Strategic Plan is NGN 86,226,863,393. 50% of this estimated cost would be spent on health care services delivery and a little below 30% on Human Resource for Health. In a nutshell, the plan lays emphasis on addressing issues around health service delivery, human resources and financing for health as illustrated below:

Figure 1: Estimated cost of Strategic Plan per Priority Area in %



Research is also considered as a veritable tool that will pave the way for initiating innovative programs that will produce the most desired break-through in addressing the negative health indices associated with the State.

5.2 Assessment of available Resources and projected Funds

Adequate resources are key to sustainable provision of health services in Bauchi state. Within the context of the state health policy, several methods have been identified for financing health services. These include resources from the state government, taxations (including VAT), levies, donor funding, health insurance and most importantly Out-Of-Pocket (OOP) expenses.

In last four years, financial allocation to the health sector has increased dramatically. Review of the report of the SMOH on Medium-Term Sector Strategy (2010 – 2012) indicates that total health budget has increased from 6.4% in 2006 to almost 15% in 2009. This is in compliance with WHO recommendation to spend 15% of total budget on health [27]. However, the challenge remains in the actual financial releases concomitant with budget.

Bauchi state government works closely with development partners to increase funding for the health sector. A manifestation of this is the presence of large donor partners such as WHO, UNICEF, World Bank, USAID, PPFN, CIDA CIET and host of other International organizations. Attempts have not been made to quantify donor contribution to the health sector response in the last couple of years. So far, the SMOH has increased funding for health. However, this has not reflected significant change at the PHC level. This might not be unconnected with the governance and control system at the Local Government level.

The available resources for the implementation of this strategic plan will be sourced primarily from the State Government. However, this will not be enough to implement a quarter of the proposed activities in the plan. Other sources of funding envisaged will come from development partners, private sector and other relevant stakeholders as illustrated in the table below:

Table 6: Source of Funds

[27] WHO 2006, Health Financing

S/N	Source of Funds	% of Contribution
1	State Government	50%
2	LGAs	20%
3	Federal Government	10%
4	Development Partners	15%
5	Privates Sector and Other Stakeholders	5%
	Total	100%

5.3 Determination of Financial gaps and Ways of closing these gaps

Two scenarios exist for the cost of implementing BASSHDP (2010 – 2015). These are based on the level of existing resources as enumerated in the state health Medium-Term Sector Strategy (2010 – 2015). The first scenario looks at implementing the state health minimum package of health under the SPHCDA using the Ward Minimum Health Care Package (WMHCP). This is more holistic and tends to capture 70% of the population particularly those in the rural areas. These targeted population are worst affected by poverty and its attendant consequences. The second approach looks at implementing both the essential and non-essential health packages. These non-essential packages include leadership, management structures, research etc which are needed to compliment the programming in the essential packages. Based on these two scenarios, the financial gaps would be estimated as either (i) difference between available resources that are released and the total cost of implementing the essential package; or (ii) difference between the resources released and the cost of implementing both the essential and non-essential packages.

Ways of closing the gaps would include:

- Additional budgetary allocation and timely release by the state and Local Governments.
- Scaling down the targeted population to be served with focus on disease prevention and control, emergency preparedness and response, nutrition, healthy lifestyles, high impact activities, pregnant women and children under the age of five, FP/RH etc.
- Increased enabling environment for more donor partners to work in the state as it currently being experienced.
- Provide more support and commitment towards the implementation of the community health insurance scheme in all the LGAs in the state.
- Develop a sustainable Public-Private Partnership (PPP) in key areas of Medical Supplies Management and Control. To some extent this would reduce cost of medical supplies and make available more resources for other health needs.

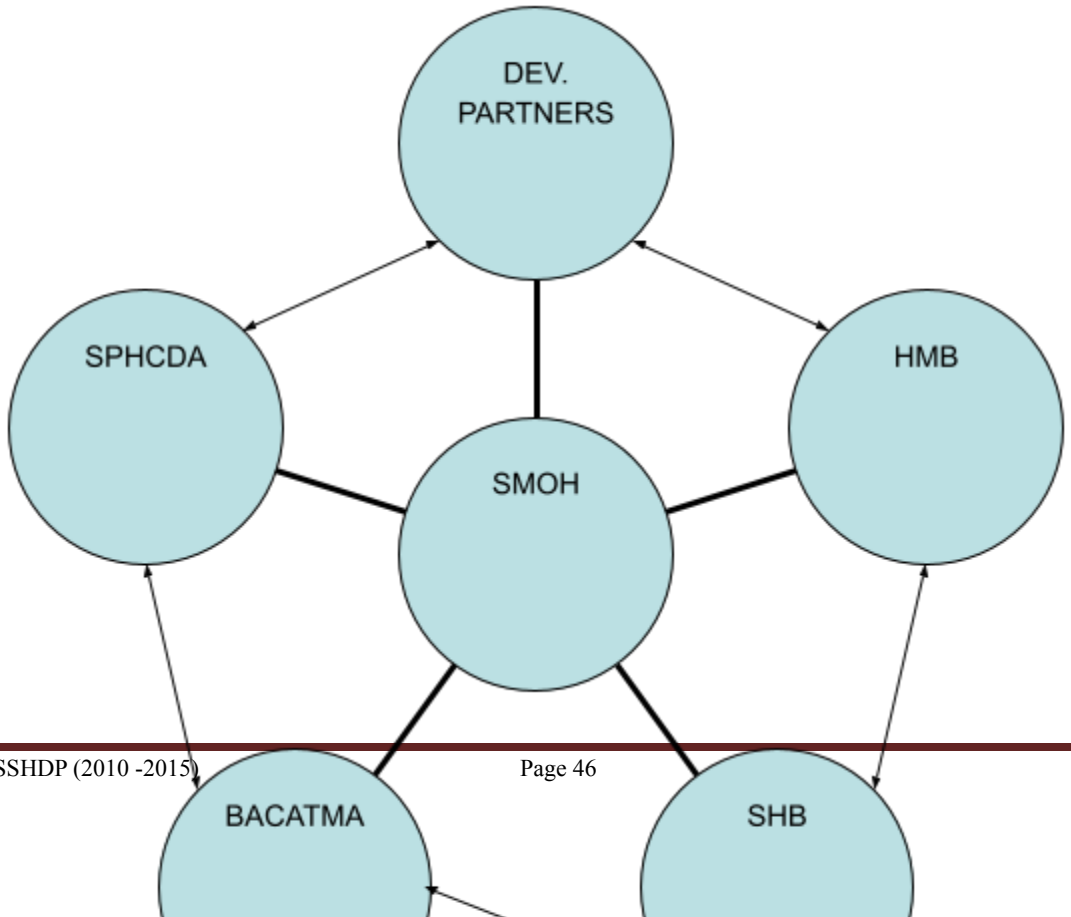
Chapter 6: Implementation Framework

The SMOH shall provide leadership for the implementation of BASSHDP (2010-2015). In particular, the Ministry shall foster partnership with other agencies and actors in the state to advance the implementation of the health sector strategic plan. To ensure proper coordination, a focal officer shall be designated to promote the effective implementation and institutionalization of the plan in the state. The designated staff would be supported to perform maximally through the provision of support staffs, infrastructure, office equipment and financial resources.

A multi-disciplinary and multisectoral Technical Advisory Group (TAG) shall also be established to effectively support the operations of the plan. The TAG will work from the secretariat domiciled within the SMOH.

While playing a leading role in the implementation of this plan, the SMOH shall provide technical assistance to all LGAs, mass media organizations, research institutions/academia, agencies, civil societies, CBOs and private institutions in the state towards the implementation of the strategic plan. Oversight for the entire strategic plan lies with the SMOH. The LGAs have direct responsibility for developing and implementing Annual Operational Plans (AOP) based on the strategic plan.

Figure 3: Implementation Framework structure



Chapter 7: Monitoring and Evaluation

7.1 Proposed mechanisms for Monitoring and Evaluation

Monitoring and Evaluation (M&E) constitute a major element of the strategic plan. The plan has built into it set targets and appropriate indicators to track performance. Bauchi State Government through the SMOH, LGAs and all relevant Agencies will institute an effective monitoring and supervision of the implementation of strategic plan. Government agencies and other partners involved in the implementation process shall submit quarterly reports to Planning, Research and Statistics (PRS) department of the SMOH.

Results of periodic researches will also constitute part of the inputs into M&E. Progress reports of BASSHDP will be produced and disseminated to all relevant stakeholders and at various fora. Result from recurrent M&E activities would be used to improve programme planning and implementation as well as development of other related frameworks.

An M&E Technical Working Group would also be established to play advisory role in monitoring the implementation of the plan at the state and LGA levels.

Conclusion

Bauchi State Strategic Health Development Plan (BSSHDP) (2010-2015) intends to reverse the trend of the health status of the people of the state. The vision of the sector is to reduce morbidity and mortality due to communicable and non-communicable diseases to the barest minimum; meeting global targets and significantly increasing life expectancy and quality of life of the citizens of Bauchi state. Towards achieving the goals of BASSHDP, a number strategic intervention and activities have been laid out in the implementation framework. These include strengthening leadership and governance, health service delivery, human resources for health, Health Management Information Systems (HMIS), community involvement, partnership, M & E and research. The costed plan has set for itself targets and indicators to monitor performance over time.

It is expected that the Health departments of the 20 LGAs as well as SMOH and its agencies would derive their Annual Operational Plans (AOP) using varying participatory approaches to reflect the context and prevailing issues within their domain. For each of the priority intervention areas, this plan provides uniform guidance on goals, strategic objectives and recommended interventions. It is recommended that specific activities be derived from the plan, costed and monitored over time.

It is anticipated that over the lifespan of BASSHDP, internal and external performance reviews would be carried by the SMOH.

