BENUE STATE GOVERNMENT

STRATEGIC HEALTH DEVELOPMENT PLAN
(2010-2015)

BENUE State Ministry of Health

2010-2015

Contents

List of Tables

Acronyms and Abbreviations

CORPs	Community oriented resource persons
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
HDCC	Health Data Consultative Committee
HF	Health Facility
HMIS	Health Management Information System
HIV/AIDS	Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement

LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria
NAFDAC	National Agency for Food Drugs Administration and Control
NGOs	Non-Governmental Organizations
SHIS	Social Health Insurance Scheme
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
SSHDPf	State Strategic Health Development Plan Framework
NYSC	National Youth Service Corps
OPS	Organized Private Sector
PEPFAR	Presidential Emergency Response for AIDS Relief
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
QA	Quality Assurance

RDBs	Research data banks
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
VHW	Village health workers
WHO	World Health Organization

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 harmonized and costed NSHDP.

Preface

Following the transition of the Nigeria's Health System from the era of the basic health services to the era of PHC as the precept for achieving 'health for all by the year 2000', Benue state moved along with other States in line with the National Health policy to build a PHC-based health system. At the time in 2000 when WHO ranked Nigeria187 out of 192 in health status, the Benue State Health indicators were worse than the Nigerian average. Worst hit are the poor and vulnerable: pregnant women, children and the elderly. Worst still activities of various actors in the health system were uncoordinated, accountability was poor, weak activity at LGA level, weak intersectoral collaboration and there was poor community participation

This strategic Health Development Plan was built on a National framework that emanated from wide stakeholder consultation. The SHDP addressed 8 National health priority areas namely: Leadership and Governance for Health, Service delivery, Human Resources for Health, Health Financing, Health Information Systems, Community ownership and participation, Partnership for health and research for Health.

The State Strategic Health Development Plan developed in collaboration with FMOH, UNICEF, WHO, PATHS and other development partners was participatory involving all stakeholders including the community. It represents the articulation of bold, new thinking on methods of fast tracking comprehensive interventions and actions to reverse the negative health status trends in Benue State in particular and Nigeria Generally. It spells out the level of investment the state is willing to commit towards attaining the MDGs while ensuring that every resident of Benue State lives a socially and economically productive life. It also provides a framework to guide development partners in their investments in the Nigeria and Benue State Health sectors.

It is hoped that all stakeholders will work assiduously to ensure full implementation, Monitoring and Evaluation of this Strategic Health Development Plan

Dr JairusErube
Honorable Commissioner Health
Benue State Ministry of Health and Human Services.

Executive Summary

Benue health system, like that of Nigeria as a whole, is failing to guarantee even the most basic health services to its citizens, especially the poor and vulnerable. The health indicators have remained below the country and state targets including the MDGs which have recorded very slow progress over the years. To address these, the SMOH keyed in into the National Strategic Health Development Plan. The Strategic Health Development Plan highlights the developmental priorities in health and related interventions to address identified gaps.

Situation Analysis (Socio-economic context / Health status of the population / Health services provision and utilization)

Benue State is one of the 36 states of the Federal Republic of Nigeria located in the North-central geopolitical zone. It was created in 1976 out of the then Benue Plateau State. It occupies a land mass of 34,059 square kilometers with a population of 4, 497,988 in 2008 projected from 2006 National population census.

Major causes of morbidity and mortality in the state (both communicable and non-communicable) include malaria, Diarrhea, HIV/AIDS, TB, Neonatal tetanus, STIs, Pneumonia, Road Traffic Accidents, Anemia, Cancer, Hypertension, Malnutrition, Typhoid fever and Diabetes Mellitus. The disease profile is as a result of present wide spread of poverty and underdevelopment in the State, poor sanitary conditions and habits, poor nutrition, bad drinking water, and high rate of early marriage especially in the rural areas. The infant mortality rate is 74/1000, Under 5 mortality rate is 117/1000, maternal mortality rate: 800/100,000 while life expectancy at birth is 51 years. HIV prevalence has remained high: 10.6%

Health care in the state is provided by the Federal, State, and Local Governments, missions, formal private providers, informal private providers, traditional healers and faith healers.

The plan of action for establishing the WMHCP includes the following six (6)interventions: Control of Communicable Diseases (Malaria, STI/HIV/AIDS), Child Survival, Maternal and Newborn Care, Nutrition, Non-Communicable Diseases Prevention, Health Education and Community Mobilization. The strategies for their provision and sustenance are outlined in the

package. These include: Provision of Essential Drugs, Human Resource for Health and Health Infrastructure development

The SHDP addressed 8 National health priority areas namely: Leadership and Governance for Health, Service delivery, Human Resources for Health, Health Financing, Health Information Systems, Community ownership and participation, Partnership for health and research for Health. Appropriate interventions, targets and activities have been developed to actualize the national priorities enumerated above. They are targeted towards accelerating the attainment of the health related MDGs and therefore reducing the worsening state health indices. They address key issues of health service delivery among which is the implementation of the minimum service package, various intervention modes of the integrated maternal, newborn and child health strategy and community ownership of health service delivery at state and Local Government Levels. They have been appropriately costed and assigned specific timelines for implementation.

