EDO STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

Edo State Ministry of Health

March 2010

Table of Contents

ACKNOWLEDGEMENT

The technical and financial support from all the HHA partner agencies, and other development partners including DFID/PATHS2, USAID, CIDA, JICA, WB, and ADB, during the entire NSHDP development process has been unprecedented, and is appreciated by the Federal and State Ministries of Health. Furthermore we are also appreciative of the support of the HHA partner agencies (AfDB, UNAIDS, UNFPA, UNICEF, WHO, and World Bank), DFID/PATHS2 and Health Systems 2020 for the final editing and production of copies of the plans for the 36 States, FCT, Federal and the harmonised and costed NSHDP.

ACRONYMS AND ABBREVIATIONS

ACPN	Association of Community Pharmacists of Nigeria
AGPMPN	Association of General Private Medical Practitioners of Nigeria
AMLSN	Association of Medical Laboratory Scientists of Nigeria
ARI	Acute Respiratory Infection
BOT	Build Operate Transfer
CHEW	Community Health Extension Worker
CORPs	Community Oriented Resource Persons
CPD	Continuing professional development
CQI	Continuous Quality Improvement
CSM	Cerebro-Spinal Meningitis
CSO	Community Service Organization
DACC	Derivation Account
DAS	Director of Administration & Supplies
DDC	Director of Disease Control
DFA	Director of Finance & Accounts
DNS	Director of Nursing Services
DMLS	Director of Medical Laboratory Services
DMS	Director of Medical Services
DOTS	Directly Observed Therapy (Short)
DP	Development Partners Forum
DPF	Donor Partners Forum
DPHC	Director of Primary Health Care
DPRS	Department of Planning, Research and Statistics
DPS	Director of Pharmaceutical Services
DRF	Drug Revolving Fund
DSN	Disease Surveillance Notification
EBF	Exclusive Breast Feeding
EDP	Essential Drugs Program
EDPA	Edo State Property Development Agency
ELSS	Expanded Life Saving Skill
ENHR	Essential National Health Research
ESHA	Edo State House of Assembly
FAAC	Federation Account
FBO	Faith Based Organization
FCT	Federal Capital Territory
FDI	Foreign Direct Investment
FHI	Family Health International
FMOH	Federal Ministry of Health
HCRC	Hospital Community Relations Committee
GLRA	German Leprosy Relief Agency
HDCC	Health Data Consultative Committee
HMB	Hospitals Management Board
HMO	Health Management Organization
HMIS	Health Management Information System

HIV/AIDS	Human Immuno-Deficiency Virus/Acquired Immune Deficiency Syndrome
HRD	Human Resource Development
HRH	Human Resources for Health
HSR	Health Sector Reform
HSRP	Health Sector Reform Program
ICC	Inter-Agency Coordinating Committee
IDA	International Development Assistance
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
ICT	Information Communication Technology
ICU	Intensive Care Unit
ISS	Integrated supportive supervision
ITNs	Insecticide Treated Nets
LG	Local Government
LGA	Local Government Area
LSS	Life Saving Skill
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MOH	Ministry of Health
MTB	Ministerial Tenders Board
NAFDAC	National Agency for Food Drugs Administration and Control
NANNM	National Association of Nigerian Nurses and Midwives
NDDC	Niger Delta Development Commission
NEEDS	National Economic Empowerment Development Strategy
NGOs	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NIMR	Nigerian Institute for Medical Research
NMA	Nigerian Medical Association
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPf	National Strategic Health Development Plan Framework
ODA	Oversea Development Assistance
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PPP	Public Private Partnerships
PSN	Pharmacy Society of Nigeria
RBM	Roll Back Malaria
RHC	Reproductive Health Cancers
ROT	Rehabilitate Operate Transfer

SACA	State Action Committee on AIDS
SCB	Sickle Cell Board
SCD	Sickle Cell Disease
SEEDS	State Economic Empowerment Development Strategy
SHC	Secondary Health Centre
SMBPED	State Ministry of Budget, Planning & Economic Development
SMOH	State Ministry of Health
SOPs	Standard Operating Procedures
SPHCDA	State Primary Health Care Development Agency
SPT	State Planning Team
SSC	State Steering Committee
SSHDP	State Strategic Health Development Plan
SWAPs	Sector-Wide Approaches
SWOT	Strength, Weaknesses, Opportunities, Threats
TB	Tuberculosis
TMB	Traditional Medicine Board
TQM	Total Quality Management
UPL	Upgraded Pit Latrine
VAT	Value Added Tax
VCT	Voluntary Counselling and Testing
VDC	Village Development Committee
VIP	Ventilated Improved Pit Latrine
WHO	World Health Organization

PREFACE

The Federal Government of Nigeria recognizes that, in order to achieve the country's health targets, inclusive of the of the health-related Millennium Development Goals (MDGs), the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a National Strategic Health Development Plan (NSHDP), with appropriate costing. The NSHDP would result from the harmonization of Federal, States and Local Governments' health plans, thereafter serving as the basis for national ownership, resource mobilization/allocation and mutual accountability by all stakeholders – government, development partners, civil society, private sector, communities, etc.

The NSHDP framework is based on the principle of Four Ones: one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. The framework identifies eight priority areas for improving the national health systems with specific goals and strategic objectives. They are: leadership and governance for health; health service delivery; human resources for health; health financing; health information systems; community ownership and participation; partnerships for health; and research for health. The framework spreadsheets are laid out using the Federal Ministry of Finance budget template so that it will be relatively easy to convey the figures that are generated into a budget for submission in the correct format.

In formulating the Edo State Strategic Health Development Plan (SSHDP), covering the period 2010 – 2015, detailed considerations were given to the need to have practical strategic objectives, interventions specifying what to be done to achieve the stated objectives, and activities that need to be undertaken to ensure that specified interventions are achieved. The SSHDP focused on Primary Health Care as the bedrock of healthcare service delivery, including linkages of service delivery to existing secondary care facilities, especially the general hospitals, emphasized managerial responsibilities at State, LGAs and the Communities for the operation and support of health care services,

and reflected/captured the priority concerns and peculiarities of Edo state (such as Lassa fever and sickle cell diseases, health laws etc).

The need to move away from vertical approach to an integrated one has become very critical to providing a continuum of care and building synergy for the impact. This paradigm shift has received a promise for commitment from the highest levels of government, hence the integration of programmes such as Integrated Maternal Newborn and Child Health, Immunization, Roll Back Malaria, HIV/AIDS, Sickle Cell Project Hope, Water and Sanitation, etc) into this document.

It is envisaged that the SSHDP would achieve/provide functional health policy with its orientation towards the PHC approach that is, people-centred, community-based and Local Government managed programmes; generate needed awareness and consensus on the package; and evolve monitoring mechanisms in relation to health management and health achievements.

Health is a major determinant of the socio-economic development of a people. Edo State Ministry of Health is one of the oldest in the nation, having been in existence since 1963. We are determined to actualize the concept of living a qualitative and productive life today and bequeathing a bright and healthy future for the coming generations. I sincerely urge all stakeholders to buy-in to the implementation of the Edo State Strategic Health Development Plan in order to adequately exploit the interventions required to improve the performance of the health sector towards the delivery of quality, efficient and sustainable health care for our citizens.

Dr. Moses Momoh,
Honourable Commissioner for Health,
Edo State Government.

EXECUTIVE SUMMARY

Edo State lies between longitude 5 degrees East and 6.45 degrees East, and latitudes 6.1 degrees North and 7.30 degrees North. It has a total land area of 19,281.93 square kilometers. The State is bounded by Delta State to the South, Kogi State to the North, Ondo State to the West and the River Niger along the Eastern border. The State produces significant proportions of the country's rubber, cocoa, palm produce, cotton, rice, plantain, corn, cassava and pineapple. Other resources include crude petroleum oil, marble, limestone, lignite, kaolin and granite. The major towns in the State include Benin City (the State Capital), Abudu, Ekpoma, Uromi, Auchi, and Sabongida-Ora.

The 2006 census puts the population of Edo State at 3,218,332. The figure is currently projected at well over 3.4 million people. Although accurate data are not available, the adult literacy rate is well above the national average of 61% male and 39% female. The major environmental/ecological problems associated with Edo State are waste management and sanitation, forest depletion, flooding and erosion of the surface of the soil.

Edo State Strategic Health Development Plan (SSHDP) is a corollary of the National Strategic Health Development Plan (NSHDP) which is aimed at providing the overarching framework for health development in Nigeria. The document provides an up-to-date situation analysis of the health system in Edo State and also outlines the development policy objectives, interventions and actions to be pursued by Edo State and its Local Governments as well as other stakeholders from 2010 to 2015. Based on a multidimensional assessment of the health sector, Edo State has succinctly identified with the 8 priority and thematic areas with specific goals and strategic objectives that it believes will rapidly improve the health system of the State.

A summary of the interventions (97) and activities (320) identified by priority areas is shown in the Table below:

NUMBER OF INTERVENTIONS/ACTIVITIES OF EDO SSHDP

S/N	PRIORITY AREA	INTERVENTIONS	ACTIVITIES
1	Leadership and Governance for Health	9	**32**
2	Health Service Delivery	25	**103**
3	Human Resources for Health	20	**60**
4	Financing for Health	9	**19**
5	Health Information System	14	**33**
6	Community Participation and Ownership	8	**15**
7	Partnerships for Health	5	**15**
8	Research for Health	14	**43**
TOTAL		**97**	**320**

The bulk of the interventions and activities are on health service delivery. Such activities include defining and implementing a ward minimum health care package and establishment of Edo State Primary Health Care Development Agency (SPHCDA).

Primary Health Care (PHC), which forms the bedrock of the national health system, remains prostrate in Edo State due to gross under funding over the years and lack of capacity at the LGA level. Immunization coverage is 72%; only 6% of under-5 sleep under insecticide treated mosquito nets (ITNs); only a third of children with fever are appropriately treated with anti-malarial at home and less than half deliveries are superintended by a skilled birth attendant.

The distribution of health manpower is skewed towards urban populations and the primary health centers do not have sufficient manpower as recommended by regulatory agencies.

The per capita health expenditure on health is about $4, much lower than the $34 recommended by the Macroeconomic Commission on Health for the attainment of the health-related MDGs. The capital budget on health for 2009 is 3.97% of the total budget of Edo State – a far cry from the recommended minimum of 15% by WHO.

About 70% of health expenditure is from out-of-pocket and yet there are no safety nets for the poor and the National Health Insurance Scheme is currently not fully operational in Edo State.

Community participation in Edo State has been limited in scope, organization and impact.

The bottlenecks hampering the implementation of our Ward Minimum Package of Care include:-

a. Inadequate manpower
b. Low budgetary allocation and performance
c. Lack of vital equipment, deterioration or obsolescence of existing ones
d. Dilapidated building infrastructures are dilapidated
e. Inadequate facilities
f. Poor remuneration of staff.
g. Lack of training
h. Inadequate materials for a well developed Health Management Information System

The Ward Minimum Health Care Package (WMHCP), consists of a set of health interventions and services that address health and health-related problems that would result in substantial health gains at low cost to government and its partners. Edo State has included the following ward minimum health care package in its SSHDP:-

a. **Malaria**
    i. Availability of Insecticide Treated Nets (ITNs) for all pregnant women and children under five (5) years of age; insecticide for re-treatment or long lasting ITNs;
    ii. Provision and use of Artemitisin-based Combination Therapy (ACT) for treatment of uncomplicated malaria; and
    iii. Provision of Sulphadoxine/Pyrimethamine for intermittent Preventive Treatment of malaria in pregnant women.

b. **Child Survival**
    i. This essentially includes Integrated Management of Childhood Illnesses (IMCI) strategy with particular emphasis on routine immunization, management of malaria in under-5 children, pneumonia, diarrhea, HIV/AIDS, etc. at State and Local Government levels.

c. Other areas of focus are communicable diseases such as:
    i. Lassa fever
    ii. Tuberculosis
    iii. Leprosy
    iv. Sexually Transmitted Infections
    v. Neglected Tropical Diseases e.g. Onchocerciasis; and

d. non-communicable diseases such as:
    i. Sickle Cell Diseases
    ii. Breast and cervical cancers
    iii. Hypertension and Diabetes.

e. Common Support Services also considered are:
    i. Essential drugs programme
    ii. Human Resources for Health

Tracer interventions have been identified for the three levels of interventions. These interventions have been selected based on their proven and high impact on health outcomes such as mortality and are internationally recommended interventions. The three levels are:

a. Household and Community level Interventions;
b. Population-oriented Interventions; and
c. Individual clinical Interventions

The targets to these interventions include:

a. Prevalence of communicable and non-communicable disease reduced by 50% by 2014
b. 50% of the population in Edo State is within 30mins walk or 5km of a health service by end 2012
c. 50% of obsolete equipment replaced in secondary hospitals and PHCs by 2011.
d. 100% of state-owned hospitals and the 18 LGAs supplied with 1 ambulance each by end of 2012
e. Average demand for health care services rises to 2 visits per person per annum by end 2011
f. 100% of health facilities offering nutrition and growth monitoring services by 2012. At least one CHEW in each PHC centre retrained on health promotion practices by end of 2013
g. Access to IMCI, Childhood immunizations & treatment of common childhood problems in 80% of Health facilities in the State by year 2012 and 100% by 2015
h. Routine immunization institutionalized by 2011.
i. Prevalence of child morbidity and mortality reduced by 50% by 2013
j. 60% of deliveries are attended to by skilled staff by end of 2012 and 80% by year 2015

Towards the effective implementation of the SSHDP, the activities identified have been costed and expected to be funded by State, LGAs and Partners.

Zero tolerance to corruption is one of the values of the present administration in Edo State. There is a standing Ministerial Tenders Board; there is a Due Process Office at the Ministry.

Over the years, Edo State has enjoyed the support of UN Agencies and other bilateral and non-government agencies in enhancing the health status of its citizenry. Such organizations include UNICEF, WHO, UNFPA, World Bank, African Development Bank, etc. Effective use of public funds shall be an important way of attracting donors into the State.

The private sector shall play some important role in the whole financing process.

Strengthening of the Health Management Information System will be carried out early in the plan to ensure that M & E and DSN units are empowered at all levels to track and monitor progress. Specifically, periodic joint assessment of achievements and progress towards MDGs will be carried out with the Local Government Councils. Monitoring and Evaluation were incorporated as key activities in each of the 8 priority areas. Expanded Health Data Consultative Committee (HDCC), Interagency Coordinating Committee and the Forum for Development Partners will be used to ensure cooperation of all stakeholders. More regular State Council on Health meetings (twice yearly) will be used to provide forum for broad-based consultation, coordination and collaboration on a continuous basis.

VISION, MISSION, AND VALUES

Development process must be premised on some operational framework that should be result-oriented, people-centred and driven, and based on a clear vision, mission and sound values. In the health sector of Edo State, our vision, mission and values are as follows:-

Our Vision**:-**
A State with healthy citizens free from the heavy burden of communicable and non-communicable diseases; where life expectancy and quality of life of the people are of the highest level possible.

Our Mission:-
To develop and implement policies and programs that will strengthen Edo State health system and enable it deliver effective, efficient, affordable, acceptable and readily accessible health services that will allow the people to live healthy and very productive lives.

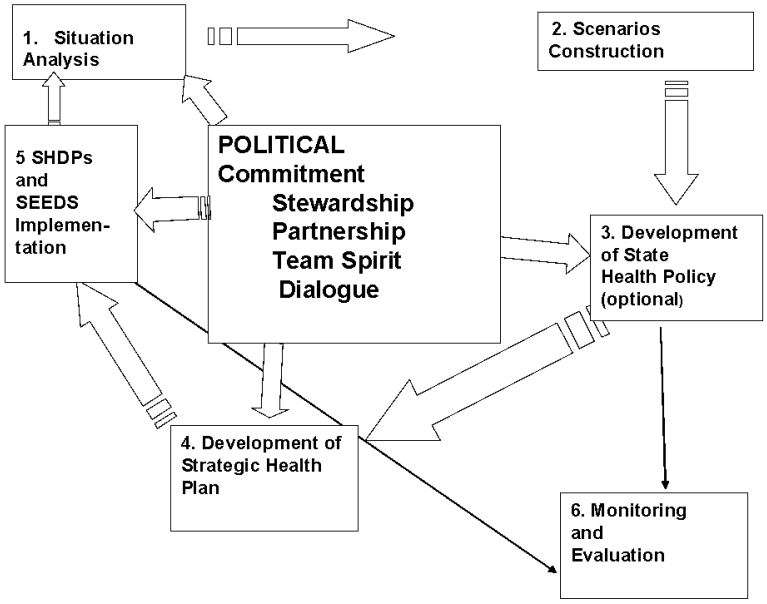
Our Values include**:-** equity, excellence, commitment, quality, teamwork, competence, effectiveness, efficiency, integrity, due process and zero tolerance for corruption.

PURPOSE OF EDO STATE STRATEGIC HEALTH DEVELOPMENT PLAN

- Provides guidance and ideas to Federal, State and LGA Health Planning teams as they formulate their own Strategic Health Development Plans (SHDPs).
- Facilitates the translation of the intentions of the National Health Policy and State Health Policies into practical objectives, strategies, interventions and activities
- Forms the basis for resource allocation to be deployed by Ministries of Health and LGA Health Departments in their implementation.
- Emphasises the increased managerial responsibility to be assumed by the State, Local Governments, and the Communities for the operation and support of their health care services.
- Reflects the priority concerns and peculiarity of individual state but based on primary health care and the goal that all Nigerian citizens receive at least basic minimum health care

Figure1. Steps for the formulation of the Strategic Health Development Plans (SHDPs) and their implementation

Figure1. Steps for the formulation of the Strategic Health Development Plans (SHDPs) and their implementation



CHAPTER 1

BACKGROUND AND ACHIEVEMENTS

1.1 Background

The challenge of frontally addressing the myriad of problems facing the health sector of Edo State has brought about a new approach to strategic health development in the State. Edo State government is therefore committed to reforming its health system to enable it to provide quality health care for its people. It is committed to provision and better management of resources for health care and partnership with national and international agencies to ensure that the State and Nigeria meets global standards/goals in health and ensure accelerated achievements of the MDGs. The objectives of this strategic plan therefore are:

- To highlight the policies, goals, strategies, interventions, activities, targets and framework for the implementation of the SSHDP in Edo State
- Present Edo State program for the accelerated achievement of the Plan over the period; 2010-2015
- Provide a framework for medium term plans and annual budgets and therefore provide a reference for governments, potential investors, donors/partners as well as assessing resource needs for SSHDP in line with our state goals.

In contrast with past health plans, this strategic plan was developed in a participatory manner with all development stakeholders, directors in the Ministry, the LGAs, NGOs, professional bodies, FBOs, etc contributing their inputs into the Plan. This strategic health plan is a plan for the overall health enhancement of the State. It is therefore the collective aspiration of Edo people on how to bring about meaningful health development in Edo State.

1.2 Achievements

The following are some of the major achievements in the public sector of Edo State in recent times:-

- Two special State Council on Health (SCH) meetings were convened within the past 5 years (first, in 2004 and again in 2009), to provide a forum for broad based consultation and participation on health sector reform programme and at ensuring partnership for effective primary health care in Edo State. At both meetings, high level commitment was obtained while priorities were determined and agenda outlined.
- Reorganization of Hospital Management Board (HMB) with decentralization of management and devolution of powers to the hospitals and creation of Hospital governing councils (HGC) with good results.
- Reorganization of Essential Drug Project to a programme and transforming it to a self sustaining, efficient and effective system of Drug Revolving Fund (DRF) capable of meeting running costs for HMB and ensuring quality.

- Inclusion of Sickle Cell Anaemia in the list of "killer diseases" for priority control based on evidence and development of a programme for its control as a non-communicable disease.
- Hospital for women and children completed and commissioned in 2006.
- Government commitment at highest level with increased budgetary allocation for health; year 2005 allocation was more than 300% over the allocation for 2004. The trend was maintained in year 2006 budgetary allocation. However, in recent years, budgetary allocations have declined remarkably.

CHAPTER 2

SITUATION DESCRIPTION (ANALYSIS)

2.1 General Context

Edo State Government has always been committed to provide qualitative, effective, efficient and comprehensive health care services to her citizenry. Nonetheless, there had been major constraints in the past that have hampered progress in health care delivery. Inadequate funding, poorly maintained and obsolete facilities and equipment have been the bane of the health sector in the State. In spite of the numerous health facilities in the State, it still registers low immunization rate, high maternal and child mortality rates, poor attendance of antenatal and family planning services, presence of harmful traditional practices and low life expectancy. This is as a result of inadequate manpower, poor state of hospitals with obsolete equipment. The health information management system is poor, and there is weak compliance from the private health institutions on basic health statistics. The challenge of bringing development outcomes to the people as well as frontally addressing the problem of inequity in health, poor infrastructure, the abysmal trend in health indicators has brought about a new approach to health care delivery services and development management in Edo State.

It is with these at the back of our minds that the Ministry of Health's strategic action plans in the past 8 years had been anchored on existing national and international documents such as the National Economic Empowerment and Development Strategy (NEEDS) as well as the attainment of the health components of the Millennium Development Goals to wit to reduce by 2/3 U-5MR; by ¾ Maternal Mortality Ratio; reverse the spread of HIV/AIDS and the incidence of Malaria and other diseases and provide access to affordable essential drugs.

2.2. Geography

Geographically, Edo State lies between longitude 5 degrees East and 6.45 degrees East, and latitudes 6.1 degrees North and 7.30 degrees North. It has a total land area of 19,281.93 square kilometers. The State is bounded by Delta State to the South, Kogi State to the North, Ondo State to the East and the River Niger along the Eastern border. The State has tropical climate with distinct dry and rainy seasons. The temperatures range from 27 to 44 degrees Centigrade with annual rainfall of 150cm.The State consists largely of flat lands with tropical rain forest in the South and guinea savannah in the North.

Edo State is blessed with abundant natural resources. Virtually all species of hardwood can be found – high quality timber is produced from most local government areas of the State. The State produces significant proportions of the country's rubber, cocoa, palm produce, cotton, rice, plantain, corn, cassava and pineapple. Other resources include crude petroleum oil, marble, limestone, lignite, kaolin and granite.

The major towns in the State include Benin City (the State Capital), Abudu, Ekpoma, Uromi, Auchi, and Sabongida-Ora.

2.3 Demography

The **demographic** features are typical of states in Southern part of Nigeria; growing rapidly with the population overstretching the weak social services. The 2006 census puts the population of Edo State at 3,218,332. The figure is currently projected at well over 3.4 million people (Table 2). The State has one of the highest enrolment rates in primary, secondary and tertiary education in the country. Although accurate data are not available, the adult literacy rate is well above the national average of 61% male and 39% female. It is estimated that infants (0 – 1 year) constitute 4.4%; children under the age of 5 years make up 18% while women of reproductive age (15 – 49 years) represent 24% of the total population. When we consider the fact that 48% of the entire population is under 15 years of age, 72% of the population is made up of mothers and children. The sex ratio is 1:1.

Table 2: Basic Demographic Data on Edo State

1 Area	**19.794 Sq Km**
2 Population	3,218,332 (2006 Census)
3 Population	3,428,725(2009) Projected)
4 Rate of natural growth	2.83
5 Total fertility rate	5.2
6 Urban Population	35%
7 Rural Population	65%
8 Adult Literacy (male)	61%
9 Adult Literacy (female)	39%
10. Sex ratio	1:1

TABLE 3: LOCAL GOVERNMENT AREAS IN EDO STATE AND THEIR POPULATION

S/N	LOCAL GOVERNMENT AREAS (LGAs)	HEAD QUARTERS	1991 POPULATION FIGURE			PROJECTED FIGURE FOR 2001 USING 3.1% AGR.
			MALE	FEMALE	TOTAL	Projected 2001
	Akoko-Edo	Igarra	59,431	64,255	123,686	167,845
	Egor	Uselu	109,745	108,167	217,912	295,710
	Esan central	Irrua	38,177	40,087	78,264	106,205
	Esan north-east	Uromi	43,694	44,993	88,689	120,351
	Esan south-east	Ubiaja	40,132	41,596	81,728	110,906
	Esan west	Ekpoma	37,635	38,197	75,832	102,906
	Etsako central	Fugar	20,008	21,073	41,081	55,748
	Etsako east	Agenebode	46,618	50,698	97,316	132,060
	Etsako west	Auchi	62,836	63,276	126,112	171,137
	Igueben	Igueben	23,096	24,515	47,611	64,609
	Ikpoba Okha	Idogbo	117,126	113,666	230,792	313,189
	Oredo	Benin City	178,327	174,591	352,918	478,917
	Orhiomwon	Abudu	72,795	74,742	147,537	200,211
	Ovia north-east	Okada	62,528	59,241	121,769	165,244
	Ovia south-west	Iguobazuwa	41,544	39,148	80,692	109,500
	Owan east	Afuze	44,569	46,358	90,927	123,390
	Owan west	Sabongida-Ora	35,432	34,942	70,374	95,498
	Uhunmwode	Ehor	51,463	47,304	98,767	134,029
	TOTAL		1,085,156	1,086,849	2,172,005	2,947,457

Source: National Population Commission, Benin city (2001) AGR: Annual Growth Rate

2.4 Governance

The rich **History** of Edo people is as old as creation; its old Bini Empire is fondly referred to as the center of civilization. However, the geographical area presently recognized as Edo State was created on the 27th of August 1991 when the defunct Bendel State was split into Edo and Delta States.