Annex 1: Social Audit of Maternal Outcome in Bauchi State; MoH, BASPHCDA, CIET 2009/10

Fact sheet from supplementary population based evidence

Socio-economic indicators	
Household with a good housing structure	26%
Households with heads having some formal education	34%
Main source of water inside the household	
Well	62%
Tap water	17%
Borehole	15%
Stream/Pond	5%
Households using bednets	26%
Knowledge about danger signs during pregnancy and child birth	
Those who knew at least one correct danger sign during pregnancy	
• Men	31%
• Women	50%
Those who knew at least one correct danger sign during child birth	
• Men	45%
• Women	50%
Women who received information about possible complications after their last delivery	39%
Main source of information on pregnancy and child birth	
Women	
• Don't get any	9%
• Family friends	22%
• Media (radio/TV)	30%
• Health worker	39%
• Non-health institutions/workers	0.5%
Men	
• Don't get any	4%
• Family friends	27%
• Media (radio/TV)	43%
• Health worker	26%
• Non-health institutions/workers	0.2%
Attitudes	
Those who think during pregnancy a woman needs to give up heavy workload completely	
• Men	45%
• Women	44%
Those who think women without birth complications need not deliver at a health facility	
• Men	55%
• Women	65%
Social norms and environment	
Women involved in some money earning work	44%
Women involved in deciding where to see care during pregnancy or child birth	1%

Those who reported that people in their communities believe a pregnant woman needs to give up heavy work completely	
• Men	62%
• Women	47%
Those who think people in their communities believe women without birth complications need not deliver at a health facility	
• Men	54%
• Women	63%
Women reporting a violent argument in the last year where their partner beat, kick or slapped them	4%
Women reporting they feared beating	33%
Women reporting to have some form of female genital mutilation	9%
Caring practice during last pregnancy/child birth	
Women who reduced their heavy workload at some point in time during their last pregnancy	32%
Women who reduced their heavy workload before or by the third trimester of last pregnancy	19%
Women who had help with their daily work from family members during their last pregnancy	68%
Maternal care services	
Coverage	
Women who registered themselves for antenatal checkups	67%
Women who had at least one government antenatal check-up	65%
Women who had four or more government antenatal checkups	40%
Women who delivered at a health facility	22%
Women who were attended by a skilled health worker	20%
Women who had an appropriate postnatal check-up	17%
Quality	
Women who took Iron folate tablets at least for one trimester	30%
Women who received at least two doses of TT	44%
Women who had their BP checked on every ANC visit at a government health facility	35%
Women who had their urine tested on every ANC visit at a government health facility	8%
Women who reported that care during government antenatal checkups was better than expected	66%
Women who received information about possible complications after delivery	39%
Women who preferred to deliver at a health facility if they had a choice	36%
Cost (among those who availed services)	
Women who paid for registration	83%
Women who paid for antenatal visits	50%
Women who paid for delivery at the health facility	49%
Average amount (Naira) paid (among those who paid)	
For registration	N 146.55
A single antenatal visit	N 111.35
At the facility for delivery	N 763.04
Complications during pregnancy and child birth	
Pre-eclampsia/Eclampsia	10%
Sepsis	6%

Annex 2: Social Audit of Maternal Outcome in Bauchi State; MoH, BASPHCDA, CIET 2009/10

Summary of findings from Review of Maternal Component of HMIS 2008

Reporting patterns

> Data from one LGA completely missing while only 8 have all eligible health facilities reporting

> Ambiguity about inclusion of data from the Secondary and tertiary care facilities (General Hospitals or Specialist hospital) in the LGA summary reports. As per policy they should include.

> Better to keep data from communities, PHC facilities and higher level care facilities segregated as these need to be viewed, analyzed and interpreted in a different service delivery context. It would also help in avoiding duplication in terms of reporting of clients if the same visit different level of health facilities.

> Lack of follow-up and feedback mechanisms at different levels (between state and LGA and between LGA and health facilities)

> Lack of logistic support with many health facilities not receiving stationery (forms). Also the health facility staff and those responsible at higher level (HMIS, M&E or MCH officers at the state and LGA level) do not have adequate logistic support (transport) to transmit the data in time and follow-up with facilities for feedback.

> General attitude towards data collection, collation and reporting is mechanical at each level and is considered more a s a burden rather than a meaningful activity. Those who are responsible mainly consider their responsibility for data as a post office whereby they just have to collate and forward it to the next tear (post box syndrome).

> This is not clear if HMIS activities are considered a part of the annual plan and if adequate resources are allocated within budget each year to support its sustainance. Two main heads which require attention for appropriation in the annual budget are stationery and transport with allocation for each tear in the system

Service coverage

The key elements of service coverage for maternal care are:

> Coverage for antenatal care

> Coverage for deliveries at the health facilities

Antenatal care

There are three key data elements reported within the existing ANC section of the summary report; 1) Number of new ANC clients, 2) revisit clients and 3) clients with problems or complications (reporting on PET and Anaemia in the summary format).

Number of new clients coming for ANC,

Reported in absolute numbers this indicator is useful to reflect the client turn over and workload at the health facilities but fails to inform much about coverage of services. Viewing crudely this figure of new ANC clients against the estimated target population for this service i.e., pregnant women may give us a better idea about proportionate use of health facilities by the target population for at least one ANC visit.

Revisits

Again this only reflects client load on a facility. However it may become more useful if it helps to assess if women are coming again for their second, third fourth and so forth visits and hence evaluate provision of recommended optimal care during pregnancy.

Problems during pregnancy (PET, Anaemia)

It is difficult to assess the extent of the problem as we are not sure that these indicate women or new cases or visits including multiple visits made by the same woman. It may be that same woman with anemia came four times and hence was recorded four times. This may therefore result in over-reporting.

Deliveries

Similar pattern as for antenatal care in terms of reporting in absolute numbers. It would be useful to use the target population of pregnant women to ascertain the proportionate use of PHC facilities for delivery. A useful additional analysis would be to compare the proportion of women coming for ANC visits to the proportion delivering at the health facilities.

Complications during pregnancy and child birth/Maternal deaths

> In summary format for PHC facilities they do report on number of deaths but do not report on its causes which may be very useful data for planners.

> Sepsis is not included as a complication in the postpartum period in this format.

> Number of complications, C/S as well as maternal deaths reported by some LGAs are far too more than others. It is not clear if the information comes only from PHC facilities or in secondary/tertiary care facilities. It is likely that some of the LGAs are including the data from general hospitals in their reporting while others not which is resulting in this unequivocal reporting pattern.

> In summary format for PHC facilities they do report on number of deaths but do not report on its causes which may be very useful data for planners.

> Sepsis is not included as a complication in the postpartum period in the summary format although facilities do receive and record information on individual clients for this complication.

Recommendations

> Prompt follow-up on completeness of reports with health facilities and LGA PHC teams to ascertain reasons and identify support mechanisms to ensure completeness.

> Better coordination among MoH, SPHCDA and Hospital Management Board to resolve ambiguities as to *who needs to report and collate on what*

> Identify ways and means to ensure availability of adequate resources for logistic management of HMIS.

> Facilities and LGAs should sue target population from census data for pregnant women to calculate service coverage for ANC and delivery

> Column for revisits should be expanded to mark and report women coming for 2nd, 3rd, and four or more visits. This would, help to assess the use for follow-up ANC visits.

> Problems or complications should be marked for new cases only and once for each woman when she first reports to a health facility and not to count if she revisits the same facility or as a referred case to another facility for the same problem.

> Section on complication during pregnancy should also include some other problems in such as Malaria, TB and HIV.

> Data from communities and that from facilities with different level of care should be reported in a segregated form in the summary format and analysed with due context for proper interpretation to avoid duplication.

Annex 3: Details of the Bauchi Strategic Health Development Plan

BAUCHI STATE STRATEGIC HEALTH DEVELOPMENT PLAN							
PRIORITY AREA							
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**TOTAL COST 2010-2015**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Bauchi State							**707,726,519**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2011**		343,261,753
		1.1.1	Improved Strategic Planning at the State and LGA levels				115,791,198
			1.1.1.1	Review and adopt the State Health Policy	State health Policy reviewed and adopted	Availability of past policies	19,758,399
			1.1.1.2	Review and adopt the National Rerpoductive Health Policy and Strategic Framework	National Reproductive Health Policy and Strategic Framework reviewed and adopted in the State	Availability of National policy	16,475,904
			1.1.1.3	Establish the State Coordinating Committee on Health	State Coordinating committee on health	Stakeholder commitment	13,700,848
			1.1.1.4	Review and adopt the Food and Nutrition policy	Food and Nutrition Policy reviewed	availability of the National Policy	27,385,839
			1.1.1.5	Develop the state Newborn health policy; and the Community case management for pneumonia and other common childhood illness protocols	Newborn policy developed for the State	availability of the National Policy	38,470,206
		1.1.2	Strangthen the capacity of SMoH, Agencies and LGAs to develop, implement and review their Health promotion, protection, prevention and rehabilitation strategy.				142,677,527
			1.1.2.1	Review and develop State Strategic Framework on the control of non-communicable diseases	Non-communicable diseases strategic framework reviewed and developed	Non-availability of previous plans	54,946,111
			1.1.2.2	Review and develop the State HIV/AIDS, Malaria and Tuberculosis Policy and Strategic Plan	State HIV/AIDS, Malaria and Tuberculosis Policy and Strategic Plan reviewed and developed	Presence of existing plan & groups that developed the previous one	33,205,528

			1.1.2.3	Review/revise national policies, standards and protocols using international evidence-based MNCH standards of care, and ensure their dissemination to all healthcare providers for their adoption and use	MNCH national policies, standards and protocols reviewed	Availablity of past policies	20,646,417
			1.1.2.4	4.1 Assess training needs and strengthen the skills and capacity of programme managers and health management teams at all levels of the IMNCH chain in programme management	Training needs assessment conducted every two years and 80% of health professionals have their skills and capacity strengthened	Availability of competent personnel to carryout the exercise	22,430,382
			1.1.2.5	Develop guidelines on free medical services for pregnant women and under 5; on the posting of health professionals	Guildelines developed	Availability of previous guidelines	11,449,089
		1.1.3	Ensure the participation of all stakeholders in the development, review ad implementation of the State Health Plan				84,793,028
			1.1.3.1	Conduct sensitization meeting with key LGA stakeholders on Health (Private/traditional medicine providers, CSO, Development groups on the development of the State strategic Plan	80% of private/traditional medicine providers, CSOs buy into the State Strategic Plan	Presence of existing unions of private and traditional health providers in all LGAs	43,481,165
			1.1.3.2	Formation of coordinating committee on Health in the State and provide for their regular meetings	The State Coordinating Committee on Health coordinates activities of 80% health service providers	Fully sensitized stakeholders	14,385,891
			1.1.3.3	Develop IMNCH advocacy and other relevant tools to reduce maternal, newborn and child mortality and promote IMNCH strategy at various levels to improve commitment of national, political , community and religious leaders			-
			1.1.3.4	Conduct bi-annual review meeting of the State Health Strategic Plan	HSSDP reviewed bi-annually	Availability of the State Strategic Health Plan	26,925,973
			1.1.3.5	Develop effective and susteinable M&E System	The State M&E mechanism fully developed	Availability of existing structure	-
		1.1.4	Accord the highest priority to support LGAs in the development of evidenced-based, costed and prioritized Strategic Health Plans for the sector		95% of LGAs in the State with evidenced-based, costed and prioritized Strategic Health Plans		-
			1.1.4.1	Formation of coordinating committee on Health in the LGAs and provide for their regular meetings	LGA Coordinating Committee on Health coordinates 80%		-

					health activities in their repective LGA		
			1.1.4.2	Conduct sensitization meeting with key stakeholders on Health (Private/traditional medicine) providers	4 Sensitization meetings conducted annually		-
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bill signed into law by end of 2009**		64,863,368
		1.2.1	Strengthen regulatory functions of government				64,863,368
			1.2.1.1	Document regulatory functions of Government and periodically checked to ensure compliance	regulatory function of government documented	Technical capacity	15,594,229
			1.2.1.2	Distribute government regulatory ethical papers for professionals for implementation	Government ethical papers distributed	Availability of the document to be distributed	856,303
			1.2.1.3	Hosting of the State Council on Health meetings	No. of State Council on Healths held	Stakeholder commitment and availability of resources to host the event	48,127,401
			1.2.1.4	Form Steering committee on the organization and hosting of the state council on Health	Steering committee established	stakeholder commitment	-
			1.2.1.5	Prepare detailed budget for the hosting of the State Council on Health	Budget prepared	availability of detailed plans for hosting the event	285,434
	1.3	**To strengthen accountability, transparency and responsiveness of the State health system**			**80% of LGAs and the State level have an active health sector 'watch dog' by 2013**		213,273,368
		1.3.1	To improve accountability and transparency				129,974,113
			1.3.1.1	Organize quarterly stakeholder dialogue and feedback forum	80% stakeholders participate in the forum	Stakeholder commitment	56,325,710
			1.3.1.2	Conduct bi-annual review of the State Health Sector performance	Conduct 6 yearly review of the State Health Sector Performance	Availability of indicators upon which reviews will be measured	26,456,592
			1.3.1.3	Organize question and answer sessions with the media on healthcare delivery situation which will be aired in all the media houses in the State	60% general public reached with basic information on health service delivery situation in the State	Availability of media houses	9,133,899
			1.3.1.4	Provide for annual auditing of the Ministry's account by external auditors, and report submitted to the Executive Governor	Health Sector account audited annually and reports submitted to SEC	Availability of competent audit firm	38,057,912