The SMOH would provide the needed policy and strategic direction, fund some of the public health and curative services in the secondary health facilities and the Benue State University Teaching Hospital. The general coordination of the plan will be sole responsibility of the SMOH. Through its relevant departments and units shall provide the much needed supportive supervision, monitoring and evaluation of this strategic plan resource generation, inputs, implementation and outcome

Plans will be monitored and evaluated by the implementing departments and special units (inbuilt M & E) and a central M & E Unit (Planning Division, PRS Department).

There are two perspectives to monitoring and evaluation in the context of the SSHDP and its implementation process. First, it is important to monitor and evaluate the plan's operational elements (activities) that are essential ingredients in ensuring the successful implementation of the plan. Secondly, it is essential to monitor and evaluate program outputs and impacts. The latter concerns measurable variables and changes in the health status of the population and the health services as a consequence of the implementation of the SHDP.

The major categories of indicators that are relevant for monitoring and evaluating the State SHDP include the policy and socioeconomic indicators, the health prevention and utilization indicators.

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

Vision

The vision of the Benue State Ministry of Health is to develop quality and affordable health care services and preventive measures of international standard, creation of favorable conditions for the population's well-being with the active participation of the individual and the community and make a strategic contribution to the attainment of the Millennium Development Goals

Mission

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

Chapter 1: Background and Achievements

Background

The vision of the Benue State Ministry of Health is to develop quality and affordable health care services and preventive measures of international standard, creation of favorable conditions for the population's well-being with the active participation of the individual and the community and make a strategic contribution to the attainment of the Millennium Development Goals.

However, Benue's health system, like that of Nigeria as a whole, is failing to guarantee even the most basic health services to its citizens, especially the poor and vulnerable. The health indicators have remained below the country and state targets including the MDGs which have recorded very slow progress over the years.

1.2 Achievements

To address these, the SMOH keyed in into the Health Sector reform program of the FMOH from 2004-2007. This recorded some initiatives which included Benue State Strategic Health Plan 2004- 2007, the first Northern states health summit on the theme **'Alarming Death Rates in Northern Nigeria: The Time for Change is Now'** whichwas held on November 12, 2007 at Arewa House, Kaduna; the establishment of the State Primary Health Care Board and its Governing Council and the Strategic Plan for HIV/AIDS control (2005-2009) in addition to other disease control programs strengthening. The Economic Team also devised an Economic development blueprint in 2007 tagged 'Our Benue, Our Future'. There was also the establishment of a Benue State University Teaching Hospital; rehabilitation and upgrading of 7 comprehensive Health Centers to General Hospitals. When commissioned each of the 23 LGAs would have one Public Secondary Health Care Facility. Recently, medical equipment and drugs worth N1.3b were supplied to 12 general hospitals in the state in order to strengthen their service delivery. Also contracts for the rehabilitation of 12 old generation hospitals have been awarded to provide conducive environment for service delivery in the state. However, the gains of the Health Sector reform were sub-optimal.

In the ongoing process of National Strategic Health Development Plan, BenueState is actively involved to contribute a state component plan in addition to having an Operational Plan. A situation analysis is being undertaken to identify the strengths, weaknesses and threats to the health system to enable her properly situate the interventions and activities that would address the yawning gaps in the health sector

Chapter 2: Situation Analysis

2.1 Socio-economic context

Benue State is one of the 36 states of the Federal Republic of Nigeria located in the North-central geopolitical zone. It was created in 1976 out of the then Benue Plateau State. It occupies a land mass of 34,059 square kilometers with a population of 4, 497,988 in 2008 projected from 2006 National population census figures using a growth rate of 2.8%. There are two main ethnic groups: Tiv and Idoma. Other ethnic groups include Etulo, Jukun and Igede. The main occupation of is subsistence farming hence the state is aptly called the 'Food Basket' of the nation. Other occupations are petty trading and civil service

Climate: The State has a tropical climate. The rainy season starts from April and lasts till October, while dry season begins from November and ends in March. The annual rainfall is between 150mm-180mm. Temperature fluctuates between 23 and 30 degrees centigrade most of the year. The State derives its name from River Benue, the second largest river in the country. It stretches across the transition belt between the forest and savanna vegetation. Due to its climatic condition, the incidence rate of malaria is very high all year round and it is the most common cause of morbidity and mortality across the state.

Governance: According to the report of the Benue Economic Team in 2007, the current structure of machinery of government in Benue state is bloated and tends to reflect more of geo-political considerations than desire for efficiency and service delivery.

Environment: Benue State is plagued by many environmental problems ranging from land degradation to air/water pollution, poor sanitation and the menace of pests. These problems are traceable to some natural and man-made factors such as erosion, land use practices, inappropriate use of agricultural chemicals and waste management practices. There is a strong causal relationship between environmental problems and poverty.