The defunct Bendel State, which was previously known as Midwest Region and later Midwest State was itself carved out of the old Western Region on the 9th of August 1963. Edo State is currently one of the 36 States, which along with the FCT, Abuja, make up the Federal Republic of Nigeria. Edo State is Nigeria's central gateway to the north, east and west; a position which has made it to be popularly referred to as the "Heartbeat of Nigeria". This appellation is also a testament to its tradition of playing vital roles in events of strategic national interest.

The system of government attune with that of the Federal Republic of Nigeria is constitutional democracy with elected Executive, Legislature and an independent Judiciary. The Governor and Chief Executive of Edo State is Comrade Adams Aliu Oshiomhole. The 18 LGAs as shown in Table 3 above form the third tier of government. Each LGA is further divided into wards while each ward consists of communities, towns and villages.

In Edo State, governance is viewed in the following ways:-

- the process by which governments are selected, held accountable, monitored and replaced;

- the capacity of governments to manage resources efficiently and formulate, implement and enforce sound policy and regulation; and
- the respect of citizens and the State for the institutions that govern economic and social interactions among them.

Experts have shown that there is a strong linkage between governance and development in many societies. The explanation for this are twofold:-

- Better governance exerts a powerful effect on per capita incomes; and
- Higher incomes lead to improvements in governance.

Problems militating against effective governance in the State in the past were:-

1. Failure to make a clear separation between public and private resources
2. Excessive rules and regulations, which impede the functioning of markets and encourage rent-seeking
3. Priorities inconsistent with development
4. Narrowly based or non-transparent decision-making
5. Money politics is the order of the day in Nigeria and Edo State is not excluded. This leads to heavy corruption.
6. Diversion of public funds, over-invoicing and payments to fictitious companies, weak management of public funds
7. The appearance of 'ghost' names on public service payrolls have led to repeated screening of staff lists in various agencies in the State and the country at large
8. Absence of punishments for non-performing contractors or for corrupt officials was an aspect of poor governance in the State.

2.5 Socio-economy

Edo State is one of the foremost centers of Arts, Crafts and Festivals in Nigeria. The State capital – Benin City – is famous world wide for its art treasures.

The State is also known for the cultural homogeneity of its people. Industrial undertakings include wood carvings, saw milling, rubber processing, cement and textile production, brewing, agriculture and agro-based production and flour milling.

Although Edo is an oil producing State, yet agriculture still dominates economic activities. The State is very rich in agriculture and is a major food basket for the south-south zone. The major agricultural crops include cassava, rice, plantain, yam, sugar cane, cashew, groundnuts, tomatoes, cotton and tobacco, which are geared towards local and national markets. With the vast forest belt, there are various species of economic trees such as Obeche, Iroko, Mahogany, and Raphia Palms. The major export crops produced in the State are rubber, palm oil, and palm kernel, timber and cocoa while fruits such as citruses, pineapples, guava, coconut, mangoes pear and cherry are also grown. These products provide the incentive for agro-based industries such as the Bendel Feeds and Flour Mill in Ewu, Oil-processing Mills at Okomu, Nigerian Institute for Oil Palm Research (NIFOR) and Presco Oil Palm Plantation at Obaretin to spring up. Limestone, marble, gravel, sandstone, clay, chalk and marble, among others, can be found in the

northern parts of the State. The limestone deposit is utilized by the Okpella Cement Factory.
The territory of Edo State became marginal in petroleum production with the State creation in 1991, contributing about 7.6 percent to the national output. With the exploitation of other fields in the southern parts of the State, production has increased shortly, especially with the exploitation of the Ologbo fields, supplementing quantities from Orhionmwon and Ovia Local Government Areas. Other mineral resources include natural gas.

2.6 Tourist Attractions

These comprise of the Palace of the Oba of Benin – a repository of arts, crafts and culture; the National Museum, Queen Emotan Statue, Igun Bronze Casters, Ogiamen's Residence, the Benin Moat – the World's largest man-made earthwork before the use of technology and the most noticeable landmark encircling the City and constructed circa the 13th century; the Ogba Zoological Garden, Okomu Wildlife Sanctuary, Somorika Hills, Egbake and Oghodoghodo Caves, Asoro Statue, Sand Beaches at Agenebode, Gelegele Fountains, Statue of the Giant Aruanruan, Lampese Crocodile Lakes, Ughoton Graves, Okada Wonderland Holiday Resort, Ososo Tourist Center, Queen Iden Statue, Amahor Waterside, Idoma Hill, Ise Lake in Weppa-Wenno and many others.

2.7 Poverty and Equity

Poverty connotes lack of resources to meet the basic needs of life. This can be monetary and non-monetary. It is a form of social and economic deprivations. It is characterised by low education, unemployment including unstable employment, low income, low status job, poor housing condition and lack of access to basic facilities.
Poverty in Edo State was as high as 60% in 1996 but evidence from the Federal Bureau of Statistics (2003 Living Standards Survey) indicated that it fell to about 40 % in 2004.

However, self-rated head counts of the same survey showed that 83.1% of Edo people are poor. On average, this shows that about 62.0% of the people in the State are poor. Besides, Edo State presented a special case of inequality with a Gini Coefficient of 0.429 after Bauchi with 0.589, Cross Rivers with 0.485, Benue with 0.470 and Adamawa with a Gini Coefficient of 0.447. This is a clear evidence that poverty and inequality are very endemic in Edo State.Its inadvertent manifestation on children is reflected in the following abysmal statistics:-

- Infant Mortality is 100 per 1000 live births
- Under-5 Mortality Rate is 191 per 1000 live births
- 29% of children are not fully immunized, 21% not vaccinated against measles
- Maternal Mortality Ratio is 700 per 100,000 live births
- 42.8% children are malnourished, severe malnutrition is 33.1%
- 20% of Under-5 children suffer from malaria; 15% diarrhea
- HIV/AIDS 5.8% prevalence rate in 2001 although declined to 4.3% in 2003 has now shot up to 5.2% in 2008 with the attendant increase in AIDS orphans

- 41% of women go through pregnancy without antenatal care
- Only 49% of them are protected against tetanus
- About 43% of pregnant women do not have access to iron tablets.
- Some 40% of child births are not attended to by a health professional
- More women than men have HIV/AIDS
- Daily consumption of water by an individual in the State is currently about 29 litres as against 100, 60, and 30 litres per day for urban, semi-urban and rural dwellers respectively

The educational dimension is attested to by the fact that majority of the poor have dropped out of school while many of the girl children had been impregnated out of schools. Others because of early marriage. Evidence shows that about 62% of children are not in school, especially girls. Fifty nine percent (59%) of women cannot read and write.

Unemployment is a major source of poverty in Edo State even though this is being alleviated by the Oshiomhole administration through the massive emplyment of teachers and youths underv the Youth Employment Scheme (YES), and the recent lifting of embargo on unemployment in the civil service. Notwithstanding, unemployment still remains more in urban areas (24.0%) than in the rural areas (11.8%). Edo State has the highest urban unemployment in the Niger Delta Region with 24.0% as against the national average of 14.2%. This, no doubt, accounts for high level of youth restiveness in the State.

2.8 Gender

Gender is about shared roles and relationship between men and women in society. In Nigeria, gender inequality and bias between sexes has been established in some respect. The situation in Edo State is not different from the global or national outlook. There exist some traditional gender practices and institutions such that the economic situation tends to be more favourable to males than females.

In terms of property rights and inheritance, because men have better access to inheritance, the incidence of poverty is more in widows than widowers.
Evidence from the State Poverty profile has shown that women and children are more affected by poverty. Women in rural areas are worst hit. The situation is even more discouraging when non-income poverty measures such as exclusion and voicelessness are considered. Women are faced with difficulties in education, access to resources, employment, health and participation in politics They are more in the informal economy than in the managerial, technical and professional jobs. Primary school enrolment in Edo State is 360,129 spead across the State with female enrolment of 172,227 representing 46.7%; that of secondary stands at 262,119 with female constututing 128,285 (48.99%).
Young women/females are faced with many health risks; they receive inadequate infor mation, guidance and services to help them go safely through adolescence to adulthood. This is important for their reproductive and sexual health. Social indicators have shown

that 41% of pregnant women do not go to antenatal care (ANC) clinics. Out of 100,000 live births, 700 still die from complications arising from pregnancy. While 41% of women go through pregnancy without antenatal care, only 49% of them are protected against tetanus. About 43% of pregnant women do not have access to iron tablets.

2.9 Food & Nutrition

2.9.1 Food

Edo State is predominantly agrarian with a landmass of about 19,035 square kilometres, of which 70% is cultivated for agricultural production as a means of livelihood. It is in the agricultural zone of the country. Wioth an average household of 9, about 2.345 million persons in the State directly or indirectly engage in agricultural activities. It is estimated that agriculture accounts for 40% of the state's GDP. Production of agricultural food and cash crop has therefore depended largely on small scale farmers, who have been shown to to be efficient, given their background and opprtunities.

Quite a number of crops thrive in Edo State. These include cash crops such as cocoa, rubber, palm produce; grains such as maize, rice, beans; root tubers such as cassava, yam, potatoes; vegetables and legumes. If properly developed, the sector is therefore capable of generating food for adequate and appropriate nutrition. Furthermore the agricultural sector is contributing significantly to the success of the poverty alleviation programme in Edo State.

The State, being richly endowed with abundant inland water bodies, is ideal for artisan fisheries, which constitute an important source of fish production from fresh water lakes, dams and reservoirs that are largely under-developed. Livestock also abound in the State and is growing annually. For example, the population of goats, sheep and cattle rose marginally from 1999 through 2004. Goats for instance rose from 800,000 to 1,010,000 during the same period. The same trends are observed for sheep, poultry and rabbits. Pigs however got de-populated during the period. They declined from 350,000 in 1999 to 305,000 in 2004.

The availability of agricultural training institutions for producing middle-level manpower for the sector, and a long history of extension services constitute another strength.

Furthermore, the State has foreign-assisted agricultural development programme, which has generated noticeable capacity building for agricultural development and management. The State has also had funding support from the International Fund for Agricultural Development (IFAD) for improvement in cassava production.

Notwithstanding all these strengths, agriculture is still largely rudimentary with most farmers relying on rain-fed agriculture. Farmers acticvities are hidered by lack of support for rural institutions to raise productivity, degradation in arable land, increasing loss of soil fertility, bad agricultural practices, rural-urban drift, limited access to farm inputs, poor marketing and storage facilities And lack of capital for operational expansion, amongst others.

2.9.2 Nutrition

As we face the impending consequences of the global economic melt down, we are poised to continue to implement nutrition actions that would reduce morbidity and mortality rates especially as they affect children and women. As we put in place internal mechanisms for determining socio-economic impact of nutrition-related disorders and diseases, we observe the following progress in nutrition across Edo State:-

- It is gratifying to note that more and more institutions/agencies have continued to score the State Nutrition Service very high;
- There has been no decrease in Under-5 mortality rate from the 2007 figure of 143;
- 12.6% rise in Exclusive Breast Feeding (EBF) rate, which translates to an increase from 27% to 37% from 1st quarter in 2008;
- Over 40% increase in attendance to and use of health facilities in the years 2005 and 2006;
- 100% salt iodization in Edo State. All salt samples tested for levels of iodine using iodine test kits supplied by UNICEF in all communities showed that they have the desired levels of iodine;
- 69.5% of children 6-59 months were provided with the desired dose of Vitamin A as against 59.1% and 45.6% for 2007 and 2006 respectively;
- 60% of the 18 LGAs now routinely provide reports on nutrition activities as against the nil situations before year 2007;
- 100% of LGAs' Nutrition Desk Officers now visit at least 30 % of their communities to monitor nutrition activities as against the nil situations before the year 2007;
- In January, 2007, 240 health workers and care-givers were trained on promotion of Vitamin A supplementation and Key Household Practices in 6 UNICEF Focal Communities;
- Using the Shakir Arm Strip to determine the level of wasting in children, there was a sharp drop in the number of children 6-59 months within the danger zone (red) in the last half of 2008;
- The prevalence of underweight in children 6-59 months was observed to reduce from 27% in 2006/2007 to 24.9% in the last quarter of 2008;
- 33% reduction in diarrhoea amongst children reporting in Primary Health Centres from 2006/2007 rates.

However, the followings are also worthy of note:-

- The number of hospitalized children for severe acute malnutrition has continued to rise;
- The incidence of low birth weight is still high; record from 12 hospitals across the State shows that 18.8% of deliveries had birth weight below 2.5gm. However, multiple births accounted for 62.1% of this figure;
- Food demonstration as a means of impacting nutrition information is practiced in only 4% of Primary Health Care facilities while no food demonstration goes on in tertiary and private health facilities.

TABLE 4: PERCENTAGE PREVALENCE OF UNDER-5 NUTRITIONAL STATUS IN EDO STATE (2007-2008)

	Underweight	Wasting	Stunting
Edo State	22.7	15.7	**33.1**
National	**25.0**	**11.5**	**34.0**

Prevalence of severe acute malnutrition in Edo State = **14%**

TABLE 5: VITAMIN A COVERAGE FOR CHILD HEALTH WEEK 2008

	6-11 MONTHS	12-59 MONTHS	P.P.M.
Target Population	123,394	493,574	**137,104**
Coverage	83,657	225,838	**2,240**
% Coverage	**67.8**	**45.8**	**1.6**

2.10 Education, Housing, Water, Sanitation and other Environmental Aspects

2.10.1 Education

Education is a fundamental lubricant of any meaningful development particularly in Edo State in terms of awareness creation and human empowerment.

Over the years, Edo State Educational policy thrusts have been to increase the level of literacy among the urban and rural population across all ages and levels and to achieve an overall sincrease in access to education.

The State educational sector can be categorised into pre-primary education, primary, secondary, tertiary, and adult and non-formal education.

In retrospect, as at 2004, Edo State has:-

- 422 pre-primary schools;
- 1472 primary schools comprising 437 private primary schools and 1035 public primary schools;
- 694 secondary schools comprising 319 public (including technical) and 375 private schools. In addition to this are three Teachers' Training Colleges to address the manpower needs of the pre-primary and primary education;
- The tertiary institutions include Ambrose Alli University, Ekpoma with a College of Medicine; Edo State College of Education, Ekiadolor; Institute of Physical Education, Afuze; and College of Agriculture, Iguoriakhi

- The non-formal educational system comprises the Institute of Continuing Education (I.C.E.), Benin City and the Agency of Adult and Non-Formal Education. These are responsible for implementing the Mass Literacy Programme that is geared towards providing adult education to the citizens of Edo State.

In addition to these, there is a Federal University – the University of Benin, Benin City, and two private Universities –Igbinedion University, Okada, and Benson Idahosa University, Benin City. There is also a Federal Polytechnic at Auchi and a Fedral Girls and Mixed Colleges in Benin City and Ibillo.

2.10.2 Housing

Housing – a basic necessity of life – is an asset of self fulfilment. Since the inception of the State, housing has been a major development focus of government havinf realised its centrality to development transformation. The provision of housing for all continues to enjoy centre stage in the scheme of things not only during past administrations but also is being vogorously pursued in the present administration of Comrade Adam Oshiomhole.
At the Local Government level, areas of land for future housing scheme were donated to EDPA during the administration of Lucky Igbinsdion. In fact, the Authority for housing estates in Abudu, Igueben, Ekpoma, Uromi and Sabongida-Ora has prepared layout plans showing programmed urban development scenario. Apart from that, site and services scheme have been completed at Egor-Egbaen Housing Estate, near Benin City for planned housing units. Depite all these efforts, several problems are confronting housing provision in the State. The provision of housing is capital intensive and hence the competing needs for public resources have substantially reduced budget appropriation on housing. In order to tackle this problem in the past, government housin agency had resolved to apply for loans from the Federal Mortgage Bank of Nigeria.

2.10.3 <u>Water</u>
Steady supply of potable water is a sine qua non for human and industrial purposes. Thus shortage of water negatively affects not only households but businesses and industrial institutions. Lack of water (and epileptic supply of electricity) is widely responsible for raising the cost of production in factories. It also has its adverse and untold effects on health care delivery services and on health generally.
The issues with potable water supply in Edo State include:-

- The supply of potable water is engulfed with inadequate facilities and poor funding;
- Inadequate supply of potable water especially in the rural areas;
- Difficulty in getting to real water table in some parts of the State especially in Edo Central and Edo North;
- Poor water distribution network;
- Dilapidated and depreciated equipment that needed to be replaced; and
- Inadequate supply of power to water projects.

The focus of government therefore, in recent times, is to pay attention to not only to urban development but rather to rural transformation. This involves rural electrification, water supply and road network.
The current main policy thrust of the State Government is to

- Improve supply of potable water by increasing the percentage of the rural populace with access to safe water from the current situation of 30% to 70% by the end of 2012;
- reduce the incidence of water borne diseases in the State by 50% by 2012;
- reduce the distance people seeking water have to trek from the current 2-3 kilometres to a maximum of 1 kilometre;
- reactivation and constant maintenance of existing water schemes;
- improvement in distribution system;
- improved supply of energy to water schemes; and
- conduct geophysical survey to locate possible water tables in the State.

The associated strategies at achieving these targets include:-

- Contracts for the rehabilitation/up-grading of Ugbowo, Iyaro, Esigie, Ojirami Dam, Urhonogbe Water Scheme to be concluded; and
- Reactivation of Ikpoba River Dam, Resuscitation of Fugar Regional Water Supply, Ogan/Abudu Water Works, Ojirami Water Dam, Ewohimi/Iyagun, Ugbalo/Ibore etc which have been costed and due for implementation.

2.10.4 Sanitation

Very few people in the State have access to good sanitation with majority living in squalors and shanties. Access to sanitation in a broader sense means the availability of sanitary facilities for human excreta/waste disposal within a convenient distance from the user so as not to discourage its use. Although waste dispiosal is regarded as a household affair, government has however come up with some policy guidelines on proper human waste disposal in the State. In the urban areas, there are the cistern connections, public sewers and ventilated improved latrine (VIP) while in the semi-urban and rural areas. Upgraded pit latrines (UPL) are in use. Recently, the Niger Delta Development Commission (NDDC) supplied some equipment to Edo State Government to facilitate environmental sanitation exercise in the State. However, several problems and constraints still inhibit sanitation in the State.

2.10.5 Environment

The major environmental/ecological problems associated with Edo State are waste management, pollution and sanitation, forest depletion, flooding and erosion of the surface of the soil. Solid waste disposal and land degradation due to flooding and erosion ranked 1st and 2nd in the objective ranking of environmental problems in Edo State. In many of the identified sites, the magnitude of devastation has resulted in loss of lives and properties, destruction of arable lands and wastage of large areas of usable lands. The site/areas constitute health hazards that has adverse effects on the socio-economic life of the citizenry of the State. In the recent times, precisely as from the early 80s, oil spillage has become incessant; destroying both terrestrial and acquatic life as well as inhibiting fishing and agricultural practices that constitute the primary occupation of the people.

The mitigating actions and the cost implication as highlighted in the Edo State Environmental Action Plan, which clearly stipulate an annual expenditure of about N1 billion for a period of over 10 years for flood and erosion control while waste management and pollution control measures would gulp about N1.5 billion annually.
There is the need for re-afforestation, regulated construction and provision of drainage facilities in urban areas as well as attitudinal change on the part of the people.

2.11 Relationship of SSHDP to existing development programmes (NEEDS, SEEDS, HSR, etc.)

In Edo State, the programme for the achievement of the SSHDP has been developed as a component content of the National Health Sector Reform Programme (HSRP) and its corresponding State Health Sector Reform Programme, which had been anchored on Edo State Economic Empowerment Development Strategy (SEEDS); a corollary of the National Economic Empowerment and Development Strategy (NEEDS) of the Federal Republic of Nigeria

that specifically addresses the International Development Targets (IDTs), which were set in 1996 to improve economic well-being, social and human development and ensure environmental sustainability and regeneration.
The main thrust, therefore, of our health component of SEEDS in tandem with NEEDS and MDGs is:-

- Setting up and equipping our comprehensive health centers;
- Immunisation and inoculation programmes;
- Introduction of the new health insurance scheme based on personal contribution; and
- Reduction of the "disease burden" attributable to priority diseases and health problems including malaria, tuberculosis, HIV/AIDS and reproductive health.

2.12 Health System of Edo State

There are 3 levels of health care delivery services in Edo State namely **primary**, **secondary** and **tertiary**. While PHC aims to make essential health care as close as possible to individuals and families in communities, secondary health care (SHC) provides a higher level of care in hospitals and attends to patients referred from PHC Centres. Teaching Hospitals and other more specialized health institutions, which provide care for specific diseases and conditions, on the other hand, provide tertiary health care. A two-way referral system between these levels of care is mandatory in the health plans and ensures that efforts at the various levels are mutually supportive. While the State Government has primary responsibility for SHC, Tertiary Health Care is intended to be mainly a Federal Government responsibility. Both the Federal and State Governments, provide support to the Local Government for provision of PHC. Primary health care therefore, as the bedrock of the nation's health policy, is given attention at all levels of government.

2.13 Health Status

2.13.1 Current Health Status in Nigeria

There is no doubt that the health status of Nigerians are generally in a deplorable state as attested to by the following appalling data from the World Health Organisation in 2000:-

2.13.1.1 *Health Status Indicators*

Health status indicators are worse than the average for sub-Saharan Africa:

- Infant mortality rate of 115/1,000 live births;
- Under-5 mortality rate of 205/1,000 live births;
- Maternal mortality ratio of 948/100,000 live births (range from 339/100,000 to 1,716/100,000).

2.13.1.2 *Low immunization coverage*

- Only 13% of children (age 12-23 months) have received the recommended course of immunization;
- 27% of children have not received immunization at all.

2.13.1.3 *High prevalence of malaria*

- Only 12% of households own a mosquito net
- Only 2% own Insecticide Treated Nets (ITNs);
- Only 6% of children Under-5 sleep under a mosquito net;

- Only 20% of women report taking a preventive anti-malaria drug during their last pregnancy.

2.13.1.4 *High prevalence of HIV/AIDS*

- Only ½ of all Nigerians know that both condom use and remaining faithful are ways to prevent HIV transmission;
- Almost about 40% of men who are sexually active reported having high-risk sex. while less than half used a condom.

2.13.2 Benchmark of Current Health Status in Edo State

The basic health and social data (Table 6) below confirm the general poor state of health of the people. There is also a wide discrepancy between data from different sources and between urban and rural areas. The data below are applicable to a cross section of Edo State.