		1.3.2	Develop Institutional capacity of the Health Sector to improve accountability and transparency				83,299,255
			1.3.2.1	Develop guidelines on financial management as well as, procurement procedures.	Guidelines developed	Presence of existing national guidelines for adoption	9,514,478
			1.3.2.2	Train and re-train financial staff on finance regulation	70% of Financial Staff in the Health Sector trained on finance regulations	Availability of financial regulations, availability of trainable staff	19,028,956
			1.3.2.3	Conduct quarterly review meeting on financial management in the State	No. of quarterly meetings conducted	Stakeholder commitment	47,952,969
			1.3.2.4	Orient health program managers and budget officers on financial management, transparency and accountability	No. of health managers and budget officers reached	Technical capacity	6,802,852
	1.4	**To enhance the performance of the State Health System**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	86,328,031
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance				44,400,897
			1.4.1.1	Conduct annual Bauchi State Demographic and Health Survey	State Health Demographic Survey institutionalized	Technical capacity	38,057,912
			1.4.1.2	Review and adopt the State Public - Private Partnership policy	60% Private health facilities participate in the State PPP	Availability of National policy	6,342,985
		1.4.2	Advocacy to mobilize support				41,927,133
			1.4.2.1	Develop State Specific advocacy tools to improve commitment of government and other stakeholders to reduce newborn, maternal and child death, communicable and non-communicable disease incidence and other epidemic prone diseases	The State Health indices improves by 50%	Technical capacity	39,643,658
			1.4.2.2	Advocate for an increase of not less than 25% of the total State budget to the health sector	Health sector budget increases up to 15%	Policy makers time and audience	2,283,475
			1.4.2.3	Establish the State Partnership for MNCH to improve coordination and support for IMNCH activities in the State	Newborn and child mortality reduced significantly in the State	Stakeholder commitment	-
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							**44,422,330,003**
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted**		514,227,688

					by all States by 2011		
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner				28,864,554
			2.1.1.1	Conduct community needs assessment to determine health needs of communities in the State	**Needs assessment conducted**	**Availability of competent assessors**	22,984,383
			2.1.1.2	Review and adopt the State Ward Minimum Health Care Package, cost and disseminate in an integrated manner at Primary health care levels.	**Ward Minimum Health Care package adopted**	**Availability of the natiional ward minimum care package for adoption**	3,830,731
			2.1.1.3	Develop detailed plan for the implementation of the Ward Minimum Health Care Package	**WMHCP implementation plan developed**	**Technical capacity**	1,647,214
			2.1.1.4	Establish a minimun package of care for MNCH at all levels of care which will include human resources, drugs, supplies, equipments etc	**Reduce Infant and Child mortality in the State by 60%**	**Availability of MNCH services at all levels**	402,227
			2.1.1.5		**All LGAs have QITs**	**Availability of consultants to train them**	-
		2.1.2	To strengthen specific communicable and non communicable disease control programmes				-
			2.1.2.1	To strengthen (train, equip and provide logistics support) to the State Epidemiological unit, as well as, support all LGAs to establish their epidemiological unit	**State and all LGAs have functional epidemiological units**	**Presence of epidemiological units**	-
			2.1.2.2	Procure EPR drugs and laboratory equipments/reagents for early diagnosis at state and LGA level	**EPR drugs procured**	**Establishment of EPR committees at State and LGA level**	-
			2.1.2.3	Establish state non-communicable disease control program	**Reduce the prevalence of non-communicable diseases in the State by 60%**	**Supportive environment for implementation of program**	-
			2.1.2.4	Equip the State to manage neglected and emerging diseases (Fillariasis, Onchocerciasis, Avian Influenza, SARS, etc)	**Oncho and Avian Influenza prevalence reduced**	**80% of emerging diseases managed at State level**	-
			2.1.2.5				-
		2.1.3	To make Standard Operating procedures (SOPs) and guidelines available for delivery of services at all levels				70,140,676
			2.1.3.1	To distribute Standard Operating Procedures and guidelines for implementation at State and LGA level	**All Health Facilities have in stock SOPs and guidelines**	**Availability of SOPs to be distributed**	7,240,081
			2.1.3.2	Train health care workers at state and LGA level on the use of SOPs and guidelines	**80% health facility staff develop skills of using SOPs and guidelines**	**State adopt the use of the revised SOPs**	22,524,695
			2.1.3.3	To re-print and distribute the National case-definition protocol to all health facilities at State and LGA level to ensure standard in	**No. of case definition protocol**	**Availabillity of National case definition protocol**	1,034,297

				diagnosis, treatment and other forms of management	**re-printed and distributed**		
			2.1.3.4	Review PES tools and distribute to all Health Facilities in the State; adapt/reproduce 2000 copies of available SOPs and SP pn the following services: Maternal and Neonatal health, FP and RH; reproduce 5000 copies of pocket sized FP/RH SOPs for distribution to health providers in Bauchi State.	**80% of health facilities have received the revised PES tools**	**Availability of PES tools**	4,960,796
			2.1.3.5	Develop IMNCH advocacy and other relevant tools to reduce maternal, newborn and child mortallity and promote IMNCH strategy at all levels.	**Reportage on newborn and child health improve in the state by 70%**	**Technical capacity**	6,703,778
		2.1.4	Improve immunization coverage				383,590,200
			2.1.4.1	Establish additional immunization outreach posts in the State	**No. of outreaches established**	**Demand for the service**	-
			2.1.4.2	Revatilize 20 existing cold stores and establish sattelite cold in the State	**No. of cold stores revatilized**	**Availability of dilapidated cold stores requiring repares**	383,073,052
			2.1.4.3	Procure and install 86 solar refrigerators in the 20 revitalized cold stores	**No. of solar refrigerators procured**	**Instability of Power Supply system**	-
			2.1.4.4	Visits to members of the state assembly and policy makers for impementing immunization policies and changing policy statement to real policies and their implementation.		**Timely supply of the equipments**	-
			2.1.4.5	Upgrade health facililties to provide routine immunization services	**Increase appropriation for nutrition programs**	**Availabillity of resources**	517,149
		2.1.5	Strengthen coordination of Nutrition interventions At State, LGA and Community levels				31,632,257
			2.1.5.1	Orientation of SCFN and LGCFN members, capacity building, data gathering and dialogue with policy makers and production of IED materials		**Supportive environment for implementation of policies**	13,704,438
			2.1.5.2	Conduct VAS exercise for children 6-59 months, procurement distribution and utilization of iron folate and zinc tablets for the treatment of diarrhea, biannual monitoring of household consumptio of iodized salt / market to market campaigns to promote MN fortified compliance	**Reduce the rate of stunting and wasting among children 0 - 59 months**	**Willingness of parents to make their children available for the exercise**	2,413,360
			2.1.5.3	WBF Celebration every year, EBF KAP study, formation of community support groups on IYCF, Capacity building of community volunteers/ monitoring and supervision of IYCF activities	**Increase awareness on breast feeding**	**Supportive policy environment**	5,363,023
			2.1.5.4	Community mobilization on SAM, procrement and distribution of supplement food, training of health workers and communty volunteers on CMAM, training of doctors on SAM, monitring ad supervison	**80% of communities mobilized on SAM**	**Supportive policy environment**	6,205,783
			2.1.5.5	Strengthen the State Nutrition Unit and LGA Nutrition offices, supply of equipments to	**The State Nutrition Unit stregnthened**	**Supportive policy environment**	3,945,652

				offices, supply of surveilance forms, capcity building, M&E			
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		21,648,281,764
		2.2.1	To improve geographical equity and access to health services				20,994,605,909
			2.2.1.1	Conduct in-depth facility and training needs assessment	**Facility and training needs assessed**	**Availability of resources**	5,669,481,167
			2.2.1.2	Expand PHC facilities/services in underserved areas through construction and equipping 148 integrated maternities and health centers in the State	**80% of wards in the State have PHC facility**	**Availability of the facility, acceptance by the people**	2,202,670
			2.2.1.3	Construct new PHC faciities at Yalwan Kagadama, Nadabo, Gurbana, Bashi, Guyaba and Rigan kela (Galambi)	**80% of wards in the State have PHC facility**	**Political will**	5,746,095,777
			2.2.1.4	Construct and equip 4 new general hospitals in Bauchi, Kirfi, warji and Bayara	**All LGAs in the State have functional General Hospital**	**Political will**	3,830,730,518
			2.2.1.5	Construct and equip 3 Specialist Hospitals (one per each senetorial district)	**All Senatorial District in the State has a Specialist Hospital**	**Political will**	5,746,095,777
		2.2.2	To ensure availability of drugs and equipment at all levels				551,625,195
			2.2.2.1	Provision of free sustenable drugs to pregnant women and children less than 5 years of age	**80% of pregnant women and children less than 5 years have access to free treatment**	**Contractor commitment**	-
			2.2.2.2	Assess and strengthen the supply chain system, as well as, procure and distribute consumables in all the secondary and 80% of the PHC Facilities in a sustained manner	**All secondary health facilities and 80% PHC facilities have steady supply of consumables**	**Contractor commitment**	-
			2.2.2.3	Construction of 3 zonal medical stores, one in each senetorial district with adequate standard facilities	**All senatorial zones have zonal medical stores**	**Availability of funds**	287,304,789
			2.2.2.4	Procure contraceptive commodities for HFs in Bauchi State	**No. of commodities procured**	**Contractor commitment**	-
			2.2.2.5	Upgrade and fully equip the surgical and maternity department in all the General Hospitals of the State	**No. of surgical and maternity department upgraded and fully equipped**	**Availability of resources**	264,320,406
		2.2.3	To establish a system for the maintenance of equipment at all levels				43,153,179