Nutrition: Though described as the 'food basket' of the nation, 17% of children in Benue State are moderately underweight, 7% are moderately wasted while 26% are moderately stunted. Proportion of households consuming adequately iodized salt is 73%. This calls for essential service packages for the prevention and management of childhood malnutrition.

Housing: Existing settlement patterns in some parts of the state hinder development of basic infrastructure. Public-private partnership housing estates are currently being developed in the State capital.

Water and Sanitation: Rural water supply is inadequate or nonexistent in most parts of the state. Use of boreholes is not wide spread. Only 24% of the population has access to improved water supply while 23% are using sanitary means of excreta disposal. Investments in safe drinking water and the hygienic disposal of human waste can have a major impact on the prevention of a wide variety of deadly infections.

Education: In 2005, 300,000 children were estimated to be out of school. Only 22% of under five children are attending organized childhood educational institutions. Net primary school completion rate is 81% in Benue State. There is poor funding, inadequate infrastructure, limited manpower and human resource base and politicization of education. There is no computer education in Public primary schools. However, there are 2,407 public primary schools. For tertiary education there are 3 Universities, 2 Colleges of Education, 1 College of Agriculture, 1 Polytechnic and 1 College of Advanced and Professional Studies. The hallmark of tertiary education in the state is poor infrastructure and high levels of social vices.

2.2 Health status of the population

The state basic health and demographic indicators are as presented in the following table

Table 2 State Basic Health & Demographic Indicators

Indicators Name	Value
Area	34,059 Square kilometers
Population (2006 census)	4,219244
Projected population 2008	4,497,988
Number of LGAs	23
Children under 1 year (2008 projection)	179,910 (4%)
Children under 5 years (2008 projection)	899,598 (20%)

Women of childbearing age (15-44yrs) 2008 projected population	989,557 (22%)
Expected deliveries (2008 projection)	224,899 (5%)
Expected life Births (2008 projection)	202,409 (4.5%)
Doctors to Patients ratio	1:12,222
Nurses to Patients ratio	1:2,071
Infant mortality rate (IMR)	74/1000
Maternal mortality rate (MMR)	800/100,000
Child Mortality rate (CMR <5)	117/1000
Life Expectancy at birth	51yrs
Deliveries by trained health workers	93%
Fertility rate	5.7%
Birth weights 2.500kg or above	75%
ANC attendance in Public facilities (2008)	55882
No of deliveries attended by health professionals in 2008	9004
Public HF based deliveries in 2008	9637
No of malaria cases in under 5 in 2008	21913
HIV prevalence	10.6%

Source: (SMOH-HMIS)

The preceding health status indicators are obtained from the health management information system of the State. However the NDHS 2008, which is a population based survey gives us the following indicators:

POPULATION (2006 Census)	BENUE
Total population	**4,253,641**
female	2,109,598
male	2,144,043
Under 5 years (20% of Total Pop)	782,828
Adolescents (10 – 24 years)	1,356,047
Women of child bearing age (15-49 years)	990,258
INDICATORS	**NDHS 2008**
Literacy rate (female)	44%
Literacy rate (male)	88%
Households with improved source of drinking water	47%
Households with improved sanitary facilities (not shared)	15%
Households with electricity	15%
Employment status (currently)/ female	78.7%
Employment status (currently)/ male	87.6%
Total Fertility Rate	5.9
Use of FP modern method by married women 15-49	13%
Ante Natal Care provided by skilled Health worker	63%
Skilled attendants at birth	52%
Delivery in Health Facility	51%
Children 12-23 months with full immunization coverage	19%
Children 12-23 months with no immunization	19%
Stunting in Under 5 children	37%
Wasting in Under 5 children	6%
Diarrhea in children	7.3%
ITN ownership	3%
ITN utilization (children)	2%
ITN utilization (pregnant women)	2%
children under 5 with fever receiving malaria treatment	
Pregnant women receiving IPT	2%
Comprehensive knowledge of HIV (female)	13%
Comprehensive knowledge of HIV (male)	21%
Knowledge of TB (female)	91.9%
Knowledge of TB (male)	94.8%

Health Policy and Plans

There is no State Health Policy available, rather the health sector makes use of the National Health policy whose main trust is use of Primary Health Care strategy as a means of achieving health for all and attaining the health related MDGs. The latest health plan in Benue State is the 3-year Strategic Health Plan (2004 -2007). The health sector sought to support the State and Local Government Economic Empowerment and Development Strategies (SEEDS and LEEDS)

through the development and implementation of this Strategic Health Plan. The plan targeted four major outputs

1 Strengthened government stewardship in policy, planning and financing
2 Improved management systems for Drug supply, information and finances
3 Capacity of staff at accredited facilities in MSP provision
4 Increased consumer awareness of their rights and responsibilities in health

The 2004-2007 plan did not consolidate its gains as it failed to strengthen the PHC system where the MSP was meant to be implemented. This resulted from poor monitoring and supervision and non-involvement of the community in planning and managing service delivery. Demand for health care is still poor.