TABLE 6: EDO STATE BASIC HEALTH AND SOCIAL DATA (JUNE 2009)

HEALTH/SOCIAL DATA	RATES / PERCENTAGES
Crude Birth Rate (per 1000)	**54**
Crude Death Rate (per 1000)	**16**
Infant Mortality (per 1000 live birth)	**100**
Maternal Mortality Ratio (per 100,000)	**700**
Under-5 Mortality Rate (per 1000 live birth)	**191 (? 143 – 2007)**
Malnutrition among Under-5: Underweight Wasting Stunting	 **22.7%** **15.7%** **33.1%**
Well-nourished Under-5	**57.2%**
Birth weight 2500g and above	**83%**
Life Expectancy of Birth: Male Female	 **50 years** **54 years** **(43.3 yr – national)**
Total Fertility Rate (2006)	**5.7%**
Exclusive Breast Feeding Rate	**45.3%**
NPI Coverage: Urban Rural	 **Not available** **Not available**
Routine immunization (June, 2009):	
BCG	**77%**
OPV3	**63%**
DPT3	**72%**
Measles	**79%**
Yellow Fever	**49%**
HBV3	**66%**
TT2	**59%**
HIV/AIDS Prevalence (2008)	**5.2%**
Physicians per 10000 population	**2.63**

Nurses per 10000 population	**21.44**
Delivery by trained attendants	**42%**
Antenatal care (Rate)	**70%**
Delivery by health professional (Rate)	**45%**
% of population with access to improved water supply	**57%**
Share of outpatient care provided by Pvt. Sector	**64%**
Share of out of pocket expenditure	**70%**

2.13.2.1 Health-related MDG Indicators in Edo State

Available health related MDG indicators are as follows:-

MDG 1: Poverty and Hunger:-

- Prevalence of child malnutrition in Edo State (Underweight) (% under 5) = 22.7%
- Prevalence of child malnutrition in Edo State (stunted) (% under 5) = 33.1%
- Prevalence of child malnutrition in Edo State (wasting) (% under 5) = 15.7%

MDG 4: Child Mortality:-

- Under-5 mortality rate (per 1000 live births) = 191
- Infant mortality rate (per 1000 live births) = 100
- Mortality due to malaria amongst under-5 with mortality rate of 201 per 1000 live births = 30%
- Measles immunization (% of children 12-23 months) = 83%

MDG 5: Maternal Mortality:-

- Maternal mortality ratio (per 100,000 live births) = 700
- Birth attended by skilled health staff (%) = 75%

MDG 6: HIV/AIDS, Malaria and Other Diseases

- Prevalence of HIV (% of adults ages 15-49) = 5.2% (2008)
- Contraceptive prevalence rate (% of women ages 15-49) = 4.2% (national = 8.6%)
- Number of children orphaned by HIV/AIDS = Not available

- Proportion of children sleeping under insecticide-treated bed nets (% of children under 5) = 6% (national)
- Proportion of children with fever treated with anti-malaria medicines = 60.3 per 1000 live
- Incidence of tuberculosis (per 100,000 per year) = 75
- Tuberculosis cases detected under DOTS (June, 2009) = 573

MDG 7: Environment

- Access to an improved water source (% of population) = Not available
- Access to improved sanitation (% of population) = Not available

Other summary indicators as contained in the NDHS 2008

POPULATION (2006 Census)	EDO
Total population	**3,233,366**
female	1,599,420
male	1,633,946
Under 5 years (20% of Total Pop)	409,104
Adolescents (10 – 24 years)	1,089,332
Women of child bearing age (15-49 years)	853,624
INDICATORS	**NDHS 2008**
Literacy rate (female)	76%
Literacy rate (male)	88%
Households with improved source of drinking water	60%
Households with improved sanitary facilities (not shared)	30%
Households with electricity	74%
Employment status (currently)/ female	65.9%
Employment status (currently)/ male	67.3%
Total Fertility Rate	5.3
Use of FP modern method by married women 15-49	19%
Ante Natal Care provided by skilled Health worker	91%
Skilled attendants at birth	80%
Delivery in Health Facility	76%
Children 12-23 months with full immunization coverage	39%
Children 12-23 months with no immunization	4%
Stunting in Under 5 children	38%
Wasting in Under 5 children	8%
Diarrhea in children	2.7
ITN ownership	6%
ITN utilization (children)	3%
ITN utilization (pregnant women)	3%
children under 5 with fever receiving malaria treatment	29%
Pregnant women receiving IPT	3%
Comprehensive knowledge of HIV (female)	36%
Comprehensive knowledge of HIV (male)	50%
Knowledge of TB (female)	74.4%
Knowledge of TB (male)	91.6%

2.14 Organization and structure of the State or LGA health system (public sector, private sector, public/private sector mix, traditional health sector)

2.14.1 State Ministry of Health

The State Ministry of Health is one of the oldest Ministries in Edo State; having been in existence since the creation of the defunct Midwest Region on the 23rd of August, 1963.

Then, it was known as the Ministry of Health and Social Welfare. The social welfare responsibility has since been transferred to another Ministry.

2.14.1.1 Organizational Set Up

The Ministry currently operates a department structure which includes the following 9 Departments with Directors heading each Department:-

- Administration & Supplies (DAS);
- Finance & Accounts (DFA);
- Health Planning, Research and Statistics (DPRS);
- Medical Services (DMS);
- Primary Health Care (DPHC);
- Disease Control (DDC);
- Pharmaceutical Services (DPS);
- Nursing Services (DNS); and
- Medical Laboratory Services (DMLS).

2.14.1.2 Functions of the Ministry

The 1984 edict on the assignment of responsibilities to Ministries and Departments assigned the following functions to the Ministry of Health:-

- The formulation and execution of health policies;
- The execution of health sector development programs;
- The administration of the state government hospitals and allied health institutions via the Hospitals Management Board (HMB);
- The monitoring and control of pharmaceutical services especially the registered pharmacies in Edo State (now 138);
- The supervision and control of traditional medicine practice through the Traditional Medicine Board;
- The control of training institutions for nurses, midwives, and supportive health care workers such as health superintendent, pharmacy assistants, other pharmaceutical staff and health workers;
- Liaison with World, International, and National bodies with respect to health services; and
- The registration and supervision of the private and voluntary health institutions across the State (now over 554).

2.14.1.3 Parastatals/Directorates

The Ministry also has parastatals and specialized directorates, which include the following:-

2.14.1.3.1 Four parastatals:

- Hospitals Management Board (HMB);
- Essential Drug Project (EDP);
- Traditional Medicine Board (TMB); and
- Sickle Cell Board (SCB).

2.14.1.3.2 Three health training institutions:

- School of Nursing

- School of Midwifery; and
- School of Health Technology.

2.15. The Current State of the Parastatals and Health Institutions

2.15.1. Hospitals Management Board

The Hospitals Management Board (HMB) is the largest of our parastatals and is in charge of the 34 government-owned hospitals offering secondary health care services throughout the State. This is as reflected in Table 9 below. They all have a total bed complement of 2006. The current staff strength of the HMB is 2,172 as depicted in Table 10 below.

These hospitals offer a higher level of care and serve as referral centers to the primary health care centers. The Central Hospital in Benin City serves as the apical referral center for all the State hospitals. The Central Hospitals at Uromi and Auchi also serve as referral centers to the other hospitals in their respective senatorial districts of operation. Activities in this parastatal are continuous with emphasis on curative, hospital-based care. Statistics on service performance generated annually indicate high level service delivery and good patronage. The Chief Executive of the Board is the Director of Hospital Services. There is currently no Board in place.

For the purposes of administration, the 34 government-owned hospitals are grouped into twelve medical zones. Each zone is headed by a Zonal Medical Director. The Zonal Medical Directors administer the zones with the assistance of Zonal Management Committees. The distribution of the 34 government-owned Hospitals with their bed complements in Edo State as at August, 2009 is as depicted in Table 9.

2.15.2. Essential Drug Project (EDP)

In order to reduce the spiraling cost of drugs and medical treatment, Edo State Government has re-positioned the Essential Drug Programme (EDP) as the central source of supply of essential drugs and medical items to all the government-owned hospitals and health facilities in the State.

The supply of efficacious and affordable drugs by the EDP to all the State Government Hospitals under the Hospitals Management Board is ongoing. Only drugs urgently required and not supplied by EDP are purchased by our hospitals from reputable pharmacy stores and chemists for emergency purposes under the drug revolving fund (DRF) scheme.

2.15.3. Traditional Medicine Board

In Edo State, the Traditional Medicine Board was originally set up to regulate traditional medical practice in the state. A Traditional Medicine Board was recently, in October, 2009, constituted and sworn-in by the Executive Governor of Edo State, Comrade Adams Oshiomhole. There are 84 trado-medical doctors/clinics and 4 alternative medicine (Acupuncture) health facilities presently registered in Edo State.

2.15.4. Sickle Cell Board

The Sickle Cell Board is the youngest of the parastatals of the Ministry of Health. There is currently no Board. The law setting up the Board was passed in 2004 while the then Hon. Minister of Health, Prof. Eyitayo Lambo inaugurated the Board during the National Council on Health meeting in Benin City in May 2005. It was a significant milestone and a pioneering legal document to back the sickle cell centre in Benin City.

The Centre now offers services, which include in-patient and out-patient treatment, genetic counselling, advocacy and IEC measures, research in better methods of control, diagnostic and blood banking services, and welfare amongst others. Medical, nursing and laboratory support staff are on ground at the Centre. The activities of the Sickle Cell Centre are coordinated by a Medical Director.

2.15.5. Health Training Institutions

Edo State has 3 health training institutions viz:-

- School of Nursing
- School of Midwifery; and
- School of Health Technology.

They all require renovation, rehabilitation, equipping, and completion of abandoned projects including hostels

2.16. Tertiary Health Care in Edo State

The tertiary health institutions include the University of Benin Teaching Hospital, Psychiatric Hospital Uselu, and Irrua Specialist Teaching Hospital, Irrua, Igbinedion University Teaching Hospital, Central Hospital Benin City. While the first three are owned by the Federal Government, Igbinedion University Teaching Hospital is privately-owned. The Central Hospital in Benin City is the only State Government-owned hospital for internship training for medical doctors (House Officers) and pupil pharmacists in Edo State. In view of the professional expertise available in the hospital, it has also been recognized for training of resident doctors in Obstetrics and Gynecology and Family Medicine. It is also a training ground for students in the State Schools of Nursing and Midwifery. Igbinedion Medical School, and Igbinedion School of Nursing and Midwifery also use the hospital for training. Although the private sector is rapidly growing, it is poorly regulated and the quality of care is poor both in the private and public sectors. The policy thrust of government is to get these existing health facilities to function properly through public private partnership, in a well-implemented Health Sector Reform (HSR) program.

2.17 Resources (Human Resources, Finance, Facilities, Equipment and Transport, Essential Drugs, etc.)

2.17.1 Current state of Human Resources for Health in Edo State Hospitals Management Board and the State Ministry of Health

The current staff strength of the Edo State HMB is 2,172. This is grossly inadequate in view of the number of government-owned hospitals (34) and the bed complement of the hospitals (2006) as depicted in Table 9 below. Table 7 depicts the staff strength of the HMB as at August, 2009 while that for the State Ministry of Health is reflected in Table 8.

TABLE 7: STAFF STRENGTH FOR HOSPITAL MANAGEMENT BOARD

S/N	CADRE OF STAFF	IN POST
1	Director of Hospital Services/Chief Executive	1
2	Consultant (O&G)	12

3	Consultant (Ophthalmology)	2
4	Consultant (Paediatrics)	4
5	Consultant (Orthopaedics)	2
6	Consultant (Radiology)	2
7	Consultant (Surgery)	3
8	Consultant (Medicine)	6
9	Consultant (ENT)	1
10	Consultant (Dermatology)	1
11	Consultant (Anaesthesia)	2
12	Senior Registrar l	6
13	Chief Medical Officer	5
14	Principal Medical Officer l	8
15	Principal Medical Officer ll	11
16	Senior Medical Officer	16
17	Medical Officer	51
18	Chief Dental Surgeon	1
19	Senior Registrar (Dentistry)	1
20	Senior Dental Officers	3
21	Dental Officers	16
22	Principal Optometrist	1
23	Senior Optometrist	3
24	Optometrist	2
25	Asst Director/Head of Administration	1
26	Assistant Director (Administration)	1
27	Assistant Director (Establishment)	1
28	Principal Secretary	2
29	Senior Hospital Administrators	3
30	Hospital Administrators l	2
31	Hospital Administrators ll	28
32	Chief Executive Officer	4
33	Principal Executive Officer l	13
34	Principal Executive Officer ll	13
35	Senior Executive Officers	10
36	Higher Executive Officers	18
37	Executive Officers	9
38	Assistant Executive Officers	5
39	Senior Clerical Officers	26
40	Clerical Officers l	19
41	Clerical Officer ll	42
42	Clerical Assistant	5
43	Director of Pharmaceutical Services	6
44	Chief Pharmacist	8
45	Senior Pharmacist	6
46	Pharmacist	8
47	Chief Pharmacy Technician	7
48	Assistant Chief Pharmacy Technician	1

49	Pharmacy Technician	4
50	Assistant Director of Med. Lab. Scientist	3
51	Chief Medical Laboratory Scientist	5
52	Principal Medical Laboratory Scientist	1
53	Senior Laboratory Scientist	1
54	Medical Laboratory Scientist	25
55	Chief Medical Lab. Technician	12
56	Assistant Chief Medical Lab. Technician	5
57	Medical Laboratory Technician	1
58	Chief Medical Laboratory Assistant	5
59	Medical Laboratory Assistant	4
60	Director of Nursing Services	1
61	Assistant Director of Nursing Services	12
62	Chief Nursing Officers	280
63	Assistant Chief Nursing Officer	33
64	Principal Nursing Officers	9
65	Senior Nursing Officers	8
66	Nursing Officers I	96
67	Nursing Officer II	204
68	Assistant Nursing Officers	7
69	Principal Midwifery Sister	3
70	Community Health Officers	8
71	Chief Medical Records Technologist	2
72	Assistant Med. Records Technologist	2
73	Chief Medical Records Technicians	2
74	Assistant Chief Medical Records Tech.	6
75	Principal Medical Records Technician	5
76	Senior Medical Records Technician	3
77	Higher Medical Records Technician	5
78	Chief Medical Records Technician	10
79	Chief Medical Records Assistant	2
80	Principal Medical Records Assistant	1
81	Higher Medical Records Assistant	3
82	Medical Records Clerk	4
83	Electrical Engineering	1
84	Chief Technical Officer	3
85	Chief Medical Artisan Instrument	1
86	Assistant Chief Electrical Technician	2
87	Principal Works Superintendent I	3
88	Principal Works Superintendent II	6
89	Senior Works Superintendent	9
90	Higher Works Super Superintendent	2
91	Chief Medical Artisan	1
92	Chief Plant Operating Assistant	4
93	Principal Plant Operating Assistant	1
94	Plant Operating Assistant	6

95	Chief Electrical Assistant	2
96	Chief Medical Artisan	4
97	Principal Medical Artisan	1
98	Chief Laundry Assistant	12
99	Principal Laundry Assistant	1
100	Laundry Assistant	3
101	Chief Telephone Assistant	1
102	Chief Kitchen Assistant	1
103	Senior Work Superintendent (AD/M) I	2
104	Senior Work Superintendent	3
105	Hospital Plaster Technician	1
106	Chief Ambulance Driver/Mechanic	19
107	Principal Ambulance Driver/Mechanic	2
108	Ambulance Driver/Mechanic	1
109	Assistant Director 9Procurement)	1
110	Principal Medical Store Technician	1
111	Senior Medical Store Technician	1
112	Higher Medical Store Technician	1
113	Medical Store Technician	1
114	Chief Medical Store Assistant	8
115	Principal Medical Store Assistant	1
116	Medical Store Assistant	1
117	Chief Store Cleansing Assistant	4
118	Principal Store Cleansing Assistant	1
119	Dental Surgeon Technician	6
120	Dental Surgeon Assistant	2
121	Chief Health Extension Technician	1
122	Assistant Chief Health Extension Technician	1
123	Principal Health Extension Technician	1
124	Director (Information)	1
125	Principal Information Officer I	1
126	Principal Executive Officer (Public Relations)	1
127	Public Relations Officer II	1
128	Principal Hostel Warden	2
129	Counselors	4
130	X-Ray Technician	1
131	Assistant Director (Account)	3
132	Accountant I	3
133	Accountant II	6
134	Director (Audit)	1
135	Assistant Director (Audit)	2
136	Senior Internal Auditor	1
137	Assistant Chief Confidential Secretary	2
138	Principal Confidential Secretary	1
139	Senior Confidential Secretary	1
140	Confidential Secretary	4

141	Chief Typist	18
142	Senior Typist I	4
143	Typist II	8
144	Typist III	2
145	Chief Hospital Office Assistant	8
146	Chief Cleansing Health Assistant	18
147	Principal Cleansing Health Assistant	1
148	Chief Environmental Assistant	12
149	Principal Environment Health Assistant	14
150	Senior Environmental Health Assistant	1
151	Environmental Health Assistant	3
152	Chief Mortuary Assistant	2
153	Higher Mortuary Assistant	5
154	Chief Security Guard	12
155	Deputy Chief Security Guard	2
156	Assistant Chief Security Guard	15
157	Principal Security Guard	16
158	Senior Security Guard	2
159	Security Guard	12
160	Chief Social Welfare Tech.	2
161	Senior Social Welfare Tech.	1
162	Higher Social Welfare Tech.	2
163	Social Welfare Tech.	1
164	Chief Hospital Ward Assistant	314
165	Principal Hospital Ward Assistant	7
166	Senior Hospital Ward Assistant	2
167	Higher Hospital Ward Assistant	88
168	Hospital Ward Assistant	203
169	House Officers	40
170	Intern Pharmacists	16
171	Intern Laboratory Scientist	19
	TOTAL	**2,172**

TABLE 8: MINISTRY OF HEALTH, BENIN CITY, EDO STATE OF NIGERIA NOMINAL ROLL SENIOR/JUNIOR STAFF AS AT AUGUST 25 TH, 2009

S/NO	R A N K	SEX	SLG	LGA	REMARKS
1	Hon. Commissioner	M	Consoli-date d		
2	Permanent Secretary	M	-do-	Esan West	
3	Admin. Officer lll	F	14	Esan Central	
4	Admin. Officer IV	F	13	Uhunmwode	
5	Admin Officer Vll	M	10	Esan N. East	
6	H.E.O.	F	08	Ovia N. East	
7	Senior Information Officer	M	12	Oredo	From Min of Information

8	Executive Office	F	07	Ovia N. East	
9	Chief Clerical Officer	M	07	Esan Central	
10	-do-	M	07	Oredo	
11	Chief Conf. Secretary l	F	14	Esan S.East	
12	Prin. Conf. Secretary l	F	12	Esan Central	
13	Prin. Conf. Secretary l	F	12	Oredo	
14	Senior Conf. Secretary	M	09	Esan S. East	
15	Senior Conf. Secretary	F	09	Esan S. East	
16	Chief Typist	M	09	Ovia N. East	
17	-do-	M	09	Uhunmwode	
18	“	F	09	Ovia N. East	
19	“	F	09	Uhunmwonde	
20	“	F	09	Akoko-Edo	
21	“	F	09	Ovia N. East	
22	“	F	09	Etsako East	
23	Senior Typist l	F	08	Oredo	
24	Senior Typist ll	F	08	“	
25	Works Superintendent	M	07	Ikpoba-Okha	
26	Works Superintendent	M	07	Esan N. East	
27	“	M	07	Orhionmwon	
28	“	M	07	Uhunmwode	
29	Chief Driver Mechanic	M	07	-do-	
30	“	M	07	Ovia N. East	
31	“	M	07	Esan S. East	
32	Works Superintendent	M	07	Owan East	From Min. of Women Affairs
33	Driver Mechanic	M	05		
34	Motor Driver	M	04	Oredo	
35	Motor Driver	M	03	Ovia S. West	
36	Asst. Director	F	15	Oredo	
37	Senior Ex. Officer (A/Cs)	M	09	Esan Central	
38	-do-	M	09	Uhunmwode	
39	“	F	09	Owan West	
40	S.D.P.O	F	09		
41	E.O. Accounts	M	07	Orhionmwon	
42	Chief Consultant	M	17	Oredo	
43	Principal Medical Officer ll	M	15	Esan West	
44	Chief Engineer	M	15	Esan N. East	
45	Medical Officer ll	M	12	Orhionmwon	
46	Senior Stat. Officer	M	12	Orhionmwon	
47	Assistant Director	F	15	Orhionmwon	
48	Assistant Director	F	15	-do-	
49	Chief Nursing Officer	F	14	Esan Central	
50	-do-	F	14	-do-	
51	Chief Health Tech.	F	14	Oredo	
52	Chief Health Tech.	F	14	Owan	
53	Asst. Chief Comm. Health Tech	F	12	Esan N. East	
54	Assistant Director	M	15	Uhunmwode	
55	Chief Nutrition Officer	M	14	Esan Central	
56	-do-	M	14	Ovia	
57	Asst. Chief Cat. Officer	F	13	Oredo	
58	Prin. Catering Officer	F	12		
59	Director	F	16	Etsako East	
60	Director	F	16	Oredo	
61	Director	F	16	Esan N. East	
62	Director	F	16	Esan Central	
63	Assistant Director	M	15	Akoko-Edo	
64	-do-	M	15	Owan East	

65	“	F	15	Owan West	
66	“	F	15	Delta	
67	“	F	15	Esan Central	
68	Chief Nursing Officer	F	14	Uhunmwode	
69	“	F	14	Etsako West	
70	“	F	14	Etsako East	
71	“	F	14	Owan	
72	“	F	14	-do-	
73	“	F	14	“	
74	“	F	14	Oredo	
75	“	F	14	Oredo	
76	“	F	14	Etsako Central	
77	“	F	14	Esan Central	
78	“	F	14	Oredo	
79	“	F	14	Esan Central	
80	“	F	14	Akoko-Edo	
81	“	F	14	Oredo	
82	“	F	14	Ovia N. East	
83	“	F	14	Ovia N. East	
84	“	F	14	Esan N. East	
85	Asst. Nursing Officer	F	13	Delta	
86	Prin. Midwife Sister	F	10	Esan S. East	
87	Chief Comm. Health Tech	F	14		
88	“	F	14	Oredo	
89	Asst. Director	F	15	Oredo	
90	Snr. Envi. Health Officer	M	12	Igueben	
91	Pharmacist	F	10	Owan	
92	Prin. Comm. H. Tech.	F	10	Uhunmwode	
93	PHC Tutor	M	09	Etsako West	
94	P. Nurse Tutor	F	08	Oredo	
95	Biochemist	F	09	Orhionmwon	
96	Env. Health Officer	M	09	Etsako East	
97	Health Record Officer	F	08	Oredo	
98	Environmental Health Officer	M	08	Esan S. East	
99	Env. Health Officer	F	08	Owan West	
100	-do-	M	08	Esan S. East	
101	Env. Health Officer	F	08	Orhionmwon	
102	Librarian ll	M	08	Akoko-Edo	
103	Env. Health Officer	M	09	Esan	
104	-do-	M	08	Egor	
105	Health Educator	F	09	Oredo	
106	-do-	M	09	-do-	
107	Med Records Officer	F	09	Owan West	
108	-do-	M	08	-do-	
109	Pharmacist Technician	F	08	Igueben	
110	Env. Health Officer	F	08	Egor	
111	Env. Health Officer	F	08	Ovia S. West	
112	Phamacist Technician	F	08	Oredo	
113	Asst. Chief Comm. H. Tech.	F	12	Ikpoba Okha	
114	Prin. Comm. H. Tech	F	10	Oredo	
115	-do-	F	10	Ikpoba Okha	
116	Asst. Chief Cat. Technologist	F	13	Uhunmwode	
117	-do-	F	13	“	
118	Asst. Chief Cat. Technologist	F	13		
119	Asst. Chief Health Educator	F	13	Oredo	
120	Senior Pharmacist	F	12	Oredo	
121	-do-	M	12	Esan West	
122	Chief Env. Health Officer	M	14	Uhunmwode	

123	Chief Comm H. Tech	M	14	Etsako West	
124	Snr. Comm H. Tech	M	09	Etsako East	
125	Assistant Director	M	15	Esan West	
126	Med Lab Scientist l	F	09	Owan East	
127	Med Lab Scientist ll	F	09	Akoko-Edo	
128	-do-	F	09	Uhunmwode	
129	-do-	F	08	Owan West	
130	“	F	08	Egor	
131	Higher Med Lab Tech	F	08	Oredo	
132	Chief Health Assistant	F	08	Oredo	
133	“	F	08	Esan S. East	
134	“	F	08	Uhunmwode	
135	“	M	08	Orhionmwon	
136	“	M	08	Esan West	
137	“	M	08	“	
138	“	F	08	Orhionmwon	
139	“	F	08	-do-	
140	“	F	08	Oredo	
141	“	F	08	Ovia N. East	
142	“	F	08	Oredo	
143	“	F	08	Orhionmwon	
144	“	F	08	Owan West	
145	“	F	08	Orhionmwon	
146	“	F	08	Oredo	
147	“	F	08	Orhionmwon	
148	“	F	08	Owan West	
149	“	F	08	Orhionmwon	
150	“	F	08	Esan N. East	
151	“	F	08	Ovia N. East	
152	“	F	08	Oredo	
153	“	F	08	Orhionmwon	
154	“	F	08	Ovia S. West	
155	“	F	08	Orhionmwon	
156	“	F	08	Orhionmwon	
157	“	F	08	Esan S. East	
158	“	M	08		
159	Prin. Comm Health Asst	F	07	Owan West	
160	Chief Health Assistant	F	08	Orhionmwon	
161	-do-	F	08	Uhunmwode	
162	“	F	08	Ikpoba Okha	
163	“	F	08	Ovia S. West	
164	“	F	08	Esan Central	
165	“	F	07	Esan N. East	
166	“	F	07	Orhionmwon	
167	“	F	07	-do-	
168	“	F	08	Ikpoba Okha	
169	“	M	07	Etsako West	
170		M	07	Imo State	
171	“	F	07	Ovia N. East	
172	“	M	07	Esan Central	
173	“	F	07	Esan N. East	
174	“	M	07	-do-	
175	“	F	07	Delta	
176	“	M	07	Imo State	
177	Senior Health Assistant	M	06	Etsako West	
178	-do-	M	06	Delta	
179	“	F	06	Oredo	
180	“	F	06	Ovia N. East	

181	"	M	06	-do-	
182	"	M	06	Ovia	
183	"	M	06	Oredo	
184	Senior Health Technician	F	06	Ovia	
185	Security Guard	M	04	Orhionmwon	
186	Health Assistant	M	04	Esan Central	
187	Clerical Officer	F	04	Esan N. East	
188	-do-	F	04	-do-	
189	Clerical Assistant	M	03	Esan West	
190	Messenger	F	02	Uhunmwode	
191		F			
192		F			
193	Labourer/Cleaner	F	02	Oredo	
194	-do-	F	02	Etsako Central	
195	"	M	02	Akoko-Edo	
196	Senior Health Technician	F	06		
197	"	F	02	Owan West	
198	Security Guard	M	02	Akoko-Edo	
199	"	M	02	Orhionmwon	
200	"	M	02	-do-	
201	Labourer/Cleaner	M	02		
202	Security Guard	M	02		
203	Security Guard	M	02	Akoko-Edo	
204	Clerical Officer	F	04	-do-	
205	Cleaner	F	02		
206	Security Guard	M	02	Owan West	
207	Security Guard	M	02	Orhionmwon	
208	Gardener	M	02		
209	Driver	M			
210		F	13		PPEB
211		F	13		"
212		F	10	Esan N. East	"
213			09		"
214		M			"
215		M			"
216		F			"
217		F			"

2.17.2. <u>The current state of the 34 government-owned hospitals</u>

2.17.2.1. General and cross-cutting issues

Virtually all the hospitals are plagued with serious problems of poorly maintained civil infrastructures, lack of basic hospital equipments, lack of support services, poor quality of services and poor facility utilization.