			2.2.3.1	Enter into agreement/retainership with companies that carry our repairs of hospital equipments for the maintenance of all the state hospital equipments	All hospital equipments functional	Both parties honor their contractual obligations	-
			2.2.3.2	Take inventory of hospital equipments with a view to identifying obsolette ones and those requiring repairs	inventory exercise carried out	Available of obsolette equipments	-
			2.2.3.3	Conduct 5 -day training anually for health facility maintenance staff on the maintenance of hospital and health facility equipments	All maintenance staff trained	Availablity of maintenance staff	32,005,753
			2.2.3.4	Build capacity for installation and maintenance of medical equipments	Improve maintenance of medical equipments	Technical capacity	4,596,877
			2.2.3.5	Resuscitate and strengthen a two-way referral system through logistics support such as radio communication and transport to each LGA	Two way referral system in place	Technical capacity	6,550,549
		2.2.4	To strengthen referral system				28,730,479
			2.2.4.1	Develop and produce guildelines on the implementation of referral system from the primary health care level to tertiary level and vice versa.	**referral system developed and No. of guidelines produced**	**availability of funds**	4,788,413
			2.2.4.2	Conduct 3 - day workshop on the dissemination of the referral guidelines	**Referral guidelines disseminated to 80% health facillities**	**Availability of referral guidelines**	6,703,778
			2.2.4.3	Training and re-training of health care workers on how to use the referral guidelines at health facility level	**80% HF staff trained on the use of referral guidelines**	**Availability of referral guidelines**	17,238,287
			2.2.4.4	Procure and distribute communication equipments and Ambulances to all health facilities at state and LGA level for referral	**60% PHCs with abulance and communication equipments**	**Availability of resources**	-
			2.2.4.5	Develop, print and distribute referal forms to all health facilities in the State, as wellas, empower CBDs to identify danger signs of pregnancy, labour and pueperium and refer as appropriate	**No. of referra forms produced and distributed**	**Availability of existing forms for adoption**	-
		2.2.5	To foster collaboration with the private sector				30,167,003
			2.2.5.1	Establish the State Private, traditional, Spiritual and Religious Health providers council	**PTSRHP Council established**	**Stakeholder commitment**	-
			2.2.5.2	Conduct quarterly meetings of the PTSRHP Council	**No. of meetings conducted**	**Stakeholder commitment**	9,308,675
			2.2.5.3	Conduct mapping of all private, traditional, spiritual and religious health providers in the State	**Mapping exercise conducted**	**Availability of resources**	8,619,144
			2.2.5.4	Organize annual consensus meeting with private, traditional, spiritual and religious health providers on the health service performance	**consensus meeting conducted**	**Committed Private sector health providers**	9,136,292
			2.2.5.5	Engage and motivate the private health facilities to contribute to scaling up of IMNCH services in the State	**60% private health facilities engage in MNCH activities**	**Technical capacity**	3,102,892

	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		4,352,303,632
		2.3.1	To strengthen professional regulatory bodies and institutions				68,014,620
			2.3.1.1	Support to MHWUN, NANNM, ACHPN, EHOAN, Pharmaceutical Associations, NMA, Association of Laboratory Scientists etc to ensure enforcement of professional ethics and etiquettes	No. of associations supported	availability of resources	57,460,958
			2.3.1.2	Support professional Associations to produce copies of professional ethics and ettiquettes of each professional body and distribute to all members.	Forum Established	Union's willingness to form the forum	-
			2.3.1.3	Annual conference of health workers associations	Annual conference held	Stakeholder Comitment	4,999,103
			2.3.1.4	Organize/involve and build the capacity of private sector service providers, teaching and research institutions and professional bodies to support the implementation of MNCH minimum package	Capacity of private service providers and other professional bodies built	Private Health Providers interested in IMNCH	5,554,559
			2.3.1.5				-
		2.3.2	To develop and institutionalize quality assurance models				42,138,036
			2.3.2.1	Conduct meeting to introduce SBM-R and evidence-based best practice approaches for 15 stakeholders at state level; Select initial SBM-R sites and facility teams	SBM-R and evidence-based best practice introduced in 15 selected sites	Availability of the modules	5,746,096
			2.3.2.2	Develop, pretest, finalize and print copies of the State Performance Standards (Maternal health, Child Health)	State Performance Standards for Maternal and child health printed	Availabity of national stadards	5,746,096
			2.3.2.3	Conduct modules 1, 2, and 3 trainings for SBM-R facilitators and HF teams, as well as, develop recognition criteria.	60% HF teams participated in the 3 modules training for SBM-R	Availability of the modules	9,576,826
			2.3.2.4	Follow-up assessment (bi-annually); review progress and challenges and identification of support needed for improvement.	3 follow-up assessment carried out	Stakeholder commitment	17,238,287
			2.3.2.5	Establish Quality Improvement Team (QIT) and train them on PDQ and provide resource materials to QITs	QIT established	Stakeholder commitment	3,830,731
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms				74,009,714
			2.3.3.1	Conduct a 2-day workshop to adapt the recommended FMoH integrated supportive supervision tools.	FMoH Integrated Supportive Supervision tools adopted	Tools for supervision is available	10,342,972
			2.3.3.2	Re-print and distribute 5000 copies of integrated supportive supervision tools to State and LGA coordinators	5000 copies of integrated supportive	Availability of copies of the tools	17,238,287

					supervision tools reprinted and distributed		
			2.3.3.3	In collaboration with SMoH/SPHCDA conduct 3-day training for 193 health care manageers from the State, LGA and HFs level on Integrated Supportive Supervision in 5 batches	193 health care managers trained on supportive supervision	Stakeholder Comitment	28,730,479
			2.3.3.4	In collaboration with the State and LGAs conduct quarterly supportive supervision visits to HFs and provide on the job training	24 meetings on supportive supervision held	Stakeholder commitment	17,697,975
			2.3.3.5				-
		2.3.4	Revitalize primary health Care Facilities in the State				3,339,554,251
			2.3.4.1	Liaise with the NPHCDA to employ the services of retired Midwives under MSS	No. of health facilities renovated	Availability of resources	3,309,751,168
			2.3.4.2	Train NYSC Doctors and other paramedical personnel on EmONC, FP/RH, Child Health and infection prevention; deploy trained NYSC Doctors and other paramedical personnel to PHC facilities	no. of basic equipments provided	PHCs upgraded	5,746,096
			2.3.4.3	Provide for mandatory training for all health workers on EmONC, FP/RH, IMCI, infection prevention and quality of care.	No. of Health facilities constructed	Availability of trainable manpower	9,576,826
			2.3.4.4	Re-establish DRF in all PHC facilities in Bauchi State, and link QIT to monitor implementation of DRF, quality improvement efforts and institutionalization of SBM-R in PHC facilities in the State.	No. of health care workers who benefitted from manadatory trainings		-
			2.3.4.5	orient newly employed MSS Staff on EmONC, FP/RH, IMCI and infection prevention practices.	No of health workers trained		14,480,161
		2.3.5	To strengthen HIV/AIDS, Malaria and Tuberculosis program				828,587,011
			2.3.5.1	Review and update BACATMA Strategic Plan for HIV/AIDS, TB and Malaria; and to sustain existing PMTCT centers and establlish more PMTCT centers in 10 PHC facilities yearly	70% of Health Facilities in the State provide PMTCT services	availability of Health Facilities	229,843,831
			2.3.5.2	To upgrade 16 General Hospitals into ART delivery centers (3 annually from 2011)	All General Hospitals in the State provide ART services	All General Hospitals have requisite capacity to provide ART services	459,687,662
			2.3.5.3	To establish 30 additional TB Microscopy centers	60% of the wards have TB microscopy Centers	Availability of trained staff to man the centers	114,921,916
			2.3.5.4	Strengthen TB/HIV/AIDS Collaboration	80% of patients with TB screened for HIV/AIDS and Vice versa	Availability of HCT and TB screening services	-
			2.3.5.5	Provide Intermittent Preventive Treatment of Malaria and ITN to Pregnant Women and Children	Increase % of women and children receiving IPT for Malaria	Availability of Health Facilities and staff to provide services	24,133,602
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		104,662,262

		2.4.1	To create effective demand for services				104,662,262
			2.4.1.1	Conduct monthly meetings with Community Development Committees (CDC), Community Coalisions and Ward Development Committees (WDC) on the need to mobilize community to utilize health care service	No. of meetings conducted	Presence of these committees	6,981,506
			2.4.1.2	Provide resources to CBOs, FBOs and NGOs and enagage them to create awareness on health issues (MNCH, FP/RH, Communicable Diseases, etc)	Capacity of community groups built	Presence of trainable CBOs	4,335,429
			2.4.1.3	Reproduce and distribute copies of English and Hausa version of Family Health booklets to community members through VDCs, CCs and WDCs; and conduct formative research to explore KAP and HSB of communities on health issues.	No. of jingles developed and aired	Presence of media houses	48,267,205
			2.4.1.4	Conduct media material development workshop to design and produce draft copies of assorted BCC materials and messages (Jingles, Spots, PSAs, Radio magazine programs, Posters, Face caps, Bill boards, Phamplets, etc); pretest and finalize draft copies; produce final copies and distribute/disseminate to media organization and HFs, as well as, emgage media organizations (print, electronic and traditional) to disseminate key messages on IMNCH, FP/RH and communicable Diseases	No. of IEC Materials developed and produced	Presence of media houses	22,984,383
			2.4.1.5	Provide technical support to VDCs, WDCs and CCs to mark special days; and Institutionalize bi-annual MNCH weeks	**MNCH week institutionalized**	**Technical capacity**	22,093,738
		2.4.2	To improve geograhical equity and access to health services continued				-
			2.4.2.1	In collaboration with NGOs/CBOs/FBOs establishment/reactivate outreach PHC services through mobile clinics	Mobile clinics functional	Commitment of CSOs	-
			2.4.2.2	Identify CBDs and empower them to provide FP information and non precriptive FP services	80% communities with empowered CBDs	Presence of functioning CBDs	-
			2.4.2.3	Construction and furnishing of Public Health Laboratories including IDRS	Public Health Laboratory constructed	Availability of space, and resources	-
			2.4.2.4	Renovate and upgrade TBL training school in Bayara	TBL training school renovated	Existing strcuture, prompt release of funds	-
			2.4.2.5				-
		2.4.3	To ensure availabillity of drugs and equipment at all levels continued				-
			2.4.3.1	Procurement and distribution of adequate specific drugs (ARV, Anti TB, Anti malaria, De-worming drugs Anti snake venom, etc			-
			2.4.3.2	Coordinate with FMoG, and DELIVER to discuss modalities to ensure constant availability of essential obstetric drugs and supplies and FP commodities including injectables at State, LGAs and HF levels			-
			2.4.3.3	Liaise wirh DELIVER and FMoH to obtain seed stock of contraceptive commodities			-