2.3 Health Services Provision and Utilization

Organization of Health and Demonstration of Health Services

In this health care strategy, the health sector is understood to be wider than the public (Government) system to encompass all other providers, formal and informal, as well as the users themselves. It is also recognized that there are many other non-health sectors influencing health, but these are generally not dealt with here.

Health care in state is provided by the Federal, State, and Local Governments, missions, formal private providers, informal private providers, traditional healers and faith healers. Formal private providers include hospitals, private doctors, nurse-delivered services (including birthing), pharmacists and other support services.

Informal ones refer mainly to the traditional practitioners, itinerant drug sellers, and so called ‘quacks’. There is little collaboration or communication between these providers and even between public providers at different levels leading to considerable inefficiencies, disjointed service duplication. Consumers move between providers, sometimes in parallel but they often self-medicate as a first step.

There is one Federal Medical Centre (Makurdi) and Benue State University Teaching Hospital offering tertiary health care, sixteen functioning General State Hospitals. These General

Hospitals are under the management of the Hospitals Board (HMB) which is a parastatal of the State ministry of health. They provide secondary health alongside out-patient services and are semi-autonomous in the sense that they generate their own money and use it to run the Hospitals without direct subvention from the State Government apart from salary payment.

Whilst national policy broadly mandates Federal Government with responsibility for tertiary health care, State Government with secondary health care and Local Government with primary care with supervision from SMoH, considerable complexity and ambiguity surround responsibilities for Primary Health Care (PHC). This confusion has been recognized as a major obstacle as there is considerable overlap of service provision and under-servicing in support and supervision.

The State Ministry of Health has seven departments and one parastatal. The departments are:

1. Administration and Supply (DAS)
2. Department of Public Health (DPH)
3. Department of Health planning, Research and Statistics (DPRS)
4. Department of Pharmaceutical services (DPS)
5 Department of Nursing Services (DNS
6. Department of Clinical Services
7. Department of Finance

The Commissioner is the political head of the Ministry while the Permanent Secretary is the accounting officer.

The only parastatal of the ministry is Hospitals Management Board.

The Statutory Roles of Ministry Of Health

The Ministry of health has the cabinet responsibility on all matters concerning health care delivery in the State and it is responsible for formulation and implementation of all health

policies in the State. The traditional roles of the ministry also include promotive, preventive, rehabilitative and curative health services as well as institutional development (Training).

The Department of Medical and Health Services of the ministry provides technical assistance to all local government Councils during immunization days and campaigns.

As a matter of obligation, the ministry of health is responsible for the following stewardship functions:

- Health policy formulation for the State
- Regulation and control of all health institutions
- Implementation of capital projects
- Administering through the Hospital Management Board, the General Hospitals, Health Centers and other preventive health services.
- Collection and analysis of health Statistics
- Monitoring progress and use of allocated resources to Hospital Management Board.
- Registration and supervision of all private and Voluntary Agency Health Institutions for the maintenance of laid down standards.
- Registration and inspection of pharmacy shops and patent medicine stores.
- Aiding Voluntary Agency Medical and Health Institutions in form of salary grant, capital grant and training grant
- Establishment and maintenance of State owned training institutions.

Hospitals Management Board

The Hospitals Management Board is a parastatal of the Ministry of Health, which is headed by the Executive Secretary. It was established by Edict No. 3 of 1979 with a retrospective effect from April 1978. The Board has the following responsibilities:

- Provision of curative and preventive services for the State through the General Hospitals, appointment of Personnel, deployment, discipline and promotion of hospitals staff
- Attending to complaints from General Hospitals
- Determine salaries and wages of her personnel
- Has power to charge fees and to dispose unserviceable vehicles

- Routine maintenance of facilities in the Hospitals

Private Sector: Private health services have expanded throughout the state but many of them are still too expensive for most people, especially the poor, to use; many of these services are not properly regulated. A large majority of the population therefore receives little modern health care and has to rely on self-treatment, traditional healers or drug sellers. This has contributed to high rates of death and illness in the state, particularly for mothers, infants and young children.

There is no framework for collaboration between the public and private sectors

Medicines and Medical Supplies: There is no written policy for the pharmaceutical sub-sector. There is a draft Essential Medicines List(EML) already in use at state level. The State operates a Drug Revolving Fund (DRF) in all 16 state-owned Secondary Health Facilities. A seed stock of N300,000,000 worth of drugs, theatre , laboratory dental and X-ray consumables was provided by the State. The Anti-retroviral Drugs and anti-TB & leprosy drugs are donor provided under separate vertical control programs. A Public-Private Partnership arrangement exists between Essential Pharmacy Ltd and the State with the State Trust owning 40% while the private sector owns 60%. However drug procurement in the state is done by competitive bidding involving all reputable drug supplies that are registered with the state government. . By this arrangement quality assured drugs are available most of the time in the State General Hospitals.