The following are some of the major findings in the hospitals:-

2.23.2 Condition of hospital buildings

In virtually all the hospitals, the civil infrastructures are in serious state of disrepair characterized by infrastructural decay, leaking roofs and ceilings, cracked walls, broken floors without tiles, torn mosquito nettings on windows, old torn mattresses, lack of beddings, and problem of termites in many cases. Some wards are completely out of use. In fact the main hospital in Sabongida-Ora is sinking. Overgrown weeds were regular features in all but a few of the hospitals especially around the staff quarters, mortuaries and generator

house that are usually located far from the wards. In most cases, the staff quarters are no longer habitable.

2.23.3 State of Hospital Equipment

All the hospitals are inundated with inadequate hospital and laboratory equipments. The ones still available in the hospitals had either become obsolete or completely broken down. X-Ray machines – a vital revenue-yielding diagnostic tool – are not functional in any of the hospitals either because of lack of radiographers or failure to install or service equipment. The mortuaries are non-functional in practically all the hospitals because of lack of power supply. The theatre tables and lamps are all obsolete. Autoclaves for sterilizing instruments are also archaic and not functioning in most of the hospitals. There is no single functional suction machine in any of the hospitals. There are no air-conditioners in the drug stores and theatres.

2.23.4 Water Supply

None of the three sources of water supply identified – public supply, rain water harvesting, and purchases through water tankers – is entirely satisfactory for hospital purposes. Public water supply is almost non-existent in Edo Central Senatorial District and unreliable in others. None of the hospitals has a functioning borehole except Central Hospital, Benin City, Stella Obasanjo Women and Children Hospital, Benin City, Cottage Hospital, Oben, and Government Hospital, Igbanke.

2.23.5 Electricity

Virtually all the hospitals are connected to national grid, which is renowned for its epileptic power supply. Back-up generators, where available, have one problem or the other. They are very old generator sets.

2.23.6 Access Roads

Access roads are terribly bad for many of the hospitals. However, those of Igbanke, Uneme-Osu, Usugbenu and Ossiomo are particularly serious.

2.23.7 Transport and Communication

None of the hospitals has a functioning utility vehicle. Some of the zonal hospitals have functioning but very old ambulances that also serve as utility vehicles, hearses or emergency rescue vans. No official telephone line or modern telecommunication gadgets in any of the hospitals.

2.23.8 Revenue Generation

This is very poor albeit to varying degrees in all the hospitals. Proceeds from drugs and other revolving funds are retained in a DRF account separate from government revenue. Only the Central Hospital, Benin City has a Bank (Skye) in its premises for the collection of hospital revenue.

2.23.9 Staffing

In spite of the size of the work force in the HMB currently put at 2,172 staff, the hospitals lack essential staff in vital areas. There is acute personnel shortage across board. There are no radiologists or radiographers in any hospital outside Benin City even in hospitals with X-Ray units. There is no single consultant pathologist in the employment of Edo State Government. There is no physiotherapist in any of our hospitals. Medical social workers are equally not

available. The Central Hospitals in Uromi and Auchi lack consultants in all key clinical departments – no paediatricians, no surgeons, no physicians, and no obstetricians/gynaecologists. Many of the hospitals do not have enough nurses to run shift for 24 hours comfortably. Field labourers are inadequate in numbers to keep the grass cut and lawns clean while most of the hospitals require security staff to wade off hoodlums. Many of the professional are managing to produce results in face of obvious difficulties but the poor working conditions and poor remunerations (compared to counterparts at Federal level) are major obstacles to motivation.

2.23.10 Hospital Utilization
There is obvious low patronage of public hospitals. In fact, in the District Hospital at Ewu, patronage is as low as one (1) patient a day. In some hospitals like the ones in Obayantor, Urhonigbe, Uneme-Osu, and Usugbenu the outpatient departments are also empty. The low facility utilization is attributable partly to poor quality of services and attitudes of staff.

2.23.11 Perimeter Fencing
Most of the hospitals have wire mesh type of fencing, which are old and have collapsed in many areas with serious security implications to patients, staff, and hospital equipment and facilities. The hospitals in Usen, Iguobazuwa, Igarra, and Iruekpen have no fence at all. Encroahment is reported in 2 hospitals.

2.23.12 Funding
Most of the hospitals are handicapped financially to the extent that they are unable to effect minor repairs, pay electricity bills, or purchase battery for vehicles and plants. In fact the entire hospitals in Igarra Medical Zone namely the General Hospital, Igarra; Government Hospital, Ibillo; and District Hospital, Uneme-Osu are disconnected by PHCN for this reason and therefore without electricity for some months. There is a system of retention of 20% of government revenue generated in a month as hospital imprest but in the face of low revenue generation, this is apparently inadequate.

It is quite glaring from the foregoing that chronic **under funding of the health sector** over the past decades has led to lack of provision or inadequate maintenance of facilities both at the State and LGA levels. Generally, services have deteriorated due to lack of vital equipment, deterioration or obsolescence of existing ones. Building infrastructures are dilapidated and the few facilities that are functioning well are over stretched. The quality of care has dropped to unacceptably low levels with declining patronage of public health facilities. Staff morale is low due to inadequate facilities, poor remuneration and lack of training.

2.23.13 Hospital support services are generally lacking. Communication within and between health institutions is poor. There are no utility vehicles in most hospitals. Ambulances, where they exist, are old and unreliable. Telephone services are lacking in virtually all facilities at State and LGA levels including those in the State capital and there are also bad access roads to many of the health institutions. The referral system is weak and in most cases non-functioning. There is erratic power supply as well as unreliable supply of portable water in most health facilities. Resources for a modern health management information system are lacking. These problems further worsen the poor referral system that has become virtually morbid.

In line with the above realities, the Ministry of Health believes that through HSR, many of the anomalies will be corrected. The State recognizes the need for better management of resources and for additional funds to be obtained through budgetary allocations, innovative financing mechanisms, and partnership with other agencies.

TABLE 9: DISTRIBUTION OF THE 34 GOVERNMENT-OWNED HOSPITALS IN EDO STATE WITH THEIR BED COMPLEMENT (August, 2009)

S/N	MEDICAL ZONE	LOCAL GOVERNMENT AREA	NAME OF HOSPITAL	BED COMPLEMENT
1	Abudu	Orhionmwon -do- “ “ “ Uhunmwode	General Hospital, Abudu Government Hospital, Igbanke Government Hospital, Urhonigbe Cottage Hospital, Oben Cottage Hospital, Egbokor District Hospital, Egba	60 30 30 20 4 6
2	Afuze	Owan East -do- Owan West -do-	Gen. Hospital, Afuze Dist Hospital, Otuo Gen. Hospital, Sabo-Ora Govt. Hospital, Uzebba	51 6 30 30
3	Auchi	Etsako West	Central Hospital, Auchi	61
4	Benin I	Oredo -do-	Central Hospital, Benin City Cottage Hospital, Obayantor	500 19
5	Benin II	Ikpoba-Okha	Stella 0basanjo Women & Children Hospital	300
6	Ekpoma	Esan Central -do Esan West -do-	District Hospital, Usugbenu District Hospital, Ewu General Hospital, Ekpoma General Hospital, Iruekpen	16 18 35 30
7	Fugar	Etsako East -do- “ “ Etsako West	General Hospital, Fugar General Hospital, Agenebode District Hospital, Apana District Hospital, Anegbette Govt. Hospital Agbede	19 30 24 6 30
8	Igarra	Akoko Edo -do- “	General Hospital, Igarra Government Hospital, Ibillo District Hospital, Uneme-Osu	60 30 20
9	Iguobazuwa	Ovia North-East Ovia South-West -do-	District Hospital, Ekiadolor General Hospital, Iguobazuwa Government Hospital, Usen	6 48 32
10	Ossiomo	Leprosy Clinic in all LGAs	Specialist Hospital, Ossiomo	257
11	Ubiaja	Esan South-West -do- “	General Hospital, Ubiaja District Hospital, Ewohimi Government Hospital, Igueben	60 19 60
12	Uromi	Esan North-East	Central Hospital, Uromi	61
TOTAL				**2006**

2.18. Budgetary Allocation and Performance

The **state approved budget**, recurrent and capital; health budget as a percentage of the state total budget as well as actual releases are shown in Table 10. Although there were increased budgetary allocation for health in the past couple of years, actual releases were very low and there remains a lot to be done to correct the problems arising from decades of under-funding bearing in mind that the World Health Organization (WHO) recommends a minimum allocation of 15% of the total annual capital budget as essential provision for health to allow meaningful capital development of the sector. The allocation for health in the current year is

the lowest in the past decade (Table 8). It is hoped the actual release of budgeted funds and better allocations and releases in subsequent years will make the difference.

TABLE 10: EDO STATE BUDGET, SHOWING STATUTORY ALLOCATION, INTERNALLY GENERATED REVENUE AND CAPITAL / RECURRENT EXPENDITURE ON HEALTH, (2001 – 2009)

	2001 (₦)	**2002** (₦)	**2003** (₦)	**2004** (₦)	**2005** (₦)	**2006** (₦)	**2007** (₦)	**2008** (₦)
STATE BUDGET	25,297,747,000	25,740,000,000	25,568,711,000	26,857,233,000	34,623,000,000	38,160,000,000	38,870,000,000	40,416,
STATUTORY ALLOCATION	11,203,472,000	11,600,000,000	8,582,000,000	11,800,000,000	20,842,000,000	28,782,000,000	29,217,000,000	28,000,
INTERNAL	1,823,548,000	2,530,000,000	3,304,000,000	3,480,000,000	4,660,000,000	6,154,000,000	6,167,000,000	8,267,0
HEALTH BUDGET (RECURRENT)	840,396,000	849,386,000	865,461,000	1,367,190,000	1,234,422,000	1,313,200,000	1,711,924,000	2,276,3
HEALTH BUDGET (CAPITAL)	1,195,824,000	979,385,000	723,871,000	657,412,000	3,031,518,000	3,022,883,000	1,898,120,000	2,942,0
PERSONNEL COST (HEALTH)	796,896,000	783,799,000	801,461,000	1,306,190,000	1,195,422,000	1,205,200,000	1,602,924,000	2,453,4
TOTAL HEALTH BUDGET	2,036,220,000	2,612,570,000	1,594,797,000	3,330,792,000	4,265,940,000	4,336,083,000	3,610,044,000	5,218,3
% ALLOCATION TO HEALTH (Capital)	8.05	7.10	6.23	7.54	12.32	11.4	9.3	7.28

2.19. Existing health programmes and services with their access and utilization

2.19.1. Prevalent Health Problems

It has been noted earlier that the challenge for the public health systems of Edo State in the past decades as indeed all the States in the Federal Republic of Nigeria is to improve the generally poor state of health of the people especially that of women and children. The limited health statistics available indicate very poor health status characterized by high child morbidity and mortality, high maternal morbidity and mortality and low life expectancy. Nigeria's health statistics is amongst the worst in the world. Most of the deaths and serious illnesses are due to conditions, which are easily preventable by vaccine and clean water or can be treated with simple remedies but lack of timely and appropriate care as well as inadequate facilities in the treatment centres often increase the risk of serious complications in the course of minor ailments especially in women and children.
Common causes of sickness and death in children are malaria, anemia diarrhea, acute respiratory infections, and malnutrition. Mothers, on the other hand, die frequently from complications of pregnancy and childbirth, unsafe abortion, anemia, obstetric hemorrhage, shock, sepsis and other reproductive health problems.

In the general population, communicable diseases like leprosy, tuberculosis, measles, malaria, STIHIV/AIDS remain major diseases of public health importance while non-communicable diseases like hypertension, diabetes, bronchial asthma, anaemia (including sickle cell anaemia) and cancers are on the increase.
Lassa fever currently poses the greatest danger to the health of the people amongst the 6 epidemic-prone and notifiable diseases (CSM, Cholera, Measles, Lassa Fever, Yellow Fever, and Avian Influenza). This is more prevalent in Edo Central North Senatorial Districts of the State.

There is a wide gap and indeed a chasm between the services that people get and what they need to get. In fact, 65% of our population in Edo State live and work in rural areas where these diseases cause high morbidity and mortality. It is therefore necessary that our interventions and activities should be aimed at controlling these disease conditions at the ward and community level. Hence, currently in Edo State we implement ward minimum health care package (WMHCP) that consists of a set of health interventions and services that address health and health- related problems that would, in the long run, result in substantial health gains at low cost to the State and our development partners. Our Package has also been harmonized with the Integrated Maternal, Neonatal and Child Health (IMNCH) Strategy document of the FMOH.

4.19.1.1. Ward Minimum Health Care Package

Our ward minimum health care package (WMHCP) in Edo State had included and will continue to include the following components:-

A. **Control of Communicable Diseases**

Malaria

1. Availability of Insecticide Treated Nets (ITNs) for all pregnant women and children under five (5) years of age; insecticide for re-treatment or long lasting ITNs;
2. Provision and use of Artemitisin-based Combination Therapy (ACT) for treatment of uncomplicated malaria; and
3. Provision of Sulphadoxine/Pyrimethamine for intermittent Preventive Treatment in pregnant women.

Tuberculosis

1. Provision of basic laboratory infrastructure and equipment in all ward health centres for case identification of tuberculosis (microscope, slides and slide covers, stains, swaps, sterile sputum receptacles, disposable gloves, etc);
2. Availability of drugs and infrastructures for Direct Observation Treatment Short Course (DOTS) {Rifampicin, INH, Pyrazinamide, Streptomycin, Ethambutol, etc for all identified cases}.

STI/HIV/AIDS

1. Availability of Voluntary Counselling and Testing (VCT) services (i.e. trained Counsellors, conducive infrastructure and Rapid Test kits for HIV) in all Wards. Counselling would include safe infant feeding options;
2. Provision of condoms and establishment of logistic mechanisms for their distribution;
3. Treatment of Opportunistic Infections (trained staff and appropriate drugs); and
4. Routine implementation of IEC and BCC activities.

B. **Child Survival**

This essentially includes Integrated Management of Childhood Illnesses (IMCI) strategy with particular emphasis on routine immunization.

Based on this, our minimum package for child survival had included and will continue to include:-

1. Each LGA to have adequate cold chain equipment (Deep freezers, cold boxes, vaccine carriers, icepacks, constant electricity supply, alternative source of power supply such as solar energy-powered refrigerators);
2. All facilities to have vaccine carriers and ice packs;
3. Each LGA to have at least a designated motor vehicle or boat as appropriate; and each ward to have designated motorcycle as appropriate for vaccine distribution;

4. Every under-5 to be provided with a child health card;
5. Essential drugs including ORT sachets, Zinc tablets and appropriate antibiotics to be available at all health facilities;
6. Sixty percent (60%) of health workers being trained and will continue to be trained on IMCI in each Ward paying particular attention to new born care and the need for prompt referral when necessary; and
7. To have at least 30 trained and functional Community Resources Persons (CORPs) per Ward.

C. **Maternal and Newborn Care**

Based on the above, the following minimum package for Safe Motherhood is being implemented in the State:-

1. The establishment of one (1) Basic Essential Obstetric Care Centre (BEOC) in each Ward that would be:-

- adequately staffed with four (4) midwives or Nurse/Midwife (double qualified) for 24 hours coverage and would be able to provide focused antenatal care, perform manual removal of placenta and placenta products, provide basic neonatal care and effective post natal care;
- that is being provided with basic obstetric equipments;
- that is being provided with adequate stock of Non-Pneumatic Anti-Shock Garment;
- that is being provided with basic obstetric drugs including oxytocin, misoprostol, sedatives and antibiotics; and
- that is being provided with transportation facilities for referral.

D. **Nutrition**

This component includes:-

1. Health and nutritional educational materials
2. Provision of equipments for food demonstration in all wards (Kitchen and food demonstration space in designated health facilities, appropriate cooking implements, appropriate refrigerating apparatus, Food demonstration charts, plates, spoons, etc);
3. Establishment of community-based growth monitoring in all communities by trained volunteers with appropriate equipment (Mosley scale, Tape rule, Child health cards) and health faculty-based growth monitoring; and
4. Implementation of food security programme at household and community levels.

E. **Non-Communicable Diseases (NCDs) Prevention**

The following minimum package is being implemented and will continue to be executed in the State:-

1. Phased capacity building of health workers for prevention and control of NCDs in all facilities;

2. Availability of IEC materials on NCDs displayed in all facilities; and
3. Provision of basic equipments for screening and early diagnosis of NCDs e.g. Sphymomanometer, Weighing Scale, Urine Test Kits, etc
4. Cervical Cancer prevention, screening (with visual inspection with acetic acid), and treatment of positive cases with cryo-therapy

F. **Health Education and Community Mobilization**

We aim at:-

1. training at least two (2) health workers and two (2) members of the VDC/WDC per Ward as health educators;
2. ensuring that every health facility in the State has relevant IEC materials conspicuously displayed with cultural acceptable language and graphics; and
3. provision of a logistic vehicle or motor cycle with public address system for the purpose of health education.

G. **Common Support Services**

These include:

1. Essential drugs
2. Human Resources for Health that would include for:

Health Post

One (1) Junior Community Health Extension Worker (JCHEWS)

Primary Health Clinic

Two (2) Community Health Extension Workers (CHEWS)
Four (4) Junior Community Health Extension Workers (JCHEWS)

Primary Health Centre (Ward Health Centre)

One (1) Community Health Officer (CHO)
One (1) Public Health Nurse
Three (3) Community Health Extension Workers (CHEWS)

- One (1) responsible for statistics (Where available, a Medical Records Officer);
- One (1) responsible for drugs (Where available, a Pharmacy Technician); and
- One (1) responsible for equipment

Three (3) JCHEWS
Four (4) Nurse/Midwives
One (1) Medical Assistant (Optional)

We have adequately captured this minimum package of health care as part of our interventions and activities under the health service delivery priority area of our SSHDP with a view to ensuring that they continue to be the focus of intervention at the ward and community levels.

The overall objective of our ward minimum health care package is the provision of quality PHC with scarce resources with an ultimate upward review of the package to that, which should by the end of 2015, constitute the minimum set of services to be provided by Edo State Government for all its citizenry.

2.19.2 Health services provision and utilization

The State has a good network of primary, secondary and tertiary health facilities across the State with a rapidly growing private sector (Tables 11-14). However, the public facilities are poorly equipped or maintained and the private facilities are inadequately regulated even though the Departments of Medical Services, Pharmaceutical Services, Medical Laboratory Services and Nursing Services have over sighting functions over the various health facilities within their jurisdiction.