				(injectables, condoms and pills) for all health facilities in Bauchi State			
			2.4.3.4	Liaise with DELIVER to upgrade State contraceptive commodities storage facility, monitor distribution and utilization of commodities and CLMS at all levels			-
			2.4.3.5	Procure essential medical and non-medical equipment and supplies needed for 148 phase 1 facilities (Delivery kits, couch and other basic FP equipments, non-clinical equipments, Episiotomy kits, Caesarian section kits, IUD insertion and removal kits, Kadelle/Implanon insertion and removal kits, emergency resuscitation trolleys (fully loaded) etc)			-
		2.4.4					-
			2.4.4.1	Distribute equipment and supplies for BOC, EmOC and FP/RH to 148 phase 1 facilities based on findings of facility needs assessment.			-
			2.4.4.2	Procure and distribute basic and specialized family planning			-
			2.4.4.3				-
			2.4.4.4				-
			2.4.4.5				-
		2.4.5	To foster collaboration with the private sector continued				-
			2.4.5.1	Conduct mapping of all privately owned health facilities in Bauchi State			-
			2.4.5.2	Train Staff of privately owned facilities to facilitate provision of FP/RH and EmONC			-
			2.4.5.3				-
			2.4.5.4				-
			2.4.5.5				-
	2.5	**To provide financial access especially for the vulnerable groups**			**1. Vulnerable groups identified and quantified by end 2010 2. Vulnerable people access services free by end 2015**		
		2.5.1	To improve financial access especially for the vulnerable groups				29,718,807
			2.5.1.1	Expand the NHIS coverage to cover all the LGAs of the State	No. of workers enrolled in the program	The State has enrolled in the program already	-
			2.5.1.2	Oganize Radio discussion program on the benefit of NHIs	Radio discussion program conducted	Political will	988,328
			2.5.1.3	Coollaborate with private health providers to provide services to vulnerable groups at subsidized rate		Both parties honor their contractual obligations	28,730,479
			2.5.1.4	Liaise with relevant line Ministries, Parastatals and Organizations to establish/or reactivate existing skills acquisition centers and increase access to microcredit facilities			-
			2.5.1.5				-

		2.5.2	Strengthen Public Health Services			68,953,149
			2.5.2.1	Establish VVF Centre and provide for its running cost	VVF Center established	Political will	-
			2.5.2.2	Establish blindness control program tagged Vision 20, 20	Blindness control programs established	Political will	34,476,575
			2.5.2.3	Establish Cancer, Diabetes and Hypertension control programs	Control programs established	Political will	34,476,575
			2.5.2.4	Reactivate the association of Public Health Practitioners in Bauchi State			-
			2.5.2.5	Support the Association of Public Health Practitioners to hold annual conference to discuss emerging Public Health issues and raise public awareness on Public Health in Bauchi State			-
		2.5.3	Improve Environmental Health				149,398,490
			2.5.3.1	Procurement of Sprayers, insecticides, protective gadgets and materials for disinfection/disinfestation	No. of materials procured	Political will	-
			2.5.3.2	Conduct periodic spray and disinfectiion of Hotels, public buildings and food business centers; and reactivate periodic household inspection by EHOs and re-introduce monthly State-Level Environmental Sanitation Days		Political will	-
			2.5.3.3	Construction of incinerators, and procurement of 40 refuse vans for State and LGAs	No. of incenerators and refuse vans procured	Political will	15,322,922
			2.5.3.4	Construction of Samplat latrines and rehabilitate toilets in affected Secondary and Primary Health Facilities and Public places/communities based on outcome of assessments; construction of compost sites for disposal of wastes	Final disposal sites constructed	Government commitment	76,614,610
			2.5.3.5	Construction of amenities (solar powered boreholes) in relevant HFs, Public places and communities; establish WESCOM at all communities to monitor installed water sources and maintain environmental sanitation		Government commitment	57,460,958
		2.5.4	Refuse disposal and waste				204,714,239
			2.5.4.1	Construction of sewage treatment plant in all the 20 LGAs in collaboration with BASEPA and UNICEF	No. of sewage treatment plant constructed	Government commitment	191,536,526
			2.5.4.2	Construct Incinerators in all Secondary and Primary Health facilities; and Map refuse disposal sites and Desginate permanent disposal sites in the State and LGAs	Mapping exercise conducted	Release of funds	4,788,413
			2.5.4.3	Procure and distribute waste disposal bins in all PHC facilities; Allocate roles and responsibilities on Environmental Health; and institute infection prevention practice and inhection safety in all Secondary and PHC facilities in the State	Roles and responsibilities allocated by 2012	Government commitment	2,873,048
			2.5.4.4	Establish the State Waste Management Board	Waste Management Board established	Release of funds	-

			2.5.4.5	Conduct quarterly meetings with Ministries, Agencies and organizations engaged in waste management	Quarterly meetings conducted	Stakeholder commitment	5,516,252
		2.5.5	Improve Immunization Coverage continued				-
			2.5.5.1	Regular review of high risk potential areas for the spread of WPV			-
			2.5.5.2	Provision of adequate pluses for supplemental immunization activities			-
			2.5.5.3	Improving comunication strategy for polio eradication including partnership with traditional and religious leaders			-
			2.5.5.4	Improving integrated disease surveillance for vaccine preventable diseases			-
			2.5.5.5	Support the introduction of new and underutilized vaccines; and targetted supplimental immunization for specific diseases e.g. Measles, CSM, TT and Yelow Fever.			-
HUMAN RESOURCES FOR HEALTH							
3. To plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care							**31,629,373,902**
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**All States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		315,470,456
		3.1.1	To develop and institutionalize the Human Resources Policy framework				25,675,318
			3.1.1.1	Establlish HRH Unit in the Ministry of Health and its Agencies, as well as, support the estblishement of HRH unit in all the LGA PHC Department	HRH unit established in the state and LGAs	Presence of structures	10,519,947
			3.1.1.2	Mapping of the State HRH at state and LGA level	HRH mapped	Availability of resources	10,027,183
			3.1.1.3	To develop and institutionalize human resource policy framework	Human resource framework developed	Stakeholder paritipation	1,432,455
			3.1.1.4	Hold meeting of stakeholders and CTC for the adoption of policy	No. of meetings conducted	Stakeholder participation	2,320,577
			3.1.1.5	Regular monitoring and evaluation of state human resources	State human resources monitored and evaluated	Release of funds	1,375,157
		3.1.2					1,375,157
			3.1.2.1	Support LGAs to train and absorb health personnel to meet speicific health needs	No. of trainings conducted	Government commitment	1,375,157
		3.1.3	Deveop the capacity of School of Health Technology Ningi				172,429,348
			3.1.3.1	Provide classroom furnitures - 1100 additional desks and tables	No of additional desks and tables provided	Commitment	29,183,877
			3.1.3.2	Construction and furnishing of 2000 capacity lecture thearter/Auditorium	Letcure thearter provided		13,934,861
			3.1.3.3	Construct and equip male and female dormitories	No. of dormitories constructed		47,748,490

			3.1.3.4	Construct demontration ground in the School of Health Technology Ningi	Demonstration ground constructed		23,874,245
			3.1.3.5	Construct school clinic at the School of Health Technology Ningi	School Clinics constructed		23,874,245
		3.1.4					76,397,584
			3.1.4.1	To upgrade the status of the school into a college with the backing of the law	The passing of the law establishing the college	Students performance	28,649,094
			3.1.4.2	Construct and furnishing 20 blocks of 3 no 2 bedroom flat/block for academic and non-academic staff	No of blocks of 2 bedroom flats constrcuted and equipped		47,748,490
		3.1.5	stregnthen the capacity of the State School of Nursing and midwifery				39,631,247
			3.1.5.1	Provide demonstration room fully equipped with basic equipments for students practical experience in the School of Nursing and midwifery	Demonstration room provided, no. of basic equipments provded.	Political will	9,549,698
			3.1.5.2	provde office furnitures and classrooms in the School of Nursing and Midwifery	No. of furnitures provided		28,649,094
			3.1.5.3	procurement of cenference hall furnitures	Conference hall furnitures provided		1,432,455
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the country has stabilised and begun to improve by end of 2012**		1,328,525,342
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels				1,328,525,342
			3.2.1.1	Develop guidelines on HRH recruitment	Guidelines developed	Release of funds	1,671,197
			3.2.1.2	Employ 124 doctors, 752 Nurses/Midwives, 10 lab scientists, Additional number of CHEWS, EHOs, Record officers according to needs assessment	Health work force strngthened	Embargo on employment	1,309,836,583
			3.2.1.3	Train SMOH management and its Agencies on the implementation of FMOH circulars, guilines on HRH	training conducted	Embargo on employment	4,297,364
			3.2.1.4	Establish State Sterring committee for the implementation of the HRH circulars and guidelines at state and LGA levels	Steering committee established		4,125,470
			3.2.1.5	liaise with training insititutions (Universities, Polytechniques, other health training institutions in the country) to increase admission quotas for state indegenes studying courses such as medicine, pharmacy, public health, nurses/midwives, CHEWS, labratory cadre etc	Admission quota increased	Admission criteria	8,594,728
		3.2.2	Capacity Building for Health Care workers				-
			3.2.2.1	Train Community Health Workers on modern methods of family planning; train Doctors and Midwives on EmONC			-

			3.2.2.2	Train Nurses/Midwives on IUCD and Implant insertion			-
			3.2.2.3	Train Doctors, Nurses and Midwives on Post Abortion Care (PAC) services, Voluntary Surgical Contraception.			-
			3.2.2.4	Train Nurses/Midwives on Interpersonal Communications and Balanced Counseling Strategy.			-
			3.2.2.5	Train State, LGA Directors and Facility incharges on CLMS; train health workers on RI, Cold Chain, MCHC/PF, MLSS, ELSS, IPC, BCC and Supportive Supervision			-
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		4,970,618
		3.3.1	To establish and strengthen the HRH Units				4,970,618
			3.3.1.1	Training of health care workers on HRH management		Availability of trainable manpower	4,970,618
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		2,233,973,276
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities				336,970,645
			3.4.1.1	Maintenance of the Three health training institutions			-
			3.4.1.2	Upgrade facilities at the 3 Health training Insitutions	3 health training institutions maintained	Wear and tear of equipments and structures	-
			3.4.1.3	strengthen and sustain allowance paid to medical students studying in various universities		Political will	2,062,735
			3.4.1.4	Review curriculas of the three training institutions to meet state priorities periodically		Political will	330,037,564
			3.4.1.5			National guidelines and standards	4,870,346
		3.4.2	To strengthen health workforce training capacity and output based on service demand				1,876,401,068
			3.4.2.1	Adopt and implement the MSS in the State			433,174,303
			3.4.2.2	Provide for training and re-training of health workers at state and LGA level			10,772,059