Challenges in pharmaceutical subsector:

i) There is a Central Medical Store that is not functioning optimally at the moment. The CMS needs to be renovated and made functional for initial storage of donated goods.

ii) Most of the trained staff for DRF have either left the service or have been promoted and transferred out of the DRF units. Some of the current DRF operators are untrained. There is a need for staff training on DRF management.

iii) In the private sector there is no regulation of medicine procurement hence private health care providers procure their medicines from the open market without quality assurance. This needs to be addressed.

Human Resources for Health

There are no existing human resources for health policy or plan in the state. However a number of health personnel are trained and employed in the state. The categories and number are presented below.

Table 3 Key Health Human Resources

CADRE OF PERSONNEL	NUMBER
Doctors	368
Nurses & Midwives	2,172
CHO	897
CHEWS	2,803
Lab. Technicians	88
Lab Assistants	46
Pharmacists	127
TBAS	64
Medical Records & Health Statisticians	125
Radiologists	5
No. of Midwives trained on LSS	468
No of CHEWS trained on LSS	69
No. of Doctors trained on LSS	42
Others (not in this list)	1,786
Epidemiologist	1

Dental Therapists	5
Dental Health Technician	9
Pharmacy Technicians	13

The above table presents the key human resources for health in the state public health facilities including Federal Medical Centre. Data on human resources in the private health institutions were not captured.

This number of personnel cut across various areas of specialization. There are 368 registered medical doctors to a projected population of 4,497,988 in 2008, giving doctor-patient ratio of 1: 12,222; while the number of registered Nurses/Midwives is 2,172 representing nurses-patient ratio of 1: 2,071. However, going by the WHO standard of 1medical personnel to a 1000 population, there is a lot of improvement desired in this area.

In the public sector, professional staff members are less than the ideal with the distribution is severally skewed towards urban areas and higher levels of care-away from much needed basic health services in more rural areas. Furthermore present utilization rates indicate that absolute number is not a great obstacle to increased output. Nevertheless a case can and should be made for recruitment of certain strategic categories of health worker upon whom effective implementation of this Strategic Health Plan depends.

Many public Health sector professionals point to poor conditions of service (facilities, supplies, training) as major grievance and as reason for offering private health services. This practice is widespread and introduces considerable complexity to reform within the public health sector.

Many PHC facilities are staffed by minimally qualified Para-professionals who are unable to deliver the scope and quality of services required. In addition there is little or no supervision; they tend to receive inappropriate in-service training if any; and systems are not in place to track nor manage their performance.

Mission facilities, whilst frequently employing under-qualified staff, manage to skill their recruits through various ongoing in-service training programs and appear to be able to achieve reasonable performance with their staff through regular support and supervision.

Health Financing

Public health expenditure in the state is skewed towards secondary health care and although hospital care is necessary for the Minimum Service Package, a better balance needs to be found.

LGAs receive a Federal allocation, through the Bureau for local government and chieftaincy affairs such that authority /supervision over LGA services by the SMOH (where it exists) is based more upon goodwill and mutual respect than structured mandates and relationships. There is no accountability by the LGAs to show the money it has received for health.

Health workers at LGAs are not effectively involved in budgeting procedures and as it at the State level budgets and expenditure vary considerably with no functioning systems of accountability to check this.

A feature of LGA health accounts is that over 90% of expenditure is on human resources with little or nothing on service provision. Not only are there poor conditions for health professionals to work, but they are further demotivated by salary gaps.

Regarding mission health services, although accurate figures are not currently available, it is a fair generalization to say that they are more efficient, in that they provide more service per Naira and that most of their finances are self-generated. Public funds/resources to assist mission services are negligible in Benue as there is no system of subvention of salaries or payment for services rendered. While missions serve the rural areas where poor people live, they need to charge for public health services and it is likely that these user fees exclude service access by many poorer people.

Most households spend a considerable amount of money buying services and over-the counter medications suggesting that people are prepared to pay for quality services improved perceptions of quality of care and value of money at public facilities may thus open the way for improved revenue collection as a way on improving finances for Minimum Package Services. Unfortunately due to weak regulation of private services and problems of consumers' ability to judge quality in health service, out-of-pocket expenditure is commonly wasted on ineffective or unnecessary products and services.

There is no health insurance scheme in the state.

External Funding: There are many externally funded projects going on in the health sector. The donor agencies disburse funds directly to the implementing departments/units. However, there is no mechanism for donor coordination. The HMIS unit had difficulty gathering information on various donor funds received and their disbursements from the various Project Officers.