TABLE 11: REGISTERED HOSPITALS, CLINICS, LABORATORIES, NURSING & MATERNITY HOMES, (BY LGA, LEVELS OF CARE AND TYPES) IN EDO STATE (February, 2009)

S/N	LOCAL GOVERNMENT AREAS	LEVELS			TOTAL	TYPES	
		TERTIARY	SECONDARY	PRIMARY		PUBLIC	PRIVATE
1	AKOKO-EDO	-	6	33	**39**	32	7
2	EGOR	2	49	94	**145**	7	138
3	ESAN CENTRAL	1	2	16	**19**	12	7
4	ESAN NORTH-EAST	1	12	18	**31**	7	24
5	ESAN SOUTH-EAST	-	6	23	**29**	21	8
6	ESAN WEST	-	13	30	**43**	19	24
7	ETSAKO CENTRAL	-	1	13	**14**	12	2
8	ETSAKO EAST	-	3	13	**16**	12	4
9	ETSAKO WEST	1	18	23	**42**	13	29
10	IGUEBEN	-	6	9	**15**	8	7
11	IKPOBA-OKHA	-	32	85	**117**	10	107
12	OREDO	1	77	156	**234**	9	225
13	ORHIONMWON	1	4	26	**31**	26	5
14	OVIA NORTH-EAST	1	1	29	**31**	27	4
15	OVIA SOUTH-WEST	-	2	19	**21**	16	5
16	OWAN EAST	-	7	24	**31**	17	14
17	OWAN WEST	-	6	34	**40**	18	22
18	UHUNMWODE	-	1	27	**28**	23	5
	TOTAL	**8**	**246**	**672**	**926**	**289**	**637**

TABLE 12: REGISTERED PHARMACIES (BY LGA) IN EDO STATE (February, 2009)

S/N	LOCAL GOVERNMENT AREAS	NUMBER OF PHARMACIES
1	AKOKO-EDO	1
2	EGOR	32
3	ESAN CENTRAL	-
4	ESAN NORTH-EAST	2
5	ESAN SOUTH-EAST	-
6	ESAN WEST	6
7	ETSAKO CENTRAL	-
8	ETSAKO EAST	-
9	ETSAKO WEST	4
10	IGUEBEN	-
11	IKPOBA-OKHA	7
12	OREDO	85
13	ORHIONMWON	-
14	OVIA NORTH-EAST	-
15	OVIA SOUTH-WEST	-
16	OWAN EAST	-
17	OWAN WEST	1
18	UHUNMWODE	-
	TOTAL	**138**

TABLE 13: HEALTH FACILITIES REGISTERED WITH THE NATIONAL HEALTH INSURANCE SCHEME (BY TYPES AND LGA) IN EDO STATE AS AT FEBRUARY 2008

S/N	LOCAL GOVERNMENT AREAS	TYPE OF SERVICE PROVIDER	
		Primary	Fee-for-Service
1	AKOKO-EDO	4	**3**
2	EGOR	7	**4**
3	ESAN CENTRAL	4	**4**
4	ESAN NORTH-EAST	2	**2**
5	ESAN SOUTH-EAST	2	**2**
6	ESAN WEST	2	**2**
7	ETSAKO CENTRAL	3	**2**
8	ETSAKO EAST	2	**1**
9	ETSAKO WEST	5	**4**
10	IGUEBEN	1	**-**
11	IKPOBA-OKHA	7	**-**
12	OREDO	25	**16**
13	ORHIONMWON	4	**4**
14	OVIA NORTH-EAST	2	**2**
15	OVIA SOUTH-WEST	2	**2**
16	OWAN EAST	2	**2**
17	OWAN WEST	2	**3**
18	UHUNMWODE	2	**2**
	TOTAL	**78**	**55**

TABLE 14: REGISTERED TRADOMEDICAL DOCTORS/CLINICS IN EDO STATE (May, 2008)

S/N	LOCAL GOVERNMENT AREAS	NUMBER OF TRADOMEDICAL DOCTORS/CLINICS
1	AKOKO-EDO	-
2	EGOR	19
3	ESAN CENTRAL	2
4	ESAN NORTH-EAST	19
5	ESAN SOUTH-EAST	10
6	ESAN WEST	-
7	ETSAKO CENTRAL	-
8	ETSAKO EAST	1
9	ETSAKO WEST	-
10	IGUEBEN	-
11	IKPOBA-OKHA	18
12	OREDO	5
13	ORHIONMWON	3
14	OVIA NORTH-EAST	2
15	OVIA SOUTH-WEST	-
16	OWAN EAST	2
17	OWAN WEST	-
18	UHUNMWODE	3
	TOTAL	84

TABLE 15: MEDICAL DOCTORS EMPLOYED BY LGAs

S/N	LGA	Number of Doctors
1	AKOKO-EDO	1
2	EGOR	Nil
3	ESAN CENTRAL	Nil
4	ESAN NORTH-EAST	1
5	ESAN SOUTH-EAST	1
6	ESAN WEST	1
7	ETSAKO CENTRAL	1
8	ETSAKO EAST	1
9	ETSAKO WEST	1
10	IGUEBEN	1
11	IKPOBA-OKHA	1
12	OREDO	1
13	ORHIONMWON	1
14	OVIA NORTH-EAST	1
15	OVIA SOUTH-WEST	Nil
16	OWAN EAST	1
17	OWAN WEST	1
18	UHUNMWODE	1

2.20. Key issues and challenges

2.20.1. Strengths, Weaknesses, Opportunities and Threats (SWOT)

From the foregoing, it is apparent that just as we have a lot of strengths in the health sector, so do we have obvious weaknesses. Even though there are threats to attaining excellence in our health care services, we do have golden opportunities to tap on.

2.20.1.1 Strengths

- Good number of federal tertiary health facilities (3)
- Good number of state-owned hospitals (34)
- A high number of PHC facilities (672)
- A high number of private health facilities (637)
- Committed public health work force (2,389)

2.20.1.2 Weaknesses

- Inadequate manpower
- Underfunding of the health sector
- Low budgetary allocation and performance
- Lack of vital equipment, deterioration or obsolescence of existing ones
- Building infrastructures are dilapidated
- Staff morale has also declined due to inadequate facilities
- Poor remuneration of staff, which has recently improved due to the 15% minimum wage.
- Lack of training
- Standard minimum per capita on health is $34 (or about N5,000); Nigeria's figure is paltry $7.00 per capita
- The World Health Organization recommends a minimum of 15% of capital budget for development of the health sector; Edo State figures for many years are less than 10%
- Inadequate materials for a well developed Health Management Information System

2.20.1.3 Opportunities

- A determined and focused Government that is currently in place in Edo State
- Recent and ongoing health sector reforms anchored on SEEDS and MDGs
- Partnership with International Agencies
- Public-private partnership in health

2.20.1.4 Threats

- Abandonment of public health system arising from poor quality of services
- Lack of commitment and failure to fully implement plans programmes and budgets

There is a wide gap between the quality of health services that we have and that which we ought to have or can have. Many countries have used available medical knowledge and technologies effectively to improve the health status of their citizens far above what we currently enjoy in Nigeria and in Edo State. Indeed a study of global health is a study of contrasts. While a girl born today in Japan can expect to live for 85 years, a girl born in Nigeria at the same time has a life expectancy of 43.3 years.

The Japanese girl receives immunizations, adequate nutrition, good education, and quality maternity care if a mother, excellent treatment services at all ages, and can afford on the average $550/yr for drugs.
The Nigerian girl on the other hand has lower chance of full immunization (18%), is undernourished in childhood, marries earlier, delivers 6 or more babies, loses 1 or more in infancy, faces risk of death at childbirth because deliveries are not attended by trained attendants, has poor health services at all ages, and can afford on the average only $4/yr on drugs. These contrasts reveal what can be achieved; they are snapshots of where we are and where we can be.

2.20.2 <u>Challenges</u>

There are indeed daunting challenges confronting effective and efficient health care delivery in Edo State.
In spite of the numerous health facilities in the State, it still registers low immunization rate, high maternal and child mortality rates, poor attendance of antenatal and family planning services, presence of harmful traditional practices and low life expectancy.
This is as a result of the following challenges in the health system:-

- The LGAs do not yet see PHC as their mandate in the Constitution. This is attested to by the lack of political will and commitment with poor capacity building.
- An effective community participation is lacking in most communities. These issues are further compounded by little support and involvement of the non-health Ministries
- Inadequate and inappropriate referral system
- The health information management system is still poor with weak compliance from the private health institutions on basic health statistics. Addressing the paucity of information from the LGAs and the private health sector on basic health statistics and other related issues continues to be a serious matter in the State. Besides, their compliance is nothing to write home about.
- Duplication of efforts and resources.
- Most equipment is obsolete while infrastructure is in a state of disrepair.
- Health status indicators remain abysmally poor despite various past efforts at improving on them. There is the need therefore to ensure appropriate and adequate interventions to stymie this trend for a meaningful healthy condition and accelerated productivity of the people.
- Infant mortality is still high in the State in spite of the huge resources into NPIs over the years by all tiers of government. In order to continue to protect our children from the six vaccine-preventable diseases and ensure a sustainable and high level of percentage coverage, there is the need for us to institutionalize routine immunization in Edo State.

- Edo State requires more support from the FMOH, NPI and other donor agencies to beef up the routine immunization level to the stipulated 65%

coverage with a view to reducing the infant and under-5 mortality rates as stated above. This can be effectively attained via the provision of cold chain facilities, vaccines, utility vehicles and other logistics.

- There is still frequent occurrence of communicable diseases such as diarrhea, malaria, HIV/AIDS, river blindness, TB/Leprosy, etc. It is impelling on us to eradicate these diseases from Edo State.
- The appropriate monitoring of fake drugs is still porous. In view of the centrality of efficacious drugs to success of the health care system in Edo State, there is the need to step up surveillance of drugs through effective monitoring of distributing and sales channels by enforcing the relevant extant regulations, and developing a system of monitoring the adverse effects of drugs
- There is a blatant manpower requirement in all aspects of the health care delivery in the State. Apart from employing or hiring more hands, training and re-training of health personnel in health planning and management are inevitable.
- Health promotion is still poor despite resources pumped into this area of intervention over the years. There is the impelling need to ensure the survival of our children by promoting healthy family environment; adequate prenatal, intra-natal and post-natal care to prevent complications of child birth through the provision of maternal/child health facilities; protecting children from the six preventable diseases via national programme on immunization; provision of nutrition supplements; and protection of children from non-communicable diseases.

In order to meet the challenges of achieving improved health status particularly for its poorest and most vulnerable population, the health system must be therefore be strengthened. In addition, proven cost-effective interventions such as the ones incorporated in Edo SSHDP must be scaled up and gains in health must be sustained and expanded.

Therefore, in order to meet the challenges of achieving improved health status particularly for its poorest and most vulnerable population, the health system must be strengthened. In addition, proven cost-effective interventions must be scaled up and gains in health must be sustained and expanded. The FMoH appreciates that this can best be done within the context of a costed National Strategic Health Development Plan, which is aimed at providing an overarching framework for sustained health development in the country. This is to be developed in accordance with extant national health policies and legislation, and international declarations and goals to which Nigeria is a signatory to, namely; MDGs, Ouagadougou Declaration and the Paris Declaration.

Some of the State strategies to surmount the aforementioned challenges include:-

- Convening a State Council on Health meeting to address our health strategies and policy thrust;
- Expansion and strengthening of primary health care services across the State;
- Setting up of Edo State Primary Health Care Development Agency and formulating the enabling laws to the House of Assembly to ensure its sustainability;
- Optimization of revenue generation by identifying and blocking "leakages"
- Enforcing lodgments of all government revenues in government accounts and to use Bank for collection of these revenues, starting with the hospitals in urban areas
- In view of budgetary constraints, problems are to be tackled in phases
- Strengthening relations, collaboration, and partnership with such International Organizations as World Health Organization, the World Bank, African Development Bank (ADB), UNICEF, UNFPA, GLRA, GHAIN, etc
- Implementation of the policy on the free antenatal care and delivery for pregnant women and free anti-malaria prevention and treatment for pregnant women and under-5 children in Edo State. This is crucial to equity in health.
- Formulating the enabling law to back the free antenatal care and delivery for pregnant women and free malaria treatment and prevention for Under-5 children and pregnant women;
- Reduction of the high prevalence of communicable and non-communicable diseases with subsequent reduction in high morbidity and mortality amongst the most vulnerable in our society;
- Improvement of the state of health of the people by improving health infrastructures;
- Enhancing a conducive environment for efficient training and effective learning by improving the infrastructures of our health training institutions;
- Enhancing the State capacity to purchase, store and monitor drug quality;
- Improvement in the accessibility, coverage, utilization, quality and equity of health care delivery services in the State;
- Enhancing and facilitating safe blood transfusion;
- Ensuring effectiveness of Health Management Information System (HMIS) as a management tool for informed decision-making at all levels;
- Adequately managing disasters through emergency/accident preparedness and response including Road Traffic Accident (RTA) management;
- Reduction to the barest minimum the prevalence of sickle cell disorders via appropriate genetic counseling and health education;
- Improving the water supply system in our state hospitals through the entire overhauling of distribution system; and
- Strengthening maternal and child health through a drastic reduction of maternal and child morbidity/mortality rates.
- Ensuring in our state hospitals adequate provision of health care delivery services that are people-oriented, people-driven, preventive and curative;
- Promotion of traditional medicine as a veritable means of promoting health for all the teeming population of Edo State;
- Enhancing research-based planning and management at all levels;

- Providing succour to all those that need medical help across the State; and
- Promoting Public-Private Partnership (PPP) Initiative in health in line with contemporary Health Sector Reforms (HSR).

2.21 Strategies and the Way Forward; 2010-2015

2.21.1 Reforms

Reforms are needed to achieve the visions, goals and targets for health sector
Accordingly, the following **Health Sector Reform Priorities** have been identified.

- Financial reforms for better management of available funds, including development of health accounts to track the flow of funds from all sources (the three tiers of government, partner agencies, private, insurance and others); mobilization of more resources for health; the State must raise health higher in the development agenda;
- Organizational reform, including decentralization of management and devolution of powers to allow greater autonomy, effectiveness and efficiency at lower levels-creation of Primary Health Care Board, Hospital Governing Councils, sector wide planning;
- Public/private partnership in health care delivery including promotion of private sector participation, compliance with regulations and enforcement of standards;
- Strengthening of Health Management Information System (HMIS) for evidence-based planning, monitoring/evaluation and overall assessment of the performance of health system as well as general improvement of Information and Communication Technology (ICT) for health;
- Improved access to Primary Health Care -PHC and disease control services; promotion of intersectoral coordination, cooperation and collaboration; the new Ministry of Budget, Planning and Economic Development is well placed to achieve this intersectoral coordination;
- Improvement of Secondary Health Care to enable it serve as referral for PHC;
- Policy and legislative reforms including enactment of appropriate health laws; Bills for -Health Act, PHC Board, Health Insurance;
- Human resource development (HRD) including support for health training schools-nursing, midwifery, health technology; staff retraining and motivation; introduction of welfare and remuneration packages that allow the State to attract and retain well trained and competent professionals to the state service;
- Essential Drug Program including quality control (and laboratory), control of fake and unwholesome drugs and supply management;

2.21.2. Expected Output from Interventions

The expected output from our strategies, reforms and interventions are as follows:-

- Improved Hospital: Population Ratio
- Reduced Doctor/Patient Ratio
- Renovation, staffing and equipping of existing state-owned secondary and PHC centres in the State;
- Provision of drugs for all our public-owned hospitals and PHC centres by 2016;
- Renovation of our 34 State Hospitals;
- Renovation and equipping of health teaching institutions to wit Schools of Nursing and Midwifery, and the State School of Health Technology

- Establishment of public health laboratory by 2016;
- Supply of modern medical equipment to all our state-owned secondary health facilities by 2016;
- Training and retraining of health personnel;
- Promotion of traditional medicine;
- Creation of awareness and sensitization of the general public on the mode of transmission of HIV/AIDS;
- Supply of drugs/funds/materials for HIV/AIDS prevention and treatment; and
- Research activities on HIV/AIDS as well as training of officers of Edo State Action Committee on AIDS (SACA).

CHAPTER THREE

EDO STATE STRATEGIC HEALTH PRIORITIES DEVELOPMENT PLAN

This SHDP seeks to provide strategic guidance to the State in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for the people of Edo state towards achieving sustainable universal access and coverage of essential health services within the planned period of 2010 - 2015.

The Honourable State Commissioner for Health therefore expects all the stakeholders to embrace '*the use of this SHDP for the development of the respective operational plans for the state.*'

3.1. Strategic orientations

This SHDP focuses on eight priority areas that are listed as follows:

- Leadership and governance;
- Service delivery;
- Human resources for health;
- Health financing;
- Health information system;
- Community participation and ownership;
- Partnerships for health; and,
- Research for health.

3.2 Goals, strategic objectives, interventions, activities, indicators and targets

Annex I specifies the goals, strategic objectives and the corresponding interventions and activities with costs.

To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions detailed below is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered.

3.3. 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 (IPTp) for malaria in pregnancy
Preventing mother to child transmission (PMTCT)
Provider Initiated Testing and Counseling (PITC)
Condom use for HIV prevention
Cotrimoxazole prophylaxis for HIV+ mothers
Cotrimoxazole prophylaxis for HIV+ adults
Cotrimoxazole prophylaxis for children of HIV+ mothers
Measles immunization
BCG immunization
OPV immunization
DPT immunization
Pentavalent (DPT-HiB-Hepatitis b) immunization
Hib immunization
Hepatitis B immunization
Yellow fever immunization
Meningitis immunization
Vitamin A - supplementation for U5

C. INDIVIDUAL/CLINICAL ORIENTED SERVICES
Family Planning
Normal delivery by skilled attendant

Basic emergency obstetric care (B-EOC)
Resuscitation of asphyxia in newborns at birth
Antenatal steroids for preterm labor
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)
Detection and management of (pre)eclipse (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 (2^{nd} line drug)
Detection and management of STI
Management of opportunistic infections in AIDS
Male circumcision
First line ART for children with HIV/AIDS
First-line ART for pregnant women with HIV/AIDS
First-line ART for adults with AIDS
Second line ART for children with HIV/AIDS
Second-line ART for pregnant women with HIV/AIDS
Second-line ART for adults with AIDS
TB case detection and treatment with DOTS
Re-treatment of TB patients
Management of multidrug resistant TB (MDR)
Management of Severe Acute Malnutrition
Comprehensive emergency obstetric care (C-EOC)
Management of severely sick children (Clinical IMCI)
Management of neonatal infections
Clinical management of neonatal jaundice
Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the VLBW infant)
Other emergency acute care
Management of complicated AIDS

CHAPTER 4

RESOURCE REQUIREMENTS

For Edo State to be able to implement this Strategic Health Development Plan, we shall require the following human, physical and financial resources:-

4.1 Human

Even though there is generally inadequate manpower in Edo State Civil Service, the State is endowed with committed public health work force of 2,389 made up of 2,172 staff of the Hospitals Management Board and 217 staff of the Ministry of Health.

4.2 Physical

There are currently 926 health facilities in Edo State made up as follows:-

Tertiary = 8
Secondary = 246
Primary = 672
TOTAL = **926**
Public = 289
Private = 637

Of the 289 public health facilities in the State, 34 are secondary health facilities owned by Edo State Governments

4.3 Financial

No doubt, the SHDP will require a huge financial investment outlay if the various interventions and activities are to be attained. To make the laudable and ultimate goals and strategic objectives of the SSHDP realizable, it is pertinent to clear financing and implementation sources, the strategies and measures to implement SHDP in Edo State.
The major sources of **funds** for projects in Edo State include the following:-

- Monthly statutory allocation from the Federation Account (FAAC);
- Internally Generated Revenue;
- Accruals from Value Added Tax (VAT);
- Accruals from Derivation Account (DACC);
- Capital Receipts in the form of Foreign Direct Investments (FDI);
- International Development Assistance (IDA);
- Oversea Development Assistance (ODA)
- Loans; and
- Grants

These are the human, physical and financial resources currently available for us to implement Edo SSHDP. No doubt, the human resources are likely to be inadequate to comprehensively execute the entire Plan unless there recruitments in the health sector as proposed in the Plan.

CHAPTER 5

FINANCING PLAN

5.1 Estimated cost of the strategic orientations

The grand total cost of the entire activities in the Plan is the sum of ₦172,066,931,040.00 (One hundred and seventy two billion, sixty six million, nine hundred and thirty one thousand, forty naira) only. The break down for each of the 8 thematic areas (strategic orientations) is as reflected in the Table below.

TABLE 16: ESTIMATED TOTAL COST OF EDO SSHDP BY PRIORITY AREA

S/N	PRIORITY AREA	TOTAL COST
1	Leadership and Governance for Health	NGN 768,712,578
2	Health Service Delivery	NGN 43,970,585,654
3	Human Resources for Health	NGN 27,006,007,865
4	Financing for Health	NGN 898,032,565
5	Health Information System	NGN 1,153,068,868
6	Community Participation and Ownership	NGN 768,712,578
7	Partnerships for Health	NGN 768,712,578
8	Research for Health	NGN 1,537,425,157
GRAND TOTAL		NGN 76,871,257,844

TABLE 17: EXPECTED CONTRIBUTIONS OF THE 18 LGAs IN EDO STATE TO THE IMPLEMENTATION OF THE SSHDP BY PRIORITY AREA

S/N	PRIORITY AREA	TOTAL COST
1	Leadership and Governance for Health	**14,040,000.00**
2	Health Service Delivery	**15,578,060,000.00**
3	Human Resources for Health	**36,684,534,000.00**
4	Financing for Health	**19,162,000.00**
5	Health Information System	**44,640,000.00**
6	Community Participation and Ownership	**5,270,000.00**
7	Partnerships for Health	**-**
8	Research for Health	**14,400,000.00**
GRAND TOTAL		**52,360,106,000.00**

TABLE 18: EXPECTED CONTRIBUTIONS OF EDO STATE GOVERNMENT TO THE IMPLEMENTATION OF THE SSHDP BY PRIORITY AREA

S/N	PRIORITY AREA	TOTAL COST
1	Leadership and Governance for Health	**189,180,040.00**
2	Health Service Delivery	**44,357,787,000.00**
3	Human Resources for Health	**71,668,420,000.00**
4	Financing for Health	**1,645,973,000.00**
5	Health Information System	**388,097,000.00**
6	Community Participation and Ownership	**66,334,000.00**
7	Partnerships for Health	**259,894,000.00**
8	Research for Health	**1,131,140,000.00**
GRAND TOTAL		**119,706,825,040.00**

5.2 Assessment of the available and projected funds

The total budget for Edo SHDP is ₦172, 066,931,040.00 out of which we expect both the State and LGAs to provide the sum of N102, 010,400,000.00 as personnel cost over the period of 6 years. Of this sum, LGAs personnel cost will be N36,633,000,000.00 while that of the State Government will be N65,377,100,000.00. The total sum expected to be expended on capital projects is the sum of N70,056,831,040.00 out of which the State will expend N54,329,725,040.00 while the remainder of N15,727,106,000.00 is expected to be spent by LGAs on capital projects. In view of the dwindling statutory allocation to States attendant on the global economic meltdown and the low price of oil, we expect an average of N3, 500,000,000.00 annually from Edo State Government on capital projects in the health sector (i.e. N21, 000,000,000.00 for the entire 6 years); hence the financing gap of N33, 329,725,040.00 for capital projects from the State Government.

5.3 Determination of the financing gap

From our computation and forecast, the State should be able to budget an average of N3.5b annually for capital expenditure on health. This is about N21.0b for six years (2010-2015). The total budget for Edo SHDP is ₦65, 873,220,040.00; hence the financing gap of N44, 873,220,040.00

5.4 Descriptions of ways of closing the financing gap

The above sources of funds have been identified with a view to ensure appropriate mobilization of funds from each source for closing the financing gaps for SSHDP implementation in Edo State

It is noteworthy that FAAC will remain the dominant source of funds for the implementation of SSHDP in Edo State bearing in mind that it accounted for 65.86% of her total revenue in 1999; 53.20% in 2000; 71.83% in 2001; 53.85% in 2002; 62.52% in 2003; and 67.71% in 2004. The proportion of IGR in the total revenue profile ranged between 9.20 and 16.24% over the same period. However, the vulnerability of FAAC as a source of funding is already apparent due to shocks in the oil market occasioned by the current global economic meltdown. This is why IGR, which though ranks much lower than FAAC is nevertheless a more stable and reliable source of financing for SSHDP. To

this end the current drive for IGR by the Comrade Adams Oshiomhole Administration in Edo State is a very welcome development that will, no doubt, boost the overall revenue of Edo State.

Besides, FDI will continue to be attracted, ODA will be welcomed from rich industrialized countries like the USA, Britain, Canada, France, Germany, Russia, China, Japan, Netherlands, etc as well as from multi-lateral institutions like WHO, UNICEF, World Bank, African Development Bank, etc especially in the areas of funding for health system development, HIV/AIDS, malaria control, provision of essential components of health care delivery services and facilities.

CHAPTER 6

IMPLEMENTATION FRAMEWORK

6.1. Structures

Whether or not the funds available for implementing Edo SHDP are judiciously utilized to achieve the goals of SSHDP will to a large extent depend on the extent of transparency or openness in the process of procurement. Wherever the procurement is tinted with corruption, it would be difficult to realize the goals and strategic objectives of SSHDP.

It is germane to note that in Edo State there exist financial instructions governing procurement of goods. In addition there are various circulars regulating procurement, receipt, verification, storage and usage of items procured. Although these rules and regulations exist, it is observed that the level of compliance by officials of the establishments is low. Some of the lapses in the system include:-

- Authorization of procurement above individual approval limit is very rampant;
- Even though there are provisions for the establishment of Tenders Boards in Government and institutions, very many are not in existence;
- There are no adequate storage facilities in most Government Ministries/Institutions
- Short supply of well trained personnel to handle the procurement and storage units of government ministries/institutions

Good enough, all these drifts are not in the character of Edo State Ministry of Health. All procurements in the past 10 years are approved before execution and within the ambit of approval capacity of the approving officers/chief executive; there is a standing Ministerial Tenders Board made up of Directors with the Permanent Secretary as Chairman; there is a Due Process Office at the Department of Planning, Research & Statistics of the Ministry with an Engineer/ Procurement Officer; and the Ministry stores all its procured goods and equipment at State Medical Stores in the Benin City where there are store officers.