			3.4.2.3	To procure modern teaching materials and upgrade existing ones in our training institutions	Teaching materials procured	Political will	-
			3.4.2.4	Establish quality assurance and education review unit in the three health training institutions	Quality assurance units established	Political will	-
			3.4.2.5	Establish 3 additional health training institutions (1 School of Nursing, 1 School of Midwifery and 1 School of Health Technology)	No. of health training institutions added	Political will	1,432,454,706
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		627,959,494
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health				592,348,670
			3.5.1.1	Provide incentive for health staff posted to rural areas			343,789,129
			3.5.1.2	Establish a HRH databse at state and LGA level	Database established	Release of funds	7,907,150
			3.5.1.3	Establlish partnership with FMC Azare and ATBU Teaching Hospital to allow their medical staff and students to assist in providing services to local communities as part of their community service		Existing guidelines establishing the insititutions	-
			3.5.1.4	Engage the service of NYSC doctors for deployment to rural area health facilities	No. of NYSC Doctors engaged and deployed to rural area health facilities	Availability of NYSC Doctors	68,757,826
			3.5.1.5	Engage consultants in fields such as gyneacology, Noma surgery, Diabetes, Heart diseases, Cancer etc on part time basis to compliment and improve the health service delivery	No. of consultants engaged on part time basis	Political will	171,894,565
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				33,805,931
			3.5.2.1	Train and re-train health care workers on IPC and BCC	No. of Health workers trained	Release of funds	7,162,274
			3.5.2.2	Establish the Bauchi State Health Sector annual Productivity merit award ceremony	No. of Health workers awarded	Political will	23,635,503
			3.5.2.3	Carryout client exit interview to monitor performance of health workers	No. of exit interviews conducted		3,008,155
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		-
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system				-
FINANCING FOR HEALTH							

4. To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels							**6,353,497,567**
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		21,974,569
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy				21,974,569
			4.1.1.1	Advocacy to policy makers for increase in budgetary allocation to health by State and LGAs	Budgetary allocation to health increased by 50%	Political will	11,182,535
			4.1.1.2	Advocacy to Development Partners and other relevant stakeholders on the improvement of health services in the State	Advocacy conducted	Political will	1,917,006
			4.1.1.3	develop and implement health financing plans at state and LGA levels	Health financing plans developed and impleented	Political will	8,875,028
			4.1.1.4	Form Techincal Working Groups at State and LGA for the implementation of the Health financing plans	No. of TWGs formed		-
			4.1.1.5	Allocate 25% of Health budget to IMNCH Activity	25% health budget allocated	Political will	-
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		5,391,579,443
		4.2.1	To strengthen systems for financial risk health protection				5,391,579,443
			4.2.1.1	Develop and adopt pricing scheme and enforcement of user fees	Pricing scheme developed and inforced	Political will	4,437,514
			4.2.1.2	Direct feeding of patients at Secondary and Primary Health facilities	Direct feeding program strengthened	Political will	35,500,112
			4.2.1.3	Support LGAs to implement Community - based insurance scheme	No. of LGAs supported	Political will	26,625,084
			4.2.1.4	Form State and LGA Technical Working Groups for the implementation of Community - Based Insurance Scheme	No of TWGs Formed	Political will	-
			4.2.1.5	Strengthen coverage of the State enrollment of its workforce in the NHIS and contribute 15% of the amount due to each state employee	No. of State Civil servants enrolled	Political will	5,325,016,734
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		853,855,783
		4.3.1	To improve financing of the Health Sector				764,139,901
			4.3.1.1	Advocacy to the State Assembly for legislation that stipulates 25% allcation of the State annual budget to be allocated to health	Advocacy conducted	Passage of the law	-

			4.3.1.2	Train State and LGA health managers on financial resource mobilization, advocacy and proposal writing	training conducted	Release of funds	18,637,559
			4.3.1.3	Provide asistance for local and oversea treatment of special medical conditions (Cancers, diabetes, heart diseases, Noma diseases etc)	No. of patients who benefitted from government assistance	Release of funds	745,502,343
			4.3.1.4	Conduct dialogue with the State lagislators to ensure adequate budgetry provision	Dialogue conducted	Political will	-
			4.3.1.5	Introduction of community based risk sharing schemes		Government commitment	-
		4.3.2	To improve coordination of donor funding mechanisms				89,715,882
			4.3.2.1	Quarterly meetings with donor partners on proper utilization of finanancial resources fo health in the State	No. of meetings conducted	Donor Participation	25,815,681
			4.3.2.2	Quarterly meeting with private and traditional health providers, on how to subsidize treatment cost to poor patients, as well as, improve service delivery	No. of meetings conducted	Private setor participation	30,175,095
			4.3.2.3	Quarterly meetings with CSOs, CBOs and other umbrella organizations on the utilization and implementation of donor funded projects	No. of meetings conducted	CSOs participation	33,725,106
			4.3.2.4	Advocacy to Ministry for Local Government to increase budgetary allocation to health at the LGA level by 5% annually		Government commitment	-
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		86,087,771
		4.4.1	To improve Health Budget execution, monitoring and reporting				26,625,084
			4.4.1.1	Train health care workers at state and LGA levels on the development of annual plans	training conducted		13,312,542
			4.4.1.2	Training of health care workers, health financial officers on proper recording and accounting of expenditures	training conducted		13,312,542
			4.4.1.3	Establish State Health Accounts	SHAs established		-
			4.4.1.4	Form Monitoring committee to track how financial resource for health is utilized	Montoring committee established		-
		4.4.2	To strengthen financial management skills				59,462,687
			4.4.2.1	Sponsor State Financial officers to undergo training on health financing	No. of persons trained	Release of funds	53,250,167

			4.4.2.2	Train Health care workers and finance officers in the health sector on financial management	training conducted	Release of funds	6,212,520
NATIONAL HEALTH INFORMATION SYSTEM							
5. To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care							**969,754,957**
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. 60% of States making routine NHMIS returns to Federal level by end 2010**		469,424,266
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels				87,418,374
			5.1.1.1	Review and improved vertical data collection collation and analysis system at all levels		**Commitment from PHC Dept**	30,999,423
			5.1.1.2	Harmonization of vertical M&E tools and system into national NHMIS		**Commitment from PHC Dept**	22,319,585
			5.1.1.3	Capacity building for health personnel responsible for data collection collation and analysis		**Commitment from PHC Dept**	12,399,769
			5.1.1.4	Provide necessary equipment and tools to improve data capture storage and analysis at LGA level		**Commitment from PHC Dept**	12,399,769
			5.1.1.5	Retrieval of obsolette vertical forms		**Commitment from PHC Dept**	9,299,827
		5.1.2	To periodically review of NHMIS data collection forms				13,329,752
			5.1.2.1	Design and adopt user friendly of data collection forms		**Commitment from PHC Dept**	2,479,954
			5.1.2.2	Establish a committee that will coordinate data collection, transmission and analysis at LGA level		Commitment from PHC Dept	-
			5.1.2.3	Conduct quarterly meetings with stakeholders at all levels		Commitment from PHC Dept	10,849,798
			5.1.2.4	Conduct annual review meetings.			-
		5.1.3	To coordinate data collection from vertical programmes				49,599,077
			5.1.3.1	Introduce electronic short (SMS) at all health facilities and other private health institutions for coordination		**Political will**	25,667,522
			5.1.3.2	Strengthened collaboration with development partner and government agencies on data mgt		**Commitment from PHC Dept**	7,749,856
			5.1.3.3	Conduct advocacy/sensitization to all stakeholders on linkages and hormonised data collection at all level		**Commitment from PHC Dept**	16,181,699
			5.1.3.4			**Commitment from PHC Dept**	-
		5.1.4	To build capacity of health workers for data management				197,714,321
			5.1.4.1	Training and re-training of health personnel in government and private sector on data management tools		Political will	5,579,896
			5.1.4.2	Recruitment of skilled manpower to man data collection units		Political will	187,484,512

			5.1.4.3	Provide guidelines to ensure quality and accurate data collection from community to all level		Commitment from PHC Dept	4,649,913
		5.1.5	To provide a legal framework for activities of the NHMIS programme				27,899,481
			5.1.5.1	LGA enact a bye-laws that will compile relevant agencies to provide health information of M&E office		**Political will**	-
			5.1.5.2	Advocacy visit to the LGA policy makers on the importance of data collection and collation analysis		**Commitment from PHC**	24,179,550
			5.1.5.3	Strengthening LGA vital registration system		**Commitment from PHC**	3,719,931
			5.1.5.4	Mechanism to enforce the enacted bye-laws to be put place by the LGA		**Commitment from PHC**	-
		5.1.6	To improve coverage of data collection				90,983,307
			5.1.6.1	Provide logistic support to data management system unit at all levels		Political will	37,199,308
			5.1.6.2	Sensitization of the community on the use of Forms 000		Commitment from PHC Dept	15,499,712
			5.1.6.3	Involve Private Health Facility at all levels through sensitization workshop		Commitment from PHC Dept	19,684,634
			5.1.6.4			Political will	18,599,654
		5.1.7	To ensure supportive supervision of data collection at all levels				2,479,954
			5.1.7.1	Develop Checklist for effective Supportive Supervision		Commitment from PHC Dept	2,479,954
			5.1.7.2	Provide incentives for officers responsible for supportive supervision		Commitment from PHC Dept	-
			5.1.7.3	Conduct regular analysis of the Checklist			-
			5.1.7.4	Documentation of supervisory findings			-
			5.1.7.5	Coduct meetings with LGA PHC Directors and incharges of Health facilities to disseminate findings			-
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**		282,404,746
		5.2.1	To strengthen the use of information technology in HIS				80,908,495
			5.2.1.1	Provide relevant ICT equipments at all levels		Commitment from PHC Dept	-
			5.2.1.2	Training of data personnel to enhance the use of health data through electronic devices		Commitment from PHC Dept	9,609,821
			5.2.1.3	Monthly dessimination of health information through media and other local means		Commitment from PHC Dept	55,798,962
			5.2.1.4	Data Bank networking at State and LGA level			15,499,712
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management				
			5.2.2.1	Adequate and timely availability of National Health Information System forms at all levels		Political will	15,499,712
			5.2.2.2	Development of data saoftware at all levels		Political will	15,499,712
			5.2.2.3	Capacity building of relevant data base staff		Political will	108,497,981
			5.2.2.4	Develop the State Data Bank at the State Ministry of Health			61,998,846