2.4 Key issues and challenges

In the quest to implement health development activities, the Benue State government encounter some challenges which include:

- High morbidity and mortality rates from both communicable and non-communicable diseases
- Difficult geographical terrain
- Inadequate funds / late release of funds for healthcare delivery
- Inadequate skilled manpower
- Inadequate level of built capacity
- Ignorance / poor orientation of the community members
- Low patronage of some public health facilities in the community
- Inability to provide logistic support in some areas
- Poor funding of some projects except the international donor supported projects
- High rate of unemployment
- Inadequate power generation and distribution
- High level of poverty

Table 4 **Summary of Benue State Indicators**

INDICATORS	BENUE
Total population	4,253,641 (2,109,598 females; 2,144,043 males)
Under 5 years (20% of Total Pop)	782,828
Adolescents (10 – 24 years)	1,356,047
Women of child bearing age (15-49 years)	990,258
Literacy rate	44% female; 88% men
Households with improved source of drinking water	47%
Households with improved sanitary facilities (not shared)	15%
Households with electricity	15%
Employment status (currently)	78.7% female,87.6 % male
TFR	5.9
Use of FP modern method by married women 15-49	13%
ANC	63%
Skilled attendants at birth	52%
Delivery in HF	51%

Full immunization coverage	19%
Children that have not received any immunization (zero dose)	19%
Stunting in Under 5 children	37%
Wasting in Under 5 children	6%
Diarrheal in children	7.3%
ITN ownership	3%
ITN utilization	2% children, 2% pregnant women
Malaria treatment (any anti-malarial drug)	children, 2% pregnant women
Comprehensive knowledge of HIV	13% female, 21% men
Knowledge of TB	91.9% female, 94.8% male

Chapter 3: Strategic Health Priorities

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 Benue Statetowards 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.*'

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.

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

HIGH IMPACT SERVICES
FAMILY/COMMUNITY ORIENTED SERVICES
Insecticide Treated Mosquito Nets for children under 5
Insecticide Treated Mosquito Nets for pregnant women
Household water treatment
Access to improved water source
Use of sanitary latrines
Hand washing with soap
Clean delivery and cord care
Initiation of breastfeeding within 1st hr. and temperature management
Condoms for HIV prevention
Universal extra community-based care of LBW infants
Exclusive Breastfeeding for children 0-5 mo.
Continued Breastfeeding for children 6-11 months
Adequate and safe complementary feeding

Supplementary feeding for malnourished children
Oral Rehydration Therapy
Zinc for diarrhea management
Vitamin A - Treatment for measles
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Antibiotics for U5 pneumonia
Community based management of neonatal sepsis
Follow up Management of Severe Acute Malnutrition
Routine postnatal care (healthy practices and illness detection)

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

C. INDIVIDUAL/CLINICAL ORIENTED SERVICES
Family Planning
Normal delivery by skilled attendant
Basic emergency obstetric care (B-EOC)
Resuscitation of asphyctic newborns at birth
Antenatal steroids for preterm labor
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)
Detection and management of (pre)ecclampsia (Mg Sulphate)
Management of neonatal infections
Antibiotics for U5 pneumonia

Antibiotics for dysentery and enteric fevers
Vitamin A - Treatment for measles
Zinc for diarrhea management
ORT for diarrhea management
Artemisinin-based Combination Therapy for children
Artemisinin-based Combination Therapy for pregnant women
Artemisinin-based Combination Therapy for adults
Management of complicated malaria (2nd line drug)
Detection and management of STI
Management of opportunistic infections in AIDS
Male circumcision
First line ART for children with HIV/AIDS
First-line ART for pregnant women with HIV/AIDS
First-line ART for adults with AIDS
Second line ART for children with HIV/AIDS
Second-line ART for pregnant women with HIV/AIDS
Second-line ART for adults with AIDS
TB case detection and treatment with DOTS
Re-treatment of TB patients
Management of multidrug resistant TB (MDR)
Management of Severe Acute Malnutrition
Comprehensive emergency obstetric care (C-EOC)
Management of severely sick children (Clinical IMCI)
Management of neonatal infections
Clinical management of neonatal jaundice
Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the VLBW infant)
Other emergency acute care
Management of complicated AIDS

Chapter 4: Resource Requirements

4.1 Human Resources

Manpower in the health sector ranges from the high-level modern technology trained doctors to the community-oriented appropriate technology-based health workers and traditional practitioners. Each is endowed with skills required to operate in his jurisdiction.

The categories of workers are as follows:

a. The professional such as doctors, nurses, pharmacists / technicians / assistants, radiologists /radiographers /X-ray technicians, dentists / technicians / assistants, nutritionists (dieticians)
b. Management personnel such as administrators, planning officers
c. Community health workers
d. Clerical officers
e. Ancillary personnel
f. Traditional practitioners

The above workers constitute the 'Health Team'. However, a big gap exists between the professional and the community health workers. These workers enumerated above have had basic education in their respective professions and therefore are equipped with the basic skills required to execute their functions. But with the ever-increasing demand for health care and introduction of new technology in the system, the skills acquired become inadequate or obsolete rendering them ineffective and unproductive. The adverse effect of this is deterioration in the provision of health care to the citizenry, which leads to increase in mortality and morbidity rates in the State. There is the need to recruit more health workforce and retrain existing ones and redistribute in favor of the rural areas

Recognizing the profound challenges facing reform of the sectors approach to human resources, and accepting that these challenges cannot be ignored in the longer-term, this strategic plan aims to stimulate adequate health worker performance at a few strategically located facilities in every ward of the state.