6.2. Institutions

The following institutions in Edo State will be involved in the implementation of the SSHDP:-

- Government House (Office of Fiscal Governance)
- Office of the Hon. Commissioner for Health
- Office of the Permanent Secretary, Ministry of Health
- Ministry of Budget, Planning & Economic Development
- Ministry of Finance
- Ministry of Health's Ministerial Tenders Board
- Edo State Steering Committee (SSC) of the SSHDP
- Department of Planning, Research & Statistics, Ministry of Health
- Office of the Accountant General of Edo State
- Office of the Auditor General of Edo State
- Edo State Ministry of Works

6.3. Strategic Partners

Over the years, Edo State has enjoyed the support of UN Agencies and other bilateral and non-government agencies in its preventive health programmes in enhancing child survival, safe motherhood, immunization, essential drug supplies, disease control, and programme management. Such organizations include:-

- UNICEF (for the promotion of better nutrition and other child survival programmes)
- WHO (for the support in disease control and surveillance)
- UNFPA (for the just concluded support to reproductive health programmes)
- World Bank (for support in setting up Essential Drug Project and the on-going Health system Development Project II)
- African Development Bank (for support to the on-going Health system Development Project II))
- Global 2000 (for Guinea Worm eradication)
- GLRA (for the support in TB and Leprosy Control)
- FHI/GHAIN (for support to PMTCT, VCT, treatment of HIV/AIDS)
- Rotary International (for the supply of vaccines especially for polio)
- FMOH (for overall support both to the State and Local Government Councils)

Effective use of public funds shall be an important way of attracting donors into the State. The ability to achieve the targeted financing strategy would largely depend on how serious government is on value for money in public spending.

6.4. Civil society

The private sector shall play some important role in the whole financing process. Since the private sector is to be used as the driving force of Edo State's economy, it shall play a leadership role in the SSHDP process. The vehicle for achieving this should be by intensive advocacy, close interactions among stakeholder all of whom will be expected to buy into the SSHDP. There shall be greater participation of the private sector in the statutory coordinating meeting of SSHDP especially the State Steering Committee at the Office of the Honourable Commissioner. There shall be annual meeting of SSC with stakeholders on implementation issues to facilitate identification of problems and subsequent resolution. This will also be discussed at the bi-annual State Council on Health meetings.

Some of the infrastructural interventions shall take the form of public-private-partnership framework. Some important ones laboratory and diagnostic services may involve Build Operate and Transfer (BOT), and Rehabilitate Operate and Transfer (ROT). An important approach to ensure the achievement of partnership in development is value for money in service delivery.

The following civil societies/ professional associations will be involved in the implementation of SSHDP:-

Nigerian Medical Association (NMA)
Pharmacists Society of Nigeria (PSN)
National Association of Nigerian Nurses and Midwives
Association of Medical Laboratory Scientists of Nigeria
Medical and Health Workers Union
Association of Community Pharmacists of Nigeria

6.5. Individuals

Individuals and communities also have a role to play in the form of counterpart funding

CHAPTER 7

MONITORING AND EVALUATION

7.1 Proposed mechanisms for monitoring and evaluation

Deliberate efforts will be made to guide and ensure faithful implementation of the plan. Strengthening of the Health Management Information System will be carried out early in the plan to ensure that M & E and DSN units are empowered at all levels to track and monitor progress. Specifically, periodic joint assessment of achievements and progress towards MDGs will be carried out with the Local Government Councils. Monitoring and Evaluation were incorporated as key activities in each of the 8 priority areas. Expanded Health Data Consultative Committees (HDCC), Interagency Coordinating Committee and the Donor Agencies Forum will be used to ensure cooperation of all stakeholders. More regular State Council on Health meetings (twice yearly) will be used to provide forum for broad-based consultation, coordination and collaboration on a continuous basis. Successful implementation of the goals, strategic objectives of SSHDP largely depend on monitoring. An independent committee shall be set up to perform monitoring and evaluation roles. It should be made up of representative of the Governor's Office, the Ministry of Health, key members of the SCC, the organized private sector and civil society organizations. The Office of the Special Adviser to the Governor on Fiscal Governance shall provide focal point for monitoring efforts. The Committee shall follow the bench mark indicators highlighted under "Indicators".

7.2 Costing the monitoring and evaluation component and plan

Details are available in the Work Plan.

CHAPTER 8

CONCLUSION

All partners, including governments, donors and civil society need to align around an agreed set of instruments and approaches for achieving sector goals and adequate sector financing. The forum provided by this state input to the NSHDP is a welcome development and should be sustained.

Achieving the health MDGs will require support for more equitable strategies in the health sector and society generally as well as efforts to ensure that health has a more prominent place in economic and development policies. There is need for more budgetary allocation for health and for actual releases of the allocated funds regularly to allow progress in solving priority problems; there is great need now more than ever before for building capacity in leadership, management and institutional capacity within the ministries of health especially in strategic planning and budgeting; there is need for greater dialogue between health and other line ministries like finance and planning as development is an intersectoral and interdependent process. The participation of National Planning Commission in the preparation of this document again is a welcome development

If the foregoing interventions as detailed in the attached work plan are faithfully implemented, it will impact positively on the accelerated achievements of the MDGs in Edo State in line with national and global goals and also position the State for continuous quality improvements in health care even beyond 2015.

Annex 1: Participants for development of the strategic plan

EDO STATE REFERENCE GROUP

S/N	NAME	POSITION / AGENCY
1	DR. I. U. OMOIKE (CHAIRMAN)	PERMANENT SECRETARY, MOH
2	DR. A. E. OMOZUWA	DPRS, MOH
3	DR. (MRS.)B. A. OSEMENE	DPHC, MOH
4	MR. GILBERT ADEGBOYEGA	DPHC MIN. OF LG & CA
5	MR. LAWRENCE AKPA	UNICEF
6	MRS. FAITH IREYE	WHO
7	DR. BASSEY	NPHCDA
8	DR. C. O. IMHANLAHIMI	HSDP
9	DR. CHRISTOPHER IGHARO	SHDP CONSULTANT
10	DR. EBOMMWONYI (SECRETARY)	M&E OFFICER, MOH

EDO STATE PLANNING COMMITTEE

S/N	NAME	DESIGNATION/INSTITUTION REPRESENTED
1	Dr. I. U. Omoike	Permanent Secretary MOH (Chairman)
2	Dr. A. U. Omozuwa	Director, PRS
3	Dr. C. O. Imhanlahimi	Assistant Director, Planning
4	Dr. (Mrs.) B. A. Osemene	Director, PHC, MOH
5	Dr. (Mrs.) H. O. Eboreime	Director, Medical Services
6	Mrs. I. Obayagbonna	Director, Accounts & Finance, MOH
7	Pharm. (Dr.) O. Enadeghe	Pharmaceutical Services
8	Mrs. B. O. Obazele	Assistant Director, Nursing Services
9	Miss Deborah Enakhimion	Director, Administration
10	Dr. M. A Osumah	DHS/CE HMB
11	Mr. T. U. Okoudoh	Director of Budget
12	Mrs. J. A. Odihirin	Director, Admin LG Service Commission
13	Mr. Gilbert Adegboyega	Director, PHC, Min. of Local Govt. & Chieftaincy Affairs
14	Dr. Osahon Enabulele	NMA
15	Pharm. Tunde Akanmu	PSN
16	Mr. Patrick Igharosa	NANNM
17	Mr. Richard Omaregie	Medical Lab Scientist
18	Mr. Sunny Osayande	Med. & Health Workers Union
19	Chief (Dr.) T. O. Omon Oleabhile	Traditional Medical Association
20	Prof. George Akpede	Provost, College of Medicine, AAU Ekpoma

21	Prof. Michael Ibadin	CMD, UBTH, Benin City

EDO STATE STEERING COMMITTEE:

S/N	NAMES	DESIGNATION/LGA/INSTITUTION
1	Dr. Moses Momoh	Hon. Commissioner for Health
2	Hon. Victor Enoghama	Hon. Commissioner for Local Govt. & Chieftaincy Affairs
3	Hon. John Inegbedion	Hon. Commissioner for Finance
4	Hon. Alhonsi Unuigbe	Hon. Commissioner for Budget and Economic Planning
5	Hon. J. A. Emaealu	Chairman, Akoko Edo LGA
6	Hon. Cosby Eribo	Chairman, Egor LGA
7	Hon. Engr. Emmanuel Agbali	Chairman, Esan Central LGA
8	Hon. John E Yakubu	Chairman, Esan North-east LGA
9	Hon. John Ojiemhenkele	Chairman, Esan South-east LGA
10	Hon. Felix Akhabue	Chairman, Esan West LGA
11	Hon. Joseph Ugheoke	Chairman, Etsako Central LGA
12	Hon. Stanley Okpo Odidi	Chairman, Etsako East LGA
13	Hon. Ganiyu Audu	Chairman, Etsako West LGA
14	Hon. Felix Imoisili	Chairman, Igueben LGA
15	Hon. Itohan Osahon	Chairlady, Ikpoba Okha LGA
16	Hon. Mike Nosa Ehimen	Chairman, Oredo LGA
17	Hon. Patrick Asien	Chairman, Orhionmwon LGA
18	Hon. Faustine Ovierioba	Chairman, Ovia North-east LGA
19	Hon. Monday Aighobahi	Chairman, Ovia South-west LGA
20	Hon. Kassietu Ohiwere	Chairman,Owan East LGA
21	Hon. Dan Asekhame	Chairman, Owan West LGA
22	Hon. Barr. A. Obaze	Chairman,Uhunmwuode LGA
23	Dr. Israel Mandi Aguele	Chairman, House Committee on Health, EDHA
24	Dr. I. U. Omoike	Permanent Secretary MOH
25	Lady (Mrs.) M. I. Oshioma	Director, Nursing Services
26	Dr. (Mrs.) H. O. Eboreime	Director, Medical Services
27	Dr. Moses Aigbirior	Director, Medical Laboratory Services
28	Pharm. I. O. Macfoy	Director, Pharmaceutical Services
29	Dr. V. A. Iyekekpolor	Director, Disease Control
30	Dr. (Mrs.) B. A. Osemene	Director, PHC
31	Mrs. M. Obayagbona	Director, Accounts & Finance
32	Dr. M. A. Osumah	Director, Health Services/Chief Executive HMB
33	Miss D. Enakhimion	Director, Admin and Supply
34	Dr. Osahon Enabulele	NMA
35	Pharm. Tunde Akanmu	PSN
36	Mr. Patrick Igharosa	NANNM
37	Mr. Richard Omaregie	Medical Lab Scientist
38	Mr. Sunny Osayande	Med. & Health Workers Union
39	Chief (Dr.) T. O. Oleabhiele	Traditional Medicine Association

40	Dr. A. E. Omozuwa	DPRS/Secretary of Committee

Annex 2: Details of Edo State Strategic Health Development Plan

EDO STATE STRATEGIC HEALTH DEVELOPMENT PLAN						
PRIORITY						
Goals					**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**TOTAL (2010-2015)**
	Strategic Objectives				**Targets**		
		Interventions			**Indicators**		
			Activities		**None**		
					0		
LEADERSHIP AND GOVERNANCE FOR HEALTH							
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria							**768,712,578**
	1.1	**To provide clear policy directions for health development**			**All stakeholders are informed regarding health development policy directives by 2010**		**572,846,377**
		1.1.1	Improve Strategic Planning at State levels		Percentage of stakeholders in the state that have copies of the state health development plan framework directives by 2011		41,760,732
			1.1.1.1	Establish a Planning Officers Forum in Edo State to include key stakeholders		Political will at State and LGA level; political stability; budgetary allocation of funds (influenced by oil prices); participation and funding by donor agencies; availability of skilled manpower; implementation of budgets; commitment of workers and communities.	1,418,498
			1.1.1.2	Generate State and LGA consensus on the development and operationalisation of the State Strategic Plan Framework			-
			1.1.1.3	Hold annual review meetings of Planning Officers at the State level			16,341,097
			1.1.1.4	Create inter-sectoral and intergovernmental steering committees for follow-up of progress with the SSHDP			1,305,018
			1.1.1.5	Document and present annual progress reports on health determinants at State and LGA levels			22,696,119
		1.1.2	Establish intra-sector mechanisms for policy synergy in the health sector		Number of meetings of ICC and DPF held annualy		258,212,025
			1.1.2.1	Reactivate State Council on Health as a forum to serve as advisory body and a consultative forum on health matters			556,051
			1.1.2.2	Hold meeting of State Council on Health twice per year			234,903,266
			1.1.2.3	Establish Interagency Coordinating Committee (ICC) and Donor Partners Forum (DPF) in the State			964,579
			1.1.2.4	Conduct quarterly meeting of ICC and DPF to harmonise donor programmes and projects in line with Edo State government health policy			21,788,129

		1.1.3	Identify and implement capacity building and reorientation/initiatives for health policy development at all levels		Number of health workers trained on work ethics and CQI annualy		272,873,620
			1.1.3.1	Train LGA officers in planning and management			53,108,564
			1.1.3.2	Train State officers in planning and management			21,561,169
			1.1.3.3	Train 300 hospital and PHC workers annualy on work ethics and continuous quality improvement (CQI) in healthcare			198,135,798
			1.1.3.4	Incorporate training modules on LSS, IMCI, CQI/TQM into the training curricula of schools of nursing, midwifery and health technology			68,088
	1.2	**To facilitate legislation and a regulatory framework for health development**			**Health Bills signed into law by end of 2011**		63,056,964
		1.2.1	Review existing health laws/edicts in Edo State (e.g. Law on mandatory reporting of maternal mortality, prohibition of female genital mutilation, free treatment for cancer patients, etc)		Number of stakeholders with documented existing laws		2,685,690
			1.2.1.1	Compile existing Health laws in the state			416,093
			1.2.1.2	Publish and disseminate laws to stake holders			1,134,798
			1.2.1.3	Set up a Committee to review the existing laws.			1,134,798
		1.2.2	Strengthen regulatory functions of government		Passage of SPHCDA and SHIS bills into laws by Edo State House of Assembly		10,950,804
			1.2.2.1	Prepare a draft bill for a law to establish SPHCDA, State Health Insurance Scheme (SHIS) and law for registration of allied health establishments			416,093
			1.2.2.2	Submit draft bills to Edo State House of Assembly (ESHA) and advocate their passage/enactment into laws			9,967,312
			1.2.2.3	Prepare and submit draft bills to fill identified legislative gaps			567,399
		1.2.3	Enforce and IEC on extant laws		Level of public awareness of extant health laws		49,420,470
			1.2.3.1	Prepare and disseminate information pamphlets on appropriate laws			1,021,319
			1.2.3.2	Hold regular TV/radio talk shows on appropriate health laws			22,979,667
			1.2.3.3	Set up monitoring teams			11,347,984
			1.2.3.4	Monitor compliance			14,071,500
	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**		110,113,270
		1.3.1	Improve accountability and transparency		Proportion of SMOH budget and donor agencies integrated work plan implemented annualy		58,366,464
			1.3.1.1	Set up a Due Process Office			13,541,927
			1.3.1.2	Train members of the Ministerial Tenders Board (MTB) on due process procedures			11,915,383

			1.3.1.3	Publish SMOH budget and donors agencies integrated work plan annually			756,532
			1.3.1.4	Establish Servicom units in public health establishments			9,456,653
			1.3.1.5	Conduct regular exit interviews amongst users of public health establishments			22,695,968
		1.3.2	Raise health higher in the development agenda		Proportion of State budget allocated to the health sector		51,746,806
			1.3.2.1	Set up advocacy team			302,613
			1.3.2.2	Organise advocacy to the State Governor, Edo State House of Assembly, LGA Chairmen, SMBED at least twice a year			40,852,742
			1.3.2.3	Use ICC to advocate for better health funding			10,591,452
		1.3.3					-
	1.4	**To enhance the performance of the state health system**			**1. State and 50% of LGAs updating SHDP annually. 2) State and 50% of LGAs with costed SHDP by end of 2011**		22,695,968
		1.4.1	Strengthen professional regulatory bodies and institutions				22,695,968
			1.4.1.1	Provide logistic support to professional regulatory bodies and institutions in the State in the discharge of their monitoring roles and maintenance of ethics and standards			22,695,968
HEALTH SERVICE DELIVERY							
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							43,970,585,654
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by State and 60% of LGAs by 2011**		14,559,193,566
		2.1.1	Implement the minimum package of care in an integrated manner		Proportion of PHC centres in Edo state providing Ward Minimun Health Package		8,128,563,366
			2.1.1.1	Provide facilities for the implementation of Ward Minimum Health Package			11,004,413
			2.1.1.2	Provide equipment and essential drugs in all the PHC centres to offer ward minimum health package in each of the 18 LGAs			6,602,647,509
			2.1.1.3	Employ adequate and skilled personnel to operate the PHC centres (10 per LGA per annum)			1,485,595,689
			2.1.1.4	Train at least 10 health staff in each LGA in basic elements of minimum health package annually			27,731,120
			2.1.1.5	Build capacity of members of Village Development Committees (VDCs)			1,584,635
		2.1.2	Strengthen specific non communicable disease control programmes		1) Number of girls age 8-11 years receiving Gardasil vaccine 2) Proportion of health facilities in the state providing specific non communicable disease control services		750,867,747

			2.1.2.1	Create awareness on reproductive health cancers (breast, cervix and prostrate), hypertension and diabetes			8,803,530
			2.1.2.2	Provide diagnostic equipment for screening and treatment of reproductive health cancers (RHCs) and Gardasil vaccines for cervical cancer prevention in 8-11 years			146,725,500
			2.1.2.3	Train staff on mass screening and treatment of RHCs			1,100,441
			2.1.2.4	Provide logistics for cervical cancer prevention in age 8-11 years			7,336,275
			2.1.2.5	Support and strengthen specific non-communicable disease control such as Hypertension, Diabetes, etc in order to reduce burdens of the diseases			586,902,001
		2.1.3	Strengthen specific communicable disease, including Neglected Tropical Diseases (NTDs) such as onchocerciasis, schistosomiasis, lymphatic filariasis, etc and other control programmes to reduce burdens of the diseases		1) Percentage of health facilities in the state providing specific communicable disease control services in the state 2) Number of public health laboratories established by 2011		1,118,781,939
			2.1.3.1	Support and strengthen NTDSs - Onchocerciasis, schistosomiasis, lymphatic filariasis, etc) in order to reduce burdens of the diseases			733,627,501
			2.1.3.2	Advocacy/sensitisation of policy makers and opinion leaders on NTDs at state and LGA levels			2,200,883
			2.1.3.3	Create awareness on NTDs using IEC			1,467,255
			2.1.3.4	Sustain the provision of Mectizan and other drugs and materials, including logistics for effective control of NTDs			14,672,550
			2.1.3.5	Establish public health laboratories			366,813,750
		2.1.4	Provision of Standard Operating Procedures (SOPs) and guidelines for delivery of services at State and LGA levels		Proportion of health facilities in the state providing Client Oriented Provider Efficiency (COPE) 2) Number of health facilities using SOP and guidelines for delivery of services at the state and LGA levels		6,712,692
			2.1.4.1	Issue a statutory guidance that formally holds the Hospitals Management Board/Top Management Team of health care facilities/organisations managerially and professionally accountable for quality of service delivery in their institutions			2,200,883
			2.1.4.2	Establish a legally enforceable right to quality healthcare by users			110,044
			2.1.4.3	Develop and implement a funded incentive programme of support for private health sector practitioners and facilities to enhance their involvement in quality programme initiatives			4,401,765
		2.1.5	Ensure availability of equipment at all levels		Proportion of health facilities with adequate and standard medical/health equipment by 2012		4,554,267,823

			2.1.5.1	Supply of new hospital equipment, generators, utility vehicles, solar powered cold chain equipment, blood banks to the 34 existing and 10 new government-owned hospitals; and Oxygen Plant to Central Hospital, Benin City			2,934,510,004
			2.1.5.2	Carry out needs assessment for replacement of obsolete medical equipment annually in each of the 280 primary health care centres			1,375,552
			2.1.5.3	Replace obsolete equipment for PHC centres			1,467,255,002
			2.1.5.4	Train staff on preventive maintenance of equipment			4,401,765
			2.1.5.5	Provide equipment for essential obstetric care in all the PHC centres			146,725,500
	2.2	**Increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		6,500,893,374
		2.2.1	Improve geographical equity and access to health services		1) Number of health facilities with potable water in the state and LGAs 2) Ratio of health facilities per population in the State and LGA 3) Number of highway accident areas established in the state		4,036,546,895
			2.2.1.1	Carry out a comprehensive mapping of health facilities at all levels and a need assessment survey to determine health care and staff needs			1,375,552
			2.2.1.2	Develop criteria for siting of new health facilities and renovating substandard ones at state level			220,088
			2.2.1.3	Renovate all existing substandard health facilities and provide potable water to all PHCs at the LGA level			2,934,510,004
			2.2.1.4	Establish Highway Accident Areas, and State Mobile Clinics for outreach services to hinterland in Edo State			366,813,750
			2.2.1.5	Provide adequate and safe water to all hospitals at state level			733,627,501
		2.2.2	Ensure availability of drugs and equipment at all levels		1) EDP adequately recapitalised by 2010 2) Percentage of health facilities at the LGAs with effective Drugs Revolving Fund programme		628,351,955
			2.2.2.1	Recapitalise State Essential Drugs Programme (EDP)			366,813,750
			2.2.2.2	Restructure and Recapitalise Drug Revolving Fund at LGAs			183,406,875
			2.2.2.3	Provide adequate manpower for EDP and train staff on drug supply management and quality control			63,458,779
			2.2.2.4	Provide logistics for adequate supply and distribution of vaccines annually			7,336,275
			2.2.2.5	Reactivate State drug quality control laboratory to monitor quality of essential drugs			7,336,275
		2.2.3	Eradicate lassa fever in Edo state		Prevalence of Lassa fever in the state and LGAs		155,675,756

			2.2.3.1	Advocacy/sensitisation of policy makers and opinion leaders on lassa fever at state and LGA levels			2,200,883
			2.2.3.2	Create awareness on lassa fever using IEC			733,628
			2.2.3.3	Train health workers on identification, prevention and control of lassa fever			2,347,608
			2.2.3.4	Provide Ribaverin for the treatment of lassa fever			146,725,500
			2.2.3.5	Provide IEC materials, PPE (Personal Protective Equipment) and logistics to Edo State Lassa Fever Awareness Committee Stakeholders Forum			3,668,138
		2.2.4	Strengthen referral system		Number of health facilities in the state operating effective 2 way referral system		306,381,185
			2.2.4.1	Establish and implement guidelines for 2-way referrals and promote the rigorous adherence to the referral guidelines and their use by State and LGA health facilities in Edo State			220,088
			2.2.4.2	Develop and promote guidelines for follow-up and referral coordination for use at each facility level with the aim of enhancing integrated provider-initiated follow-up of care referral system			220,088
			2.2.4.3	Map out referral health centres, and develop a network of PHC centres linked to the 34 government-owned health facilities for emergency obstetric care			751,968
			2.2.4.4	Purchase ambulances and communication gadgets for each of the existing 34 state-owned hospitals for referral services			199,546,680
			2.2.4.5	Purchase ambulances and communication gadgets for each of the 18 LGAs for referral services			105,642,360
		2.2.5	Reduce the burden of malaria through the RBM programme		1) Prevalence of malaria cases in the state 2) Proportion of under-5 children and pregnant women provided with ITNs		1,373,937,584
			2.2.5.1	Advocacy/sensitisation of policy makers and opinion leaders on malaria fever at state and LGA levels			1,467,255
			2.2.5.2	Train malaria control officers and other health workers on the use of ITNs, ACT and SP drugs, and environmental control of malaria			7,923,177
			2.2.5.3	Provide ITNs, anti-malarial drugs and fumigating chemicals and equipment			1,320,529,502
			2.2.5.4	Support the celebration of RBM day at state and LGA levels			44,017,650
	2.3	**To improve the quality of health care services**			**50% of health facilities involved in a Quality Improvement programme by end of 2012**		12,519,544,047
		2.3.1	Reduce morbidity and mortality in the target group for the survival of the sickle cell child		Number of deaths annually		454,115,423
			2.3.1.1	Provision of infrastructural facilities and equipment to the Sickle Cell Centre, Benin City			73,362,750
			2.3.1.2	Improve accessibility and affordability through the establishment of sickle cell clinics at the sickle cell centre and all the 34 state hospitals			374,150,025
			2.3.1.3	Build capacity of work force to ensure adequate genetic counselling and pre-natal diagnosis			4,401,765