	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010 2. NHMIS annually reviewed and new versions released**		137,327,445
		5.3.1	To strengthen the Hospital Information System				97,028,195
			5.3.1.1	Employment of 10 medical record officer in each LGA to strengthening Health infomation		Political will	89,278,339
			5.3.1.2	Establish contact group between PHC Dept of LGA and Hospital management at Secondary Health facility		Commitment from PHC Dept	-
			5.3.1.3	Periodic meeting between LGA and hospital policy makers.		Commitment from PHC Dept	7,749,856
		5.3.2	To strengthen the Disease Surveillance System				40,299,250
			5.3.2.1	Establish and strengthen community based disease surveillance system		Commitment from PHC Dept	15,499,712
			5.3.2.2	Ensure prompt and regular reporting of notifiable diseases by all health facilities		Commitment from PHC Dept	8,369,844
			5.3.2.3	Sensitization workshop for 30 Clinician/communities on standard case definition on epidemic prompt diseases		Commitment from PHC Dept	12,399,769
			5.3.2.4	Collaborate with development partners to support diseases surveillance system		Commitment from PHC Dept	4,029,925
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs				37,199,308
			5.4.1.1	Provision of quality assurance handbook at each health facilities		Political will	9,299,827
			5.4.1.2	Quarterly meeting with LGA NHMIS Desk Officers in the State		Commitment from PHC Dept	27,899,481
		5.4.2	To strengthen data transmission				21,699,596
			5.4.2.1	Establish Traditional/Religious Leaders forum on Health		Commitment from PHC Dept	17,049,683
			5.4.2.2	Srengthened data transmission through local town announcers and Religious/Traditiona Leaders at LGA level		Commitment from PHC Dept	4,649,913
			5.4.2.3			Political will	-
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. 50% of States have Units capable of analysing health information by end 2010 2. All States disseminate available results regularly**		21,699,596
		5.5.1	To institutionalize data analysis and dissemination at all levels				21,699,596

			5.5.1.1	Production of bulletin on Health information by M&E Unit in the LGA		Political will	9,299,827
			5.5.1.2	Improve the capacity of the Budget and planning Dept of the 20 LGAs on health statistics and research		Commitment from PHC Dept	12,399,769
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							**477,848,626**
	6.1	**To strengthen community participation in health development**			**All States have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		293,549,156
		6.1.1	To provide an enabling policy framework for community participation				105,924,695
			6.1.1.1	Formulate a policy guidline that will ensure community participation in all health activities at LGA		Commitment from PHC Dept	34,674,900
			6.1.1.2	Revitalize the various strata of health development committee e.g WDV, VDCs at LGA level		Commitment from PHC Dept	71,249,795
		6.1.2	To provide an enabling implementation framework and environment for community participation				187,624,460
			6.1.2.1	Established a stakeholder forum on health care services		Political will	9,499,973
			6.1.2.2	Support the establishment of CBOs on health/health realated issues		Commitment from PHC Dept	47,499,863
			6.1.2.3	Update guidelines for establishing development committee for proper community involvement		Commitment from PHC Dept	59,374,829
			6.1.2.4	Strengthen Community involvement in planning, management, monitoring and evaluation of health interventions		Commitment from PHC Dept	71,249,795
	6.2	**To empower communities with skills for positive health actions**			**All States offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		47,499,863
		6.2.1	To build capacity within communities to 'own' their health services				47,499,863
			6.2.1.1	Empower Communities with skills and knolwedge on positive health actions		Commitment from PHC Dept	14,249,959
			6.2.1.2	Identification of key stakeholders and resources within the community for utilization of health services		Commitment from PHC Dept	-
			6.2.1.3	Orientation of community based health care givers on resources mobilization and utilization in the LGA		Commitment from PHC Dept	14,249,959
			6.2.1.4	Produce gender sensitive Information and communication activities (IEC) on health related issues by the LGA		Political will	11,874,966
			6.2.1.5			Political will	7,124,980

	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		35,624,898
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points				35,624,898
			6.3.1.1	Review of existing health delivery structures linkages with the community		Commitment of PHC Dept	16,624,952
			6.3.1.2	Strengthening community health services linkages		Commitment of PHC Dept	11,874,966
			6.3.1.3	Facilitate the structuring of health delivery services to ensure CP in health promotions		Commitment of PHC Dept	7,124,980
	6.4	**To increase national capacity for integrated multisectoral health promotion**			**50% of States have active intersectoral committees with other Ministries and private sector by end 2011**		60,799,825
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development				60,799,825
			6.4.1.1	Advocacy visit to the traditional/religious leaders in the communities		Commitment from PHC Dept	23,749,932
			6.4.1.2	Increase awareness to community gatekeepers on community participation and health promotion		Commitment from PHC Dept	11,874,966
			6.4.1.3	Develop a community Health orientated programmes		Commitment from PHC Dept	11,874,966
			6.4.1.4	Formulation of action plan to facilitate the development of health promotion and protection at community level		Commitment from PHC Dept	3,799,989
			6.4.1.5	Provision of support by LGAs to all communiies that provide health/health related activities		Political will	9,499,973
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement guidelines by end 2010**		40,374,884
		6.5.1	To develop and implement systematic measurement of community involvement				40,374,884
			6.5.1.1	Establish simple mechanism to support and measure the inpact of their own health programmes		Commitment from PHC Dept	11,874,966
			6.5.1.2	Document lesson learnt from a specific community level approach method and initiative		Commitment from PHC Dept	4,749,986
			6.5.1.3	Conduct Dissemination of findings to enhance knolwedge sharing among stakeholders		Commitment from PHC Dept	23,749,932

PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							**602,992,133**
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. FMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. FMOH has an active PPP forum that meets quarterly by end 2010 3. All States have similar active committees by end 2011**		**602,992,133**
		7.1.1	To promote Public Private Partnerships (PPP)				337,029,394
			7.1.1.1	Conduct biannnual meetings of Public-Private & public-Public to explre areas of collaboration	No. of meetings conducted	Stakeholder comitment	128,037,657
			7.1.1.2	Advocacy and sensitization to NGOs, trade unions and professional bodies to strengthen partnership	No. of advocacy visits conducted	Government commitment	109,138,992
			7.1.1.3	Review, update and disseminate State PPP Policy for the State			55,960,515
			7.1.1.4	Develop mechanisms for engaging the private sector through contracting, outsourcing, leases, concessions, franchizing and provision of incentives			31,977,437
			7.1.1.5	Create desk officer to promote, oversee and monitor PPP initiatives			11,914,793
		7.1.2	To institutionalize a framework for coordination of Development Partners				163,526,217
			7.1.2.1	Identify and train key members of NGOs, Trade union and professional bodies on partnership		Government commitment	13,334,591
			7.1.2.2	Develop professional ethics and distribute to relevant partners	Professional ethics formed	Government commitment	5,596,051
			7.1.2.3	Strengthen biannual Development forum comprising health development partners			144,595,574
		7.1.3	To facilitate inter-sectoral collaboration				71,578,295
			7.1.3.1	Formation of Health Committees in relevant Ministries and other Sectors.	Health commitees formed		32,105,347
			7.1.3.2	Conduct quarterly meetings with relevant stakeholders	No. of meetins conducted	Release of funds	17,440,494
			7.1.3.3	Liaise with private and traditional health providers for quality referral service		Political will	4,796,616
			7.1.3.4	Set up inter-sectoral ministrial forum at the state and LGA levels to facilitate intestoral collaboration involving relevant MDA directly engaged in implementation of health programmes such as Environment & Forestry in Malaria control and Prevention, Agriculture in Nutrition programme, Water Resources in control of water borne dieases, Women Affairs in MNCH and Information in BBC.			17,235,838
		7.1.4	To engage professional groups				30,858,227

			7.1.4.1	Promote partnership with professional groups through setting standards, trainings and dissemination	Collaboration established	Stakeholders commitment	4,796,616
			7.1.4.2	Engage professional groups in planning, implementation, monitoring and health plans and programmes	No. of committees established	Political will	7,674,585
			7.1.4.3	Convene public/scientific update lectures through coordinated approach by professional associations	Orientation conducted	Political will	3,997,180
			7.1.4.4	Promote linkage with academic institutions to undertake continous professional development.	No. of meetings documented	Political will	-
			7.1.4.5		No. of supervisions conducted	Political will	14,389,847
		7.1.5	To engage with communities				-
			7.1.5.1	Improve availability of Information to communities in forms that are accessible, useful using culturally acceptable and gender sensitive dissemination channels			-
			7.1.5.2	Establish Ward/ Village Health Development Committees			-
			7.1.5.3	Orientation of WDCs, VDC, FBOs, and CBOs			-
			7.1.5.4	Empower Women and youth groups to conduct referral and linkages on health and health related issues			-
		7.1.6	To engage with traditional health practitioners				-
			7.1.6.1	Develop Policy guidelines for the operation of traditional health practitioners			-
			7.1.6.2	Coordinate traditioner health practitioners into an organized group recognized by the SMOH & PHC Dept of LGA			-
			7.1.6.3	Train traditioner health practitioners to improve their skills and know their limitations and ensure their use of prompt referral systems			-
			7.1.6.4	Regulate traditional health practitioners from advertising themselves			-
			7.1.6.5	Promote researches in some claims made by traditional health practices			-
RESEARCH FOR HEALTH							
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform							**1,063,339,688**
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research priorities 2. FMOH publishes an Essential Health Research agenda annually from 2010**		873,298,312

		8.1.1	To finalise the Health Research Policy at Federal level and develop health research policies at State levels and health research strategies at State and LGA levels				45,978,607
			8.1.1.1	Develop the State Health research Policy	Health research Policy Developed	Presence of existing Policy document	14,185,695
			8.1.1.2	Support LGAs to develop and implement guidelines on health research in line with the State Health Research Policy			5,677,306
			8.1.1.3	Conduct annual review of the health research guidelines to meet state research goals	review meeting conducted	Political will	20,438,301
			8.1.1.4	Conduct dissemination workshop and training of Health workers, CSOs, and Associations on the use of the State health research guidelines and policy	training conducted	Release of funds	5,677,306
		8.1.2	To establish and or strengthen mechanisms for health research at all levels				19,022,759
			8.1.2.1	Strengthen the State Planning, Research & Statistics Department of the SMOH			8,462,970
			8.1.2.2	To train key health care workers on health research			1,892,435
			8.1.2.3	To establish the State Health research data bank at state and LGA levels	Health research data bank established	Political will	4,087,660
			8.1.2.4	Train Private health providers, CSOs, development groups on research methodology, analysis and presentation of research findings	training conducted	Release of funds	2,649,409
			8.1.2.5	Support CSOs, Health Care Workers, Academic Insitutions, LGAs to undertake research on key health issues	research activities conducted	Political will	1,930,284
		8.1.3	To institutionalize processes for setting health research agenda and priorities				594,830,249
			8.1.3.1	Develop the State Research Priority Agenda	Health Strategic Plans developed	Political will	2,270,922
			8.1.3.2	Establish Mini-State Public Health Laboratory in the State	Public Health Laboratory established	Political will	75,697,410
			8.1.3.3	Introduce the State Health Research Grants in ATBUTH, ATBU, Federal Polythecnic, State Polytechnic, and the health institutions in the state	State Health Grant established	Political will	508,686,596
			8.1.3.4	Establish the State Technical Working Group to coordinate the State Research Agenda	Technical Working Group Established	Political will	8,175,320
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors				102,191,504
			8.1.4.1	Establish the Bauchi State Committee of Research Officers	Research Officers Committee formed	Availability of Researchers	11,354,612
			8.1.4.2	Organize Forum of Research Stakeholders twice a year to identify State Research Priorities	No. of research forum conducted	Stakeholders commitment	45,418,446
			8.1.4.3	Establish Health Learning Resource Center in the State	No. of Learning resource Centers established	Government commitment	45,418,446