4.2 Physical/Materials

Benue State has primary, secondary and tertiary health facilities that are distributed in the 23 LGAs. There is also numerous private health facilities with majority located in Makurdi, the State capital. There is need for commissioning the 7 additional General Hospitals in the 7 LGAs without secondary Health Care facilities.

4.3 Financial

In Benue State the percentage of budgetary allocation to health sector has been within the range of 5.1% to 5.5% between 2000 and 2003 & 11.4% in 2005, 8.16 in 2006, 6% in 2007, 12.0% in 2008 and 8.9% in 2009 of the total budgetary allocation. Other sources of funds for healthcare delivery include:

- Federal Government of Nigeria
- Benue State Government
- LGA
- Social contribution for free medical care
- Development partners, e.g. The World Bank, UNICEF, WHO, African Development Bank, PEPFAR, Netherlands Leprosy Relief Association

CHAPTER 5: Financing Plan

5.1 Estimated cost of the strategic orientation

Estimated cost of the strategic orientation for the 6 year period is **N71,660,290,553,** broken down into:

• Leadership and governance;	N716,602,906
• Service delivery;	N40,787,715,590
• Human resources for health;	N24,495,062,181
• Health financing;	N1,719,593,896
• Health information system;	N1,074,904,358
• Community participation and ownership;	N716,602,906
• Partnerships for health; and,	N716,602,906
• Research for health.	N1,433,205,811
Total	**N71,660,290,553**

5.2 Assessment of the available and projected funds

The Benue State 2009 budget appropriation was N5,670,486,461 consisting of N1,222,209,970 recurrent and N 4,445,576,491 capital budget . The projected figures for the period from 2010 to 2015 using 5% appropriation rate is N46,169,148,699.

State approved recurrent and capital budget 2007 -2009

Total State Budget	Total Recurrent budget(Health)	Total Capital Budget(Health)	Total Health Budget	Year
44,836,321,020	1,112,041,820	1,400,177,000	2,512,218,820	**2007**
64,646,986,957	**948,578,745**	**6,866,876,878**	**7,815,455,623**	**2008**
63,287,242,072	1,222,209,970	4,445,576,491	5,670,486,461	2009

Table 5: Percentage of State Budget allocated to Health sector

% of actual health budget released	% of recurrent budget to total health budget	% of capital budget to total health budget	% of total State budget allocated to health sector	Year
89.0%	44%	56%	6%	**2007**
24.3%	**12.1%**	**88%**	**12.0%**	**2008**

NA	21.6%	78.4%	8.96%	2009

Source: SMoH budget dept. /MOF budget Dept.

5.3 Determination of the financing gap

The estimated Strategic Orientation Cost minus The projected cumulative appropriation for the plan period. N71,660,290,553-**N46,169,148,699.= N25,491,141,854. The financing gap is therefore: N25,491,141,854**

5.4 Descriptions of ways of closing the Financial Gap.

It is envisaged that the development partners would support some of the activities. The Global Fund for Tuberculosis, AIDS and Malaria through Gowon Foundation have signed an MOU to supply 2million ITNs for distribution in Benue State.

The Harvard/ PEPFAR is continuing the provision of Anti-Retroviral Drugs. Other Development Partners that have ongoing projects in the State Health Sector are World Bank, African Development Bank, WHO, UNICEF.

It is anticipated that donor funds from these partners would close the gap.

In this strategy, the concept of securing adequate finances is not about sourcing domestic and external money but also about aligning various activities and service providers to work towards common goals-getting others 'on plan'. It is also about attracting users to facilities that will guarantee good value for money through a minimum service package.

Most State and LGA financing is from the Federal government which depends upon oil revenues – a volatile base since oil prices continuously fluctuate, making transfers unpredictable. States and LGAs have considerable discretion to allocation between sectors and to allocate within the sector (capital vs. recurrent). This is done with little guidance so that great variation is witnessed throughout the state and unwise allocations are common place at all levels.

Benue State Budget and budgetary allocation to Health Sector

The percentage of budgetary allocation to health sector has been within the range of 5.1% to 5.5% between 2000 and 2003 & 11.4% in 2005, 8.16 in 2006, 6% in 2007 , 12.0% in 2008 and

8.9% in 2009. This shows an increase of health budgetary allocation from 5.5% in 2003 to 11.4% in 2005 and a slight decline of 8.16% and 6% in 2006 and 2007 respectively. Then a drastic budget rise in 2008. The drastic rise in the budget was as a result of construction and equipment of Benue State University Teaching Hospital

Chapter 6: Implementation Framework

There is an existing health system structure in the state: (a) the Federal Ministry of Health;(b) the State Ministry of Health in every State c) parastatals under the state ministry of health: the Hospital Management Board and the Primary Health Care Board and outside the MOH: the Local Government Service Commission (d) all local government health authorities;(e) the ward health committees;(f) the village health committees;(g) the private health care providers; and(h) traditional and alternative health care providers.