			2.3.1.4	Carry out public enlightenment campaign against destigmatization and to attract increased private and public sector participation in the control and prevention of sickle cell diseases			2,200,883
		2.3.2	Develop and institutionalise quality assurance models		Number of health workers trained on quality assurance annually		32,573,061
			2.3.2.1	Train and re-train health workers on quality assurance annually			32,573,061
		2.3.3	Increase access to HIV/AIDS control and management		1) Level of public awareness on HIV/AIDS 2) Number of trained health workers on prevention, management and injection safety practices		194,264,562
			2.3.3.1	Advocacy/sesitisation of policy makers and opinion leaders on HIV/AIDS at state and LGA levels			1,467,255
			2.3.3.2	Create awareness on HIV/AIDS and feeding options for infants of HIV posotive mothers using IEC			1,467,255
			2.3.3.3	Provide injection safety commodities such as safety boxes, AD syringes and needles, personal protective equipment (PPE), and incinerators in all state health facilities			73,362,750
			2.3.3.4	Train health workers at the primary and secondary health care levels on the prevention, management and control of HIV/AIDS, including injection safety practices			117,967,302
		2.3.4	Improve access to quality primary health care		1) Number of functional PHC centres in the LGAs 2) Number of PHCs with potable water		3,255,178,585
			2.3.4.1	Construct 1 new primary health centre in each of the 18 LGAs annually			2,376,953,103
			2.3.4.2	Equip and staff the new health centres			540,756,831
			2.3.4.3	Construct boreholes for 2 PHC centres per LGA annually where feasible or the supply 2 water tankers for each of the LGAs for quality primary health care services			264,105,900
			2.3.4.4	Construct Treatment Plants for river water and reticulate them in 1 PHC centre per LGA in Edo North and Edo Central annually			73,362,750
		2.3.5	Rehabilitate/Complete health facilities		Number of health facilities rehabilitated/constructed/completed annually		8,583,412,416
			2.3.5.1	Complete on-going hospitals at Otuo, Ewohimi, Okada, Uhi, Ekiadolor and Okpella			2,200,882,503
			2.3.5.2	Construct new hospitals at Sobe, Eme-Ora, Ekpoma, Ugo, Uhi, Iyamho, Ikpoba Hill, Ososo, and Government House			396,158,851
			2.3.5.3	Repair/Renovate existing Hospitals: Sabongida-Ora, Iruekpen, Agenebode, Ibillo, Ewu, Usen, Abudu, Igbanke, Ubiaja, etc; and renovate 50 MCH/FP Clinics at the LGAs annually			1,357,210,877

			2.3.5.4	Rehabilitate and expand Central Hospitals at Benin City, Auchi and Uromi and Ossiomo Leper Settlement			4,401,765,006
			2.3.5.5	Set up and equip 3 Intensive Care Units (ICUs) and train personnel on intensive care at the 3 Central Hospitals of Edo State			227,395,180
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end of 2011**		2,597,848,344
		2.4.1	Create effective demand for services		1) Number of MOH employed 2) Number of members of VDCs trained		623,840,145
			2.4.1.1	LGAs to employ Medical Officers of Health (MOH) to provide competent leadership at each LGA			130,732,421
			2.4.1.2	Train and define clear job description for LGA Medical Officers of Health			8,913,574
			2.4.1.3	Build capacity of members of Village Development Committees (VDCs)			88,035,300
			2.4.1.4	Promote sustainable disease-specific support by registered advocacy groups or NGOs in rural areas			396,158,851
		2.4.2	Promote positive health care seeking behaviour		1) Prevalence of common childhood diseases 2) Prevalence of malnutrition of under-5 in the state		667,674,389
			2.4.2.1	Promote Baby Friendly Hospitals Initiative and other nutrition promotion activities for mothers and children			220,088,250
			2.4.2.2	Promote appropriate case management of common childhood diseases (Diarrhoea, Anaemia, Malaria, A.R.I, etc.)			110,044,125
			2.4.2.3	Support health education, nutrition promotion, growth monitoring, and nutrient supplementation			146,725,500
			2.4.2.4	Train 2 CHEWs in each PHC centre on health promotion practices			7,409,638
			2.4.2.5	Provide IEC materials on safe motherhood			183,406,875
		2.4.3	Promote Traditional Medicine		1) Number of traditional medicine practitioners registered and trained. 2) Botanical garden established		39,359,115
			2.4.3.1	Register traditional medicine practitioners			183,407
			2.4.3.3	Train and retrain Traditional Medicine Practitioners on basic hygiene & drug safety			2,494,334
			2.4.3.4	Develop Botanical Garden of medicinal plants and herbs			36,681,375
		2.4.4	Reactivate school health service to promote health of the school age child		School health services reactivated at both state and LGAs		150,393,638
			2.4.4.1	Provide logistics (One vehicle, screening equipment and 10 First Aid Boxes) and IEC materials for each of the 18 LGAs for School Health activities.			132,052,950
			2.4.4.2	Provide logistics (2 vehicles) to support school health services at the ministry of health			18,340,688
		2.4.5	Reduce the burden of of Tuberculosis & Leprosy (TBL) in Edo state		Prevalence of TBL		1,116,581,056

			2.4.5.1	Advocacy/sensitisation of policy makers and opinion leaders on TBL at state and LGA levels			1,467,255
			2.4.5.2	Create awareness on TBL using IEC			1,467,255
			2.4.5.3	Rehabilitate the only existing leprosarium at Ogan, via Abudu, Edo state			733,627,501
			2.4.5.4	Provide logistics, drugs and materials for effective management of TBL			366,813,750
			2.4.5.5	Support the celebration of world Tuberculosis and Leprosy days and the State Tuberculosis and HIV Working Group			13,205,295
	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**		7,793,106,322
		2.5.1	Improve financial access especially for the vulnerable groups		1) Reduced maternal mortality ratio 2) Number of indigent citizens treated free		6,210,156,796
			2.5.1.1	Provide logistic support to NGOs, FBOs on free health care services at rural areas			11,004,413
			2.5.1.2	Provide free medical care for indigent citizens			1,797,387,377
			2.5.1.3	Provide free ante-natal care, delivery, and post-natal care, including anti-malaria prevention and treatment for pregnant women in government-owned secondary health facilities			1,320,529,502
			2.5.1.4	Provide free ante-natal care, normal delivery and post-natal care, including anti-malaria prevention and treatment for pregnant women in PHC centres at LGAs			1,320,529,502
			2.5.1.5	Provide free medical services for complicated pregnacies at State owned hospitals			1,760,706,002
		2.5.2	Emergency Preparedness and response		Number of staff trained		735,058,075
			2.5.2.1	Train 50 staff in SMOH and HMB for appropriate response to emergencies			1,430,574
			2.5.2.2	Provide logistics for emergencies			733,627,501
		2.5.3	Promote child survival initiatives to reduce infant and child mortality		Reduced under-5 morbidity and mortality rate		494,171,485
			2.5.3.1	Provide free anti-malaria treatment and prevention for Under-5 in government-owned secondary health facilities in Edo State			79,231,770
			2.5.3.2	Provide free anti-malaria treatment and prevention for Under-5 in all PHC centres at the LGAs			158,463,540
			2.5.3.3	Provide IEC materials, ITNs, zinc for diarrhoea management, vitamin A, anthelmintics and equipment for IMNCH activities			183,406,875
			2.5.3.4	Train health workers on IMNCH and appropriate case management of common childhood/adolescent problems			65,733,024
			2.5.3.5	Promote key household practices that improve the health of newborn, children & mothers (exclusive/continued breast feeding, use of sanitary latrines, safe drinking water, etc),			7,336,275

		2.5.4	Institutionalise routine immunization		1) Number of health facilities with cold chain equipment 2) Proportion of 1 year old children immunised against measles		114,850,853
			2.5.4.1	Provide one 4x4 utility vehicle for each of the 18 LGAs in the State to ensure uninterrupted supply of vaccines			66,026,475
			2.5.4.2	Provide full complement of cold chain equipment (including solar power) for each of 18 LGC headquarters to ensure vaccine potency			26,410,590
			2.5.4.3	Provide regular TV, Radio and printed information on NPI			11,004,413
			2.5.4.4	Train and retrain 54 staff of LGAs (3 in each LGA) on vaccine supply management annually			11,409,375
			2.5.4.5				-
		2.5.5	Improve Maternal and Reproductive Health Services in order to reduce maternal mortality		Number of health workers trained and retrained		238,869,114
			2.5.5.1	Train/retrain midwives, CHOs, CHEWs on family planning supplies management, safe motherhood, LSS; and doctors on ELSS			118,334,116
			2.5.5.2	Advocacy to ensure commitment to human resource provision for improved services especially at LGA level			2,200,883
			2.5.5.3	Train/retrain health workers on Basic and Comprehensive Emergency Obstetrics and Neonatal Care (B&C-EONC), management of severely sick children (IMCI)			118,334,116
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							27,006,007,865
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**Edo State and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		1,701,818
		3.1.1	Develop and institutionalize the Human Resources Policy framework		Edo state human resources for health policy developed		37,386
			3.1.1.1	Develop state specific human resource policy based on the national Human Resource Policy			37,386
		3.1.2	Adapt the National HRH 2006 Policy and Strategic Plan at State and LGA levels to guide human resources for health development and to implement the plan		Committee on HRH set up in Edo state		801,061
			3.1.2.1	Develop a training programme and material to train the SMOH and 18 LGAs on how to customize the National HRH 2006 Policy and the Strategic Plan			311,551
			3.1.2.2	Set up a committee with State and LGA representation to develop principles of health workforce recruitment by the relevant bodies			104,681
			3.1.2.3	Develop and promote a roll-out of the customization of the HRH policy and Plan by the State and all the LGAs			49,848
			3.1.2.4	Monitor the adaptation of the National HRH Policy and Plan by the State and LGAs			334,980

		3.1.3	Develop/Promote non-discriminatory recruitment policies in Edo State especially for critically needed professionals, irrespective of their LGA of origin		Ratio of male/female health workers recruited annually		484,525
			3.1.3.1	Update Edo State policy on recruitment of health workers to ensure non-discrimination			37,386
			3.1.3.2	Develop a training programme and material, and promote a roll-out of the non-discriminatory recruitment policies by all LGAs			112,158
			3.1.3.3	Monitor the adaptation of the State non-discriminatory recruitment policies at the LGA level			334,980
		3.1.4	Reappraise the principles of health workforce requirements and recruitment at all levels		Staffing norm developed		112,158
			3.1.4.1	Develop staffing norms, in line with WHO guidelines, based on workload. Guide planning and use service availability to determine staffing needs. Introduce utilisation of established norms by State and LGAs			112,158
		3.1.5	Collect baseline data and consult professionals to identify appropriate health professional targets		Production of baseline data by 2011		266,688
			3.1.5.1	SMOH to consult appropriate professional bodies on health professional targets			229,302
			3.1.5.2	Construct a model to project training and output requirements of health professionals to provide for the health requirement needs of Edo State			37,386
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The Human Resources for Health crisis in the Edo State has stabilised and begun to improve by end of 2012**		26,488,470,216
		3.2.1	Reappraise the principles of health workforce requirements and recruitment at all levels		Number of staff recruited annually		5,131,250,846
			3.2.1.1	Annual recruitment of staff at HMB			1,682,377,327
			3.2.1.2	Annual recruitment of staff for SMOH			420,594,332
			3.2.1.3	Annual recruitment of staff at LGA level			3,028,279,188
		3.2.2	Payment of salaries and emolument for health workforce in the state		Payment of salaries monthly		21,357,219,370
			3.2.2.1	Payment of salaries and emoluments at HMB			14,254,222,296
			3.2.2.2	Payment of salaries and emoluments at SMOH			1,046,438,697
			3.2.2.3	Payment of salaries and emoluments at LGA level			6,056,558,376
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. Edo State has functional HRH Unit in the SMOH by end 2010 2. 50% of LGAs have functional HRH Units by end 2011**		23,784,578
		3.3.1	Establish and strengthen the HRH Units		Number of HRH units established by 2010		4,984,822
			3.3.1.1	Create HRH Unit in the Health Planning Department of the State Ministry of Health			498,482
			3.3.1.2	Create HRH Unit in the Health Planning Department of the LGA level			4,486,340

		3.3.2	Design and implement training programmes to build technical capacity at all levels of the health sector and other relevant sectors for human resources, planning and management		Number of health managers trained		3,188,790
			3.3.2.1	HRH unit to establish a training programme and manual for the training of managers in human resource planning and management from the health and other relevant sectors			37,386
			3.3.2.2	HRH unit to identify existing training institutions that are willing and able to provide the training courses for HRH management and planning			49,848
			3.3.2.3	Train managers in human resource planning and management from the health and other relevant sectors			2,766,576
			3.3.2.4	Monitor training courses output on HRH management and planning			334,980
		3.3.3	Establish multi-sectoral HRH system for planning, management and development at State and Local Government level		Inter-sectoral committees established at state and LGAs levels		12,135,548
			3.3.3.1	Establish state level intersectoral committee to discuss issues of human resource for health and meet quarterly			7,477
			3.3.3.2	Establish LGA level intersectoral committee to discuss issues of human resource for health and meet quarterly			44,863
			3.3.3.3	Support the state level intersectoral committee			1,854,354
			3.3.3.4	Support the LGA level intersectoral committee			10,228,854
		3.3.4	Promote proactive regular engagement with various professional groups to enhance dialogue and harmony		Number of meetings held annually		3,475,418
			3.3.4.1	Establish and promote a State level forum for regular meetings of professional groups			44,863
			3.3.4.2	Conduct 2 meetings of representatives of professional groups with SMOH management annually			493,497
			3.3.4.3	Establish LGA health professional groups			448,634
			3.3.4.4	LGAs to conduct 2 meetings of health professional groups with SMOH management annually			2,153,443
			3.3.4.5	Monitor the meetings that are taking place and the matters discussed and resolved at the State and LGA Professional Fora			334,980
	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**			**Edo State health training institutions producing health workforce including multipurpose skilled graduates and mid-level health workers by 2015**		425,290,034
		3.4.1	Support and strengthen health training institutions for manpower training and output based on service demand		1) Health training institutions renovated and provided with teaching aids by 2011 2) Department of Nursing Education established in at least one of the tertiary institutions in Edo state		343,952,698

			3.4.1.1	Renovate Schools of Health Technology, Nursing, and Midwifery and the hostel of School of Health Technology Hostel, Dumez Road, Benin City			149,544,651
			3.4.1.2	Complete the abandoned School of Nursing Hostel, Sapele Road, Benin City			74,772,326
			3.4.1.3	Provide teaching aids and logistics for the three health training institutions			74,772,326
			3.4.1.4	Support the establishment of Department of Nursing Education at the tertiary health institutions in Edo State for the training of nurses and midwives			14,954,465
			3.4.1.5	Support College of Medicine, Ambrose Ali University, Ekpoma			29,908,930
		3.4.2	Strengthen health workforce training capacity and output based on service demand		Incentives and reward system established		321,521
			3.4.2.1	Establish incentives and regular upgrading structure for academic staff so as to ensure their retention			47,356
			3.4.2.2	Develop and implement a reward system for training institutions to promote high quality standards and innovations			24,924
			3.4.2.3	Conduct a survey to establish the requirements of infrastructure, teaching and learning materials and budget financial support for state-owned health training institutions			249,241
		3.4.3	Revitalize periodic accreditation of all institutions involved in the training of health personnel in Edo State		Health training institutions in Edo state accredited annually		2,617,031
			3.4.3.1	Support accreditation of eligible private sector health facilities to increase training opportunities for internship and post-basic training for all health professionals			2,492,411
			3.4.3.2	Carry out periodic survey of the manpower and equipment needs of the Central Hospital, Benin City for internship and post graduate training			124,621
			3.4.3.3	Carry out periodic survey of the manpower and equipment needs of Schools of Nursing, Midwifery and Health Technology			-
		3.4.4	Establish a programme to fund in-service training, human capital capacity building and Continuing Professional Development (CPD) by government and healthcare provider institutions and coordination of same by SMOH		Number of health professionals trained annually		78,398,783
			3.4.4.1	Establish a process and the financial resources to sponsor candidates and bond them to return to serve for an agreed period after training		HMB	53,873,461
			3.4.4.2	Establish a process and the financial resources for rotational sponsorship of 300 candidates per annum for CPD			8,972,679
			3.4.4.3	Train and re-train staff on management, Health Account, RBM, HMIS, sickle cell genetic counselling			15,552,644
		3.4.5					-
	3.5	**To improve organizational and performance-based management systems for human resources for health**			**Edo State has implemented performance management systems by end 2012**		65,759,269
		3.5.1	Achieve equitable distribution, right mix of the right quality and quantity of human resources for health		Urban/rural ratio of health workers		2,718,722
			3.5.1.1	Monitor the deployment of professional staff to promote equity in mix, needs and geographical space			669,960

			3.5.1.2	Collaborate with Federal institutions located in Edo State to leverage available human resource so as to expand service coverage and quality			1,749,672
			3.5.1.3	Design and embark on a campaign to encourage diaspora trained health professionals to the service to strengthen the human resource availability in the State			299,089
		3.5.2	Establish mechanisms to strengthen and monitor performance of health workers at all levels		Absenteeism of health workers at duty posts		6,231,027
			3.5.2.1	Provide logistics (2 vehicles, fueling, etc) to HMB for monitoring activities of health workers at semi-urban and rural areas			6,231,027
		3.5.3	Rationalize and align supply of health workforce to the priorities of the health sector		1) Job description for all categories of health workers developed 2) Number of midwives retained after National Midwifery Scheme		46,266,623
			3.5.3.1	Create a State Database for Human Resources for Health			37,386
			3.5.3.2	Develop and provide job descriptions and specifications for all categories of health workers			37,386
			3.5.3.3	Collaborate in designating, refurbishing and equipping health training institutions to cater for the special training needs of Edo State in medical, pharmaceutical, paramedical, nursing and midwifery education			162,007
			3.5.3.4	Support the National Midwifery Scheme and the Community Midwifery Programme in LGAs			807,541
			3.5.3.5	Retain and employ midwives after Midwifery Scheme			45,222,303
		3.5.4	Develop and implement retention strategies for health workers		Number of retired health professional retained/hired on contracr basis		10,542,898
			3.5.4.1	Develop and implement incentives to retain health workers particularly in deprived areas			5,022,208
			3.5.4.2	Design and embark on a campaign to encourage retired health professionals to be of service after retirement			535,868
			3.5.4.3	Provide incentives for retired health professional by engaging their services on contract			4,984,822
	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**Edo State has regular HRH stakeholder forums by end 2011**		1,001,949
		3.6.1	Strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system		Number of meetings held annually		1,001,949
			3.6.1.1	Support quarterly meetings between management and staff of public and private sectors			650,519
			3.6.1.2	Support bi-annual meetings between management and regulatory bodies and associations			351,430
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							898,032,565
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**Edo State has a documented Health Financing Strategy by end 2012**		6,576,664

		4.1.1	Develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy		Health Financing Techinical Working Groups created at state and LGA levels by 2010		1,167,567
			4.1.1.1	Create Health Financing Technical Working Group at state level			245,378
			4.1.1.2	Create Health Financing Technical Working Groups at LGA level			922,189
		4.1.2	Implement the Strategic Plans at all levels		Edo state strategic health development plan adopted for implementation by end of 2009		5,409,097
			4.1.2.1	Draft the Strategic Plan at State and LGA levels			16,179
			4.1.2.2	Build capacity for the implementation of the Strategic Plans at all levels			5,392,919
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Edo State citizens by end 2015**		390,233,740
		4.2.1	Strengthen systems for financial risk health protection		NHIS implemented for the formal sector in Edo state by 2010		388,290,133
			4.2.1.1	Implementation of the NHIS for the formal sector in Edo State Civil Service			388,290,133
		4.2.2	Develop social health protection mechanisms to cushion households from catastrophic cost of out-of-pocket expenditures on health services		Number of health institutions implementing Social Health Protection Models		1,943,608
			4.2.2.1	Scale up all Social Health Insurance Programmes (formal, informal, and community-based) at all levels			1,132,513
			4.2.2.2	Develop and implement social health protection models (Free maternal and child health services, Vouchers, Health Card, Exemptions) for targeting vulnerable groups such as children less than 5 years of age, pregnant women, TB and HIV/AIDS patients, etc to access essential services			811,095
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated State and LGA health funding increased by an average of 5% pa every year until 2015**		486,408,892
		4.3.1	Improve financing of the Health Sector		Percentage of total budget allocated to capital expenditure		323,575
			4.3.1.1	Carry out advocacy to Ministry of Budget, Planning and Economic Development (MBPED) on the need to implement WHO recommended allocation of a minimum of 15% of total budget on capital expenditure for health annually			323,575
		4.3.2	Improve coordination of donor funding mechanisms		Percentage of donor funds utilised		107,858
			4.3.2.1	Develop guidelines and recommendations for Edo State to utilize donor assistance			53,929
			4.3.2.2	Establish a mechanism for coordinating resources and resource management for health development			53,929
		4.3.3	Governments at all levels to allocate at least not less than 15% of their total budgets on health		1) Passage of bill on mandatory allocation of 15% of budget to health 2) Counterpart fund		485,977,459

					contribution provided for projects		
			4.3.3.1	Secure statutory protection through State House of Assembly and LGA legislature to allocate 15% of budget to the health sector			593,221
			4.3.3.2	Ensure that one tenth of the target 15% allocation should be earmarked for social health protection programmes, that 2% of the consolidated fund from the Federation Account is released for Primary Health Care services in the State as provided in the National Health Bill, and that 2% of the total health budget is allocated to Research for Health at all levels			21,572
			4.3.3.3	Provide Counterpart Cash Contribution for Health Systems Development Project (HSDP)			161,787,555
			4.3.3.4	Provide Counterpart Cash Contribution for other International Agency-assisted Projects			323,575,111
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Edo State and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. Edo State and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		14,813,269
		4.4.1		Improve Health Budget execution, monitoring and reporting	Number of LGAs monitored		2,135,596
			4.4.1.1	Ensure that 45% of the health budget is allocated to capital expenditure			53,929
			4.4.1.2	Develop and implement annual expenditure tracking at all levels			539,292
			4.4.1.3	Monitor the use of the annual health accounts at States and LGAs on an annual basis			1,542,375
		4.4.2		Strengthen financial management skills	Number of health managers trained		12,677,673
			4.4.2.1	Conduct hands-on training for State Health Management Team on budgeting, planning, book keeping, monitoring and evaluation annually			4,044,689
			4.4.2.2	Conduct hands-on training for Health Management Teams on budgeting, planning, book keeping, monitoring and evaluation at LGA level annually			8,632,984
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							1,153,068,868
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010 2. Edo State making routine NHMIS returns to Federal level by end 2010**		370,495,954
		5.1.1		Ensure that NHMIS forms are available at all health service delivery points at all levels	Number of health facilities in the state		50,472,759

					with standardised NHMIS Forms		
			5.1.1.1	SMOH to print annually and distribute the standardised NHMIS Forms to all the 18 LGAs for re-distribution to all the 926 health facilities in the State			50,472,759
		5.1.2	Periodically review of NHMIS data collection forms		Number of LGAs with properly completed NHMIS data collection forms		5,675,587
			5.1.2.1	Review annually data collection tools by the Department of PRS with stakeholders to ensure feedback and user friendliness of data collection tools			5,675,587
		5.1.3	Coordinate data collection from vertical programmes		Number of HDCC meetings held		7,114,469
			5.1.3.1	Strengthen Health Data Consultative Committee (HDCC) on data management in Edo State			1,998,446
			5.1.3.2	Hold review meeting of HDCC quarterly			5,116,022
		5.1.4	Build capacity of health workers for data management		Proportion of health facilities with trained personnel on the use of the NHMIS forms		**192,650,222**
			5.1.4.1	Provide training and re-training at all the 926 health facilities in Edo State on NHMIS and the use of the new Forms			192,650,222
		5.1.5	Provide a legal framework for activities of the NHMIS programme		Passage of bill by 2011		11,857,448
			5.1.5.1	Ensure Draft Bill to State House of Assembly on mandatory forwarding of all health data to the SMOH and propose sanctions on private care providers that fail to submit health data to the relevant health authorities			3,064,284
			5.1.5.2	Advocacy to leaders, policy makers, LGA Chairmen, and top government functionaries on the value and usefulness of health data			8,793,164
		5.1.7	Ensure supportive supervision of data collection and transmission at all levels		Number of HMIS review meetings held at LGAs		102,725,468
			5.1.7.1	Provision of 2 No. 4-Wheel Drives to the SMOH			37,304,331
			5.1.7.2	Provision of 5 Motor Cycles for each of the 18 LGAs to enhance and facilitate collection of data at all levels in the State			23,981,355
			5.1.7.3	Provide incentives for supervisors at all levels			18,417,681
			5.1.7.4	Establishment of a quarterly HMIS review meeting at the LGA levels			23,022,101
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS at the State level and 50% of the LGAs by 2012**		458,043,889
		5.2.1	Strengthen the use of information technology in HIS		Availability of e-health at the Central hospitals		48,762,089
			5.2.1.1	Train relevant SMOH and LGA staff on the use of acquired database software for data collection			11,457,759
			5.2.1.2	Establishment of e-health (Patient Information System, Website, and Electronic Management Intelligence Information System) in the 3 Central			10,658,380