		8.1.5	To mobilise adequate financial resources to support health research at all levels				111,275,193
			8.1.5.1	To create Budget-line for Research			90,836,892
			8.1.5.2	Provide funding for evidence-based research to Academic institutions, CSOs, and Associations on key health issues			20,438,301
		8.1.6	To establish ethical standards and practise codes for health research at all levels				-
			8.1.6.1	Reestablish standards and practice codes at the state level adapting the national standard.			-
			8.1.6.2	Provide regular review of ethical committee activities			-
			8.1.6.3	Share findings of research conductied in the State regularly			-
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		190,041,376
		8.2.1	To strengthen identified health research institutions at all levels				75,359,800
			8.2.1.1	Conduct mapping of all research institutions, (public, private), organizations conducting health research in the State	Mapping Conducted		13,247,047
			8.2.1.2	Strengthen identified research institutions at all levels		Political will	11,354,612
			8.2.1.3	Conduct annual review meetings of health research institutions, organizations to review performance and identify research gaps	No. of review meetings conducted	Stakeholders commitment	30,319,841
			8.2.1.4	Conduct periodic capacity assessment of research organizations/institutions in the State		Stakeholders commitment	20,438,301
		8.2.2	To create a critical mass of health researchers at all levels				42,012,063
			8.2.2.1	Review curriculum of the three training institutions to involve building the capacity of students on research	Curriculum of the three health training institutions reviewed	Government commitment	10,219,150
			8.2.2.2	Provide sponsorship for further trainings in the country's tertiary institutions and abroad with particular emphasis on research knowledge	No. of individuals who benefitted from the sponsorship	Government commitment	31,792,912
			8.2.2.3	Suppport Research institutions regular clinical reviews to identify risky LGAs and Communities			-
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels				47,689,368
			8.2.3.1	To provide for regular dissemination of research findings conducted in the State		Government commitment	13,625,534
			8.2.3.2	Publish research findings regularly where key research findings conducted in the state will be published	No. of research journals published	Government commitment	22,709,223
			8.2.3.3	Document best practices, lesson learned on the use of research findings in planning, and implementation			11,354,612
		8.2.4	To undertake research on identified critical priority areas				24,980,145

			8.2.4.1	Institute 2 year Bauchi State Health and Demographic Survey	No. of Demographic surveys conducted	Government commitment	18,167,378
			8.2.4.2	Assessment of the performance of government			6,812,767
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012**		-
		8.3.1	To develop strategies for getting research findings into strategies and practices				-
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system				-
			8.3.2.1	To develop policy direction for best practices that have proved replicable in the State			-
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		-
		8.4.1	To create a framework for sharing research knowledge and its applications				-
			8.4.1.1	To devlop a Health research framework for Research Activities in the State			-
			8.4.1.2	Provide regular desimination of research communication activities			-
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				-
			8.4.2.1	Provide forum for dessimination fo research findings in the state			-
Total Cost							**86,226,863,393**

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

BAUCHI STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. Literacy Rate (Female)	NDHS 2008	13%	20%	35%	60%
	2. Literacy Rate (Male)	NDHS 2008	52%	60%	70%	85%
	3. Household with improved source of drinking water	NDHS 2008	36%	50%	70%	95%
	4. Household with improved sanitary facilities (not shared)	NDHS	22%	30%	45%	70%
	5 Household with electricity supply	NDHS	18%	25%	40%	60%
	6. Current employment Status (female)	NDHS	59.10%	65%	70%	78%
2. Improved Legislative and Regulatory Frameworks for Health Development						
	7. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	0	15%	30%	70%
3. Strengthened accountability, transparency and responsiveness of the State health system	8. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	50	75	100
	9. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	10. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	30	75	100
4. Enhanced performance of the State health system	11. % LGA public health facilities using the essential drug list	Facility Survey Report	TBD	40	80	100%
	12. % LGA health facilities not experiencing essential drug/commodity stock outs in the last three months	Facility Survey Report	TBD	10	25	60%

STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	13. Maternal Mortality Rate	SPHCDA Survey Report	1380/100,000 LBs	1200/100,000 LBs	1000/100000 LBs	600/100000 LBs
	14. Infant Mortality Rate	NDHS	109/1000	89/1000	69/1000	40/1000
	15. Under five mortality rate	NDHS	222/1000	180/1000	140/1000	100/1000
	16. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	SPHCDA Reports	TBD	50%	75%	100%
	17. % health facilities implementing the complete package of essential health care	SPHCDA Survey Report	TBD	50	75	100%
	18. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	19. Contraceptive prevalence rate	NDHS	2%	8%	25%	50%
	20. % service delivery points without stock out of family planning commodities in the last three months	Health facility Survey	TBD	10	20	60%
	21. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD	50%	70	90%
	22. % of women age 15-19 who have begun child bearing	NDHS/MICS	51%	45%	40%	30%
	23. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	50.60%	60%	75%	85%
	24. Proportion of births attended by skilled health personnel	HMIS	13%	25%	40%	60%
	25. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	TBD	5%	10	25%
	26. Case fatality rate among women with obstetric complications in EmOC facilities per complication	HMIS	TBD	20%	15%	10%
	27. Perinatal mortality rate**	HMIS	37/1000LBs	25/1000LBs	15/1000LBs	10/1000 LBs
	28. % of women who received postnatal care based on standards within 48h after delivery	MICS	10%	20%	35%	50%
	29. % of children exclusively breastfed 0-6 months	NDHS/MICS	TBD	40%	60%	80%
	30. Proportion of 12-23 months-old children fully immunized	NDHS	1.00%	25%	45%	60%

	31. % children <5 years stunted (height for age <2 SD)	NDHS	51.00%	40%	20%	8%
	32. % Children <5 who are wasted (moderate or severe)	NDHS	41.00%	35%	25%	10%
	33. % Children <5 who are underweight (moderate or severe)	NDHS	52.00%	40%	28%	12%
	34. % of under-five that slept under LLINs the previous night	NDHS	4%	15%	40%	85%
	35. % of pregnant women that slept under LLINs the previous night	NDHS	8%	25%	65%	95%
	36. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS	8%	20%	60%	90%
	37. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	1%	10%	40%	70%
	38. HIV prevalence rate among adults 15 years and above	NARHS	3.10%	2.90%	2.50%	2%
	39. HIV prevalence in pregnant women	NARHS	3.10%	2.90%	2.50%	2%
	40. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	N/A	40%	60.00%	80%
	41.Condom use at last high risk sex	NDHS	54%	60%	70%	85%
	42. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS	17%	30%	60%	95%
	43. % women with complete knowledge of tuberculosis	NDHS	70%	85%	95%	100%
	44. Prevalence of tuberculosis	NARHS	N/A	5%	4.50%	2%
	45.Death rates associated with tuberculosis	NMIS	N/A	2%	1.50%	0.50%
	46. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	N/A	45%	60%	85%
Output 6. Improved quality of Health care services	47. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	35%	60%	90%
	48. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	35%	60%	95%
	49. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	20%	55%	80%
	50. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	10%	30%	60%
	51. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	25%	50%	90%
	52. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	20%	40%	80%

Output 7. Increased demand for health services	53. Proportion of the population utilizing essential services package	MICS	TBD	40%	60%	100%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	54. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	20%	35%	60%
	55. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	30%	50%	80%
	56. % of LGAs implementing performance-based management systems	HR survey Report	TBD	25%	30%	50%
	57. % of staff satisfied with the performance based management system	HR survey Report	TBD	20%	30%	80%
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	58. % LGAs making available consistent flow of HRH information	NHMIS	0%	25%	60%	100%
	59. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	60. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	61. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	62. Medical doctor density per 10,000 population	MICS	TBD	1:10000 pop	1:8000 pop	1:5000 pop
	63. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	64. HRH database mechanism in place at LGA level	HRH Database	TBD	50	75	100%
Output 10: Strengthened capacity of training institutions to scale up the						

production of a critical mass of quality mid-level health workers						
PRIORITY AREA 4: FINANCING FOR HEALTH						
NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoverishment as a result of using health services in the State	65. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	15%	30%	75%
	66. Decreased proportion of informal payments within the public health care system within each LGA	MICS	TBD	80%	60%	30%
	67. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	35%	60%	90%
	68. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	35%	60%	90%
Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	69. LGAs health budgets fully aligned to support state health goals and policies	State and LGA Budgets	TBD	50%	70%	100%
	70. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	71. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	40	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
Outcome 10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation						
Outcome 11. National health management information system and sub-systems provide public and private sector data to inform health plan development and implementation at Federal, State and LGA levels						
Output 13: Improved Health Data Collection, Analysis, Dissemination,	72. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	34%	70%	90%	100%

Monitoring and Evaluation						
	73. % of LGAs receiving feedback on NHMIS from SMOH		TBD	50%	75%	100%
	74. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	40%	70%	100%
	75. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	40%	60%	80%
	76.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	77. % of LGA PHC Coordinator trained in data dissemination	Training Reports	TBD	40%	75%	100%
	78. % of LGAs publishing annual HMIS reports	HMIS Reports	TBD	25%	50%	75%
	79. % of LGA plans using the HMIS data	NHMIS Report	TBD	40%	75%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	80. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	25%	50%	75%
	81. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	82. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	83. % increase in community health actions	HDC Reports	TBD	30%	50%	70%
	84. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the SHDP						
Output 15: Improved Health Sector Partners' Collaboration and Coordination	85. Increased number of new PPP initiatives per year per LGA	SSHDP Report	TBD	25%	40%	60%
	86. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	40%	70%	90%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
Output 16: Strengthened stewardship role	87. % of LGAs partnering with researchers	Research Reports	0%	25%	50%	75%

of government for research and knowledge management systems						
	88. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	89. % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	0%	10%	25%	50%
	90. % of LGAs participating in state research ethics review board for researches in their locations	LGA Annual SHDP Reports	0%	40%	75%	100%
	91. % of health research in LGAs available in the state health research depository	State Health Research Depository	0%	40%	75%	100%
Output 17: Health research communication strategies developed and implemented	92. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	0%	40%	75%	100%