				Hospitals, Stella Obasanjo Women & Children Hospital, Benin City, and the SMOH			
			5.2.1.3	Set up State Drug Information System			26,645,950
		5.2.2	Provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management		Number of PHC centers equipped with NHMIS Minimum Package		261,663,234
			5.2.2.1	Implement the NHMIS minimum package at the SMOH and 18 LGAs of Edo State (Provision of 109 desktops, 15 laptops, 63 printers, 2 publication equipment, 30 binding machines, etc)			93,260,827
			5.2.2.2	Provision of furniture, equipment, and stationeries for the HMIS Unit of SMOH			5,329,190
			5.2.2.3	Provision of furniture, equipment, and stationeries for the HMIS Unit of LGAs			47,962,711
			5.2.2.4	Annual maintenance of equipment			115,110,506
		5.2.3	ICT for SMOH and HMB		Number of staff of SMOH & HMB trained on ICT annually		147,618,566
			5.2.3.1	Provision of V-SAT to serve SMOH & HMB			7,993,785
			5.2.3.2	Establish electronic-Library at Central Hospitals in Benin City, Auchi and Uromi, and the Stella Obasanjo Women & Children Hospital, Benin City			15,987,570
			5.2.3.3	Train and retrain staff on ICT			78,339,094
			5.2.3.4	Provide telephone and intercom support services in all state-owned hospitals			45,298,116
	5.3	**To strengthen sub-systems in the Health Information System**			**NHMIS and Disease Surveillance System strengthened by end 2012**		123,956,962
		5.3.1	Strengthen the Hospital Information System				42,633,521
			5.3.1.1	Provision of desktops, printers in all the Departments of the 3 Central Hospitals and Stella Obasanjo Women and Children Hospital to strengthen information system in state-owned hospitals			42,633,521
		5.3.2	Strengthen the Disease Surveillance System		Number of surveillance review meetings held annually		81,323,441
			5.3.2.1	Provision of 1 No. 4-Wheel Drive to ensure community based surveillance and regular reporting of notifiable diseases by all health facilities			26,645,950
			5.3.2.2	Provision of 5 Motor Cycles for each of the 18 LGAs to ensure community based surveillance and regular reporting of notifiable diseases by all health facilities			23,981,355
			5.3.2.3	Establishment of a quarterly disease surveillance review meeting			30,696,135
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		16,834,912
		5.4.1	Establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs		Availability of monitoring guidelines for HMIS activities in the state		399,689
			5.4.1.1	Prepare and establish monitoring guidelines for State HMIS programme implementation at SMOH and LGA levels			399,689
		5.4.3	Strengthen monitoring and evaluation capacity for effective NHMIS in Edo State		Number of LGAs forwarding NHMIS report quarterly		16,435,222

			5.4.3.1	Monitor training and re-training on the revised NHMIS Forms at the LGA monthly			3,581,216
			5.4.3.2	Collect and collate health data from the 18 LGAs monthly			12,854,007
	5.5	**To strengthen analysis of data and dissemination of health information**			**1. Edo State has a Unit capable of analysing health information by end 2010 2. Edo State disseminates available results regularly by 2011**		183,737,152
		5.5.1	Institutionalize data analysis and dissemination at all levels		Number of state health bulletin distributed annually		183,737,152
			5.5.1.1	Recruit Computer Analyst, and Engineer			101,920,761
			5.5.1.2	Production of State Health Bulletin annually			48,522,276
			5.5.1.3	Production of Directory of Health Facilities once in 2 years			24,261,138
			5.5.1.4	Production and distribution of Annual Report of the Departments of the Ministry of Health			9,032,977
COMMUNITY PARTICIPATION AND OWNERSHIP							
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							768,712,578
	6.1	**To strengthen community participation in health development**			**Edo State has at least an annual Forum to engage community leaders and CBOs on health matters by end 2012**		66,668,135
		6.1.1	Provide an enabling policy framework for community participation		Health Service Charters established in all state-owned hospitals by 2010		6,119,297
			6.1.1.1	Create an enabling policy to foster effective community participation in health actions in Edo State in conformity with the National Health Policy			1,610,341
			6.1.1.2	Establish Health Service Charters in all state-owned hospitals to promote the concept of citizens' rights and entitlement to quality and accessible basic health services			4,508,956
		6.1.2	Provide an enabling implementation framework and environment for community participation		All HCRCs strengthened by 2010		54,751,608
			6.1.2.1	Strengthen Hospital Community Relations Committee (HCRC) in all state-owned hospitals to serve as an interface between communities and hospitals		HMB	54,751,608
		6.1.3	Encouraging community participation		Number of consultations with SMOH annually		5,797,229
			6.1.3.1	Ensure that LGAs consult with SMOH and involve users and other stakeholders in major service planning and delivery (Example: construction of a new health facility and service re-design)			2,898,615
			6.1.3.2	Design and implement an information and consultation programme to be driven primarily by the service providers to learn about and respond to the			2,898,615

				needs of service users, potential users and the communities in which they are located			
	6.2	**To empower communities with skills for positive health actions**			**Edo State offers training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		491,089,718
		6.2.1	Build capacity within communities to 'own' their health services		Number of training conducted annually		151,050,025
			6.2.1.1	Identification and mapping of community stakeholders in the state			10,735,609
			6.2.1.2	Assessment of the capacity needs of stakeholders			5,367,805
			6.2.1.3	Capacity building of stakeholders			81,268,563
			6.2.1.4	Support to communities in management, implementation of policies/programmes and basic interpretation of health data			53,678,047
		6.2.2	Support NGOs, CBOs, FBOs engage in free health expeditions in the State		Availability of guidelines by 2010		340,039,693
			6.2.2.1	Formulate guidelines to prospective NGOs/FBOs on free health expedition			1,610,341
			6.2.2.2	Monitor free health expeditions and adherence to extant guidelines			16,361,069
			6.2.2.3	Offer logistic support for free health expeditions			322,068,283
	6.3	**To strengthen the community - health services linkages**			**80% of public health facilities in Edo State have active Committees that include community representatives by end 2011**		1,610,341
		6.3.1	Restructure and strengthen the interface between the community and the health services delivery points		Number of health facilities with functional Management/Development committees		1,610,341
			6.3.1.1	Develop and pilot guidelines for functional Management/Development Committees (Ward and Village), driven by communities and users to influence delivery of quality care at local facilities			1,610,341
	6.4	**To increase State capacity for integrated multisectoral health promotion**			**80% of LGAs involved in community health development by end 2011**		128,827,313
		6.4.1	Develop and implement multisectoral policies and actions that facilitate community involvement in health development		Number of LGAs visited		128,827,313
			6.4.1.1	Periodic advocacy to community gate-keepers (Oba, Chiefs, Enogies, Hon. LGA Chairmen, etc) to increase awareness and support for the use of health promotion to facilitate involvement in health development			128,827,313
		6.4.2					-
	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**		80,517,071

					guidelines by end 2012		
		6.5.1	Develop and implement systematic measurement of community involvement		Number of annual review meetings held		80,517,071
			6.5.1.1	Hold annual review meetings of all health community committees in the state as a forum to measure community involvement efforts (comparison of methods, impact, opportunities to learn from best practices, review of models that yield unacceptable results)			80,517,071
PARTNERSHIPS FOR HEALTH							
7. To enhance harmonized implementation of essential health services in line with national health policy goals							768,712,578
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**			**1. SMOH has an active ICC with Donor Partners that meets at least quarterly by end 2010 2. SMOH has an active PPP forum that meets quarterly by end 2010**		768,712,578
		7.1.1	Promote Public Private Partnerships (PPP)		1) Establishment of PPP units in HMB 2) Non-profit yielding contracts supported annually		649,910,276
			7.1.1.1	Set up PPP Unit in Hospital Management Board (personnel, office space, furniture, stationery, etc)			5,363,535
			7.1.1.2	Contract management support for clearing, security and horticulture services in the 34 government hospitals			579,261,791
			7.1.1.3	Contract management support for mortuary, catering, and laundry services in the 34 government hospitals			48,271,816
			7.1.1.4	Provide support to private health care providers (Private Consultant services, training, monitoring & evaluation, immunization activities and other PHC interventions)			13,408,838
			7.1.1.5	Monitor contracted services			3,604,296
		7.1.2	Institutionalize a framework for coordination of Development Partners		Number of meetings of ICC and DPF held quarterly		29,445,808
			7.1.2.1	Establish Development Partners Forum (DPF) for harmonization of work plan with SMOH			429,083
			7.1.2.2	Establish a Unit for Development Partners Forum (DPF) and ICC coordination in the SMOH			2,681,768
			7.1.2.3	Strengthen Interagncy Coordinating Committee (ICC)			2,681,768
			7.1.2.4	Conduct quarterly meetings of ICC and DPF			23,653,190
		7.1.3	Facilitate inter-sectoral collaboration		Number of specialists participating in intra and extramural consultancy services		10,727,070
			7.1.3.1	Promote and strengthen intra-mural and extra-mural consultancy services in state-owned hospitals			10,727,070
		7.1.4	Engage professional groups		Number of review meetings held		6,892,143
			7.1.4.1	Strengthen collaboration with professional bodies (NMA, PSN, NANNM, AGPMPN, AMLSN, ACPN, etc) in Edo State			536,354

			7.1.4.2	Hold bi-annual review meetings on implementation of state health policies with professional bodies			3,137,668
			7.1.4.3	Organise seminars/workshops, training on key health policies and programs to enable private practitioners participate in health program implementation			3,218,121
		7.1.6	Engage with Alternative Medicine Practitioners		Number of training workshops conducted annually		71,737,282
			7.1.6.1	Identify and register Alternative Medicine Practitioners in the state			5,765,800
			7.1.6.2	Conduct annual training workshops for Alternative Medicine Practitioners			65,971,482
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							1,537,425,157
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**Health Research Steering Committee (HRSC) established by end 2010 to guide health research priorities**		15,903,843
		8.1.1	Develop health research policies at state level and health research strategies at state and LGA levels		1) Production of health research policy document 2) Constitution of Health Research Steering Committee		4,093,394
			8.1.1.1	Convene Health Research Technical Working Group (HRTWG) to develop health research policies at state level and research strategies at both state and LGA levels			2,818,403
			8.1.1.2	Develop and provide guidelines for the establishment of Health Research Steering Committee (HRSC) at the state level			469,734
			8.1.1.3	Monitor the activities of HRSC at all levels and evaluate their functions and values			805,258
		8.1.2	Promote cooperation and collaboration between ministry of health and LGA health authorities with universities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors		Number of consultations held by stakeholders annually		9,394,675
			8.1.2.1	Develop and disseminate guidelines for a collaborative research agenda			469,734
			8.1.2.2	Establish and promote a forum of health research officers at SMOH and LGAs			469,734
			8.1.2.3	Convene a multi-stakeholders forum to identify research priorities and for harmonization of research efforts			7,247,321
			8.1.2.4	Support development of collaborative research proposals and their implementation			1,207,887
		8.1.3	Mobilise adequate financial resources to support health research at all levels		Percentage of mobilised funds deployed for health research		1,207,887
			8.1.3.1	Promote the designation of at least 2% of health budgets for health research at state and LGA levels			805,258
			8.1.3.2	Encourage SMOH to deploy mobilised funds for health research in a targeted manner			402,629
		8.1.4	Establish ethical standards and practise codes for health research at all levels		Development of guidelines on ethical standards for research in health		1,207,887
			8.1.4.1	Develop and promote guidelines on ethical standards for research in health			402,629

			8.1.4.2	Establish mechanisms to monitor, evaluate and regulate research and the use of research findings at all levels			805,258
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**SMOH involving wide range of actors including researchers in health research policy making by end 2010**		1,391,472,169
		8.2.1	Strengthen identified health research institutions at all levels		Inventory of institutions and organisations undertaking health research done		2,415,774
			8.2.1.1	Take inventory of all public and private institutions and organisations undertaking health research			603,943
			8.2.1.2	Conduct periodic capacity assessment of health research organisations and institutions			805,258
			8.2.1.3	Develop and implement measures to address research capacity gaps/weaknesses			335,524
			8.2.1.4	Mobilise extra funds from the private sector, foundations and individuals for health research			671,048
		8.2.2	Create a critical mass of health researchers		Number of PhD scholarships in health-related research awarded annually		1,350,417,439
			8.2.2.1	Develop appropriate training for research, based on the identified needs			8,186,788
			8.2.2.2	Establish a fund and adjudication mechanism for provision of competitive research grants for prospective researchers			134,210
			8.2.2.3	Motivate tertiary education institutions to increase PhD level enrolment and graduation in health through the awarding of PhD student scholarships			1,342,096,441
		8.2.3	Develop transparent approaches for using research findings to aid evidence-based policy making		Number of meetings held with researchers annually		3,690,765
			8.2.3.1	Improve liaison and links between research users (e.g. Policy makers, development partners) and researchers			3,355,241
			8.2.3.2	Involve wide range of actors including researchers in policy-making			335,524
		8.2.4	Undertake health systems research on identified critical priority areas		Number of operations research carry-out annually		17,916,987
			8.2.4.1	Carry out Operations research on child survival to provide additional data for M & E			5,972,329
			8.2.4.2	Conduct baseline survey on child immunisation			1,342,096
			8.2.4.3	Conduct survey on health facility utilisation			1,342,096
			8.2.4.4	Conduct Operations research on reproductive health			5,972,329
			8.2.4.5	Conduct research on sickle cell diseases: search for non-addictive pain killer; anti-sickling agents; major crisis precipitating factor; role of blood pH in management of sickle cell crisis; trial of local herb remedies; etc			3,288,136
		8.2.5	Undertake operations research on identified critical priority areas		Number of surveys carried out annually		17,031,204
			8.2.5.1	Establish process for the bi-annual estimation of the burden of identified priority diseases			120,789

			8.2.5.2	Undertake bi-annual studies into Human Resource for Health			2,415,774
			8.2.5.3	Undertake bi-annual studies into health system governance			2,415,774
			8.2.5.4	Conduct surveys on: maternal mortality, drug sources and outlets, impact of HSR in Edo state, KAP surveys on HIV/AIDS, SCDs			12,078,868
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. Edo State has GRISP Units at all levels by end 2010 2. GRISP Units manage an accessible repository by end 2012**		42,477,352
		8.3.1	Develop strategies for Getting Research findings Into Strategies and Practices (GRISP)		Number of PhD theses tracked annually		8,455,208
			8.3.1.1	Establish GRISP Units at all levels			402,629
			8.3.1.2	Support GRISP Unit at SMOH			805,258
			8.3.1.3	Support GRISP Units at LGA level			7,247,321
		8.3.2	Enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		1) Availability of guidelines by 2010 2) Number of health research forum meetings held by 2015		34,022,145
			8.3.2.1	Promote a state annual Health Research Policy Forum and the same at LGA level			8,589,417
			8.3.2.2	Conduct needs assessment to inform required health research at all levels			872,363
			8.3.2.3	Promote and provide guidelines for annual operations research to be conducted by all departments, agencies and parastatals in SMOH			5,234,176
			8.3.2.4	Promote and provide guidelines for annual operations research to be conducted by all Departments in LGAs			19,326,189
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A State health research communication strategy in place by end 2012**		87,571,793
		8.4.1	Ceate a framework for sharing research knowledge and its applications		Number of meetings held annually		2,013,145
			8.4.1.1	Develop and implement a framework for sharing research knowledge at all levels		PS	1,409,201
			8.4.1.2	Hold annual meeting of Health Research Policy Forum		DPRS	603,943
		8.4.2	Establish channels for sharing of research findings between researchers, policy makers and development practitioners		Number of workshops and seminars held annually		77,304,755
			8.4.2.1	Hold annual health conference on research findings at state level		Hon. Comm. for Health	23,352,478
			8.4.2.2	Conduct annual seminars and workshops on key thematic areas (financing, human resources, MDGs, health research, etc) at state level		PS	53,952,277
		8.4.3	Support a critical mass of state high quality health sector journals		Number of health journals circulated to SMOH and LGAs annually		8,253,893

			8.4.3.1	Undertake inventory of state journals according to priority health areas		DPRS	201,314
			8.4.3.2	Select journals to be supported, which information addresses issues related to Essential National Health Research (ENHR) and have discussions with the editors		DPRS	-
			8.4.3.3	Circulate identified journals to SMOH and LGAs regularly		DPRS	8,052,579
							76,871,257,844

Annex 3: Results/M&E Matrix for Edo Strategic Health Development Plan

EDO STATE STRATEGIC HEALTH DEVELOPMENT PLAN RESULT MATRIX						
OVERARCHING GOAL: To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system						
OUTPUTS	**INDICATORS**	**SOURCES OF DATA**	**Baseline**	**Milestone**	**Milestone**	**Target**
			2008/9	**2011**	**2013**	**2015**
PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH						
NSHDP Goal: To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						
OUTCOME: 1. Improved strategic health plans implemented at Federal and State levels						
OUTCOME 2. Transparent and accountable health systems management						
1. Improved Policy Direction for Health Development	1. % of LGAs with Operational Plans consistent with the state strategic health development plan (SSHDP) and priorities	LGA s Operational Plans	0	30	50	100%
	2. % stakeholders constituencies playing their assigned roles in the SSHDP (disaggregated by stakeholder constituencies)	SSHDP Annual Review Report	0	30	50	75%
2. Improved Legislative and Regulatory Frameworks for Health Development	3. State adopting the National Health Bill? (Yes/No)	SMOH	TBD			
	4. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	1	1	1	1
	5. % of LGAs enforcing traditional medical practice by-laws	LGA Annual Report	100	100%	100%	100%
3. Strengthened accountability, transparency and responsiveness of the State health system	6. % of LGAs which have established a Health Watch Group	LGA Annual Report	TBD			
	7. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	TBD			
	8. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	TBD			
	9. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	TBD			
	10. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report				
	11. % LGAs implementing their peer review recommendations	LGA / SSHDP Annual Review Report				
	12. Number of LGA Health Watch Reports published	Health Watch Report				
	13. Number of "Annual Health of the LGA" Reports published and disseminated annually	Health of the State Report	TBD			

4. Enhanced performance of the State health system	14. % LGA public health facilities using the essential drug list	Facility Survey Report	80	85	90	100%
	15. % private health facilities using the essential drug list by LGA	Private facility survey	TBD			
	16. % of LGA public sector institutions implementing the drug procurement policy	Facility Survey Report	80	85	90	100%
	17. % of private sector institutions implementing the drug procurement policy within each LGA	Facility Survey Report				
	18. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	No Baseline			
	19. % of LGAs implementing a performance based budgeting system	Facility Survey Report	TBD			
	20. Number of MOUs signed between private sector facilities and LGAs in a Public-Private-Partnership by LGA	LGA Annual Review Report				
	21. Number of facilities performing deliveries accredited as Basic EmOC facility (7 functions 24/7) and Comprehensive EmOC facility (9 functions 24/7)	States/ LGA Report and Facility Survey Report	TBD			
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	22. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	80	85	90	100%
	23. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	24. % of the population having access to an essential care package	MICS/NDHS	TBD	40	75	100%
	25. Contraceptive prevalence rate	NDHS	6%	15%	25%	30%
	26. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD			
	27. % of new users of modern contraceptive methods by type (male/female)	NDHS/HMIS	35%	45%	55%	60%
	28. % service delivery points without stock out of family planning	Health facility Survey	40%	50%	60%	70%

	commodities in the last three months					
	29. % of facilities providing Youth Friendly RH services	Health facility Survey	TBD			
	30. Adolescent (10-19 year old) Fertility rate (using teeenage pregnancy as proxy)	NDHS/MICS				
	31. % of pregnant women with 4 ANC visits performed according to standards*	NDHS	44%	64%	75%	90%
	32. Proportion of births attended by skilled health personnel	HMIS	55%	65	80%	95%
	33. Proportion of women with complications treated in an EmOC facility (Basic and/or comprehensive)	EmOC Sentinel Survey and Health Facility Survey	50	60	70%	85%
	34. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	22%	20%	15%	10%
	35. Case fertility rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD			
	36. Perinatal mortality rate**	HMIS	No Baseline			
	37. % women receiving immediate post partum family planning method before discharge	HMIS	TBD			
	38. % of women who received postnatal care based on standards within 48h after delivery	MICS	TBD			
	39. Number of women presented to the facility with or for an obstetric fistula	NDHS/HMIS	No Baseline			
	40. Number of interventions performed to repair an obstetric fistula	HMIS	No Baseline			
	41. Proportion of women screened for cervical cancer	HMIS				
	42. % of newborn with infection receiving treatment	MICS	No Baseline	10%	15%	25%
	43. % of children exclusively breastfed 0-6 months	NDHS/MICS	48%	65%	75%	80%
	44. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	72.00%	77%	87%	95%
	45. % children <5 years stunted (height for age <2 SD)	NDHSMICS	38.00%	33%	28%	23%
	46. % of under-five that slept under LLINs the previous night	NDHS/MICS	5.50%	7.50%	10%	15%
	47. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	29%	35%	55%	75%
	48. % malaria successfully treated using the approved protocol and ACT;	MICS	TBD			
	49. Proportion of population in malaria-risk areas using effective malaria prevention and treatment measures	MICS	TBD			

	50. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	TBD			
	51. HIV prevalence rate among adults 15 years and above	NDHS	5.2	4.2	3.2	2.2
	52. HIV prevalence in pregnant women	NARHS	No Baseline			
	53. Proportion of population with advanced HIV infection with access to antiretroviral drugs	NMIS	No Baseline			
	54.Condom use at last high risk sex	NDHS/MICS				
	55. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	43%	55%	65%	75%
	56. Prevalence of tuberculosis	NARHS	2%	1%	0.50%	0.10%
	57.Death rates associated with tuberculosis	NMIS	10%	7.50%	5%	2.50%
	58. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	77%	85%	90%%	60 - 100%
Output 6. Improved quality of Health care services	59. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD			
	60. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD			
	61. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD			
	62. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD			
	63. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD			
	64. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD			
	65. % of facilities with deliveries organizing maternal and/or neonatal death reviews according to WHO guidelines on regular basis	Facility Survey Report	TBD			
Output 7. Increased demand for health services	66. Proportion of the population utilizing essential services package	MICS	TBD			
	67. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD			
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						

Output 8. Improved policies and Plans and strategies for HRH	68. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD			
		HR survey Report	TBD			
	70. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD			
	71. Stock (and density) of HRH	HR survey Report	TBD			
	72. Distribution of HRH by geographical location	MICS	TBD			
	73. Increased number of trained staff based on approved staffing norms by qualification	HR survey Report	TBD			
	74. % of LGAs implementing performance-based managment systems	HR survey Report	TBD			
	75. % of staff satisfied with the performance based management system	HR survey Report	TBD			
Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	76. % LGAs making availabile consistent flow of HRH information	NHMIS	TBD			
	77. CHEW/10,000 population density	MICS	TBD			
	78. Nurse density/10,000 population	HMIS	21.44	25	30	35
	79. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD			
	80. Medical doctor density per 10,000 population	HMIS	2.63	3:10,000 pop	4:10,000 pop	5:10,000 pop
	81. Other health service providers density/10,000 population	MICS	TBD			
	82. HRH database mechanism in place at LGA level	HRH Database	TBD			
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	83. % of LGAs implementing state specific safety nets	SSHDP review report	TBD			

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

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

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