The **FMOH** is providing and will continue to provide tertiary service delivery at the Federal Medical Centre Makurdi. It will form the apex of the strengthened two-way referral system and provide leadership in partnership with the Benue State University Teaching Hospital in Biomedical Research

The **SMOH** would provide the needed policy and strategic directions; fund some of the public health and curative services in the secondary health facilities and the Benue State University Teaching Hospital. The general coordination of the plan will be sole responsibility of the SMOH. Through its relevant departments and units shall provide the much needed supportive supervision, monitoring and evaluation of this strategic plan resource generation, inputs, implementation and outcome.

The State Government have concluded plans to launch a free maternal and child health program that will provide services at no cost to the pregnant women and under-fives. This will address most issues around maternal and child mortality reduction

Benue State Action Committee on AIDS (**BENSACA**) will continue to provide the lead in HIV/AIDS prevention and care.

The Local Government Health Authorities will be responsible for implementing the activities at community and household levels under the supervision of the Local Government Service Commission and the Director of Public Health in the SMOH.

The Hospital Management Board (HMB) takes responsibility for overseeing the hospital services, will monitor the operation of the DRF in the General Hospitals. They will register and set standards and monitor the private health facilities' practice.

The Association of General and Private Medical practitioners would be the medium of collaboration between the private medical practitioners and the Government.

Association of Community Pharmacists will collaborate with the state government and NAFDAC in the provision of high quality, essential and affordable drugs and are potential actors in the Health care financing schemes and health promotion.

The Private Health Care providers in addition to the traditional medicine practitioners are meant to be regulated by state organs in this strategic plan. They are closer to individuals and households hence their collaboration will be courted by the SMOH.

The communities and Households whom these planned activities are targeting would need to actively participate. Hence their mobilization and involvement in health committees at all levels is crucial. The aim is to create appropriate demand for health care and appropriate health seeking behaviour

The development partners active in the State include World Bank and African Development Bank who are funding and providing technical support in Health System Development.

The Netherland Leprosy Relief is supporting the TB and Leprosy program under a project agreement from 2009-2013.

HARVARD/PEPFAR program is supporting HIV/AIDS care and treatment and is expected to continue for another five years.

The WHO, UNICEF and UNAIDS are already involved in specific programs in the state through funding and technical support.

Chapter 7: Monitoring and Evaluation

7.1 Proposed mechanism for monitoring and evaluation

Plans will be monitored and evaluated by the implementing departments and special units (inbuilt M&E) and a central M&E Unit within the Planning Division of the Department of PRS.

There are two perspectives to monitoring and evaluation in the context of the SSHDP and its implementation process. First, it is important to monitor and evaluate the plan's operational elements (activities) that are essential ingredients in ensuring the successful implementation of the plan. Secondly, it is essential to monitor and evaluate program outputs and impacts. The latter concerns measurable variables and changes in the health status of the population and the health services as a consequence of the implementation of the SHDP.

The major categories of indicators that are relevant for monitoring and evaluating the State SHDP include the policy and socioeconomic indicators, the health prevention and utilization indicators.

Types and sources of data

The sources of data for the monitoring and evaluation of the state of health of the population and the health system are:

a) disease and related reporting mechanisms
b) vital statistics, e.g. from the National Population Commission
c) sentinel surveillance, focusing on the monitoring of key health indicators in the general population or in special population
d) registries – mostly for monitoring the public health impact of non-acute diseases, e.g. exposure and work related registries may be particularly useful in tracking the health protection objectives
e) surveys – health demographic surveys
f) administrative and routine service data collection system as captured by HMIS

Categories of data

The four major categories of data are:

1. Input database

   Input refers to resources and requirements to create and enable the success of health programmes. They are the precedent actions that must be taken (invested) for the health system. They are not limited to physical inputs, but may also include provision of appropriate institutional arrangements, policy instruments and legislation.

2. Process database

   Process refers to a set of activities that must be undertaken or actions and rules and regulations that are required to take place. This may include for instance protocols for immunization, for collecting, storing, processing and making available health data, etc.

3. Output database

   Output database will concern itself to keeping the time-series data on activities completed in relation to set targets. An example is interval data on immunization status of children under 5 years of age. Another example is the efficiency of health intervention programmes, e.g. the eradication of poliomyelitis and the control of tuberculosis.

4. Outcome or impact database

   These are concerned with health status measures or indicators. An example is the level of morbidity and mortality for a given condition and specific target population, e.g. under-5 mortality rate, maternal mortality rate and prevalence of HIV/AIDS.

Overall statutory responsibility for monitoring, evaluating and reporting on SSHDP is vested in the Department of Planning, Research and Statistics (DPRS) of the State Ministry of Health. Health priority areas implementing agencies shall work with the DPRS to establish a simple flexible and acceptable monitoring and evaluation protocols.

Costing the monitoring and evaluation component and plan

Chapter 8: Conclusion

This strategic Health Development Plan was built on a National framework that emanated from wide stakeholder consultation. The SHDP addressed 8 National health priority areas namely: Leadership and Governance for Health, Service delivery, Human Resources for Health, Health Financing, Health Information Systems, Community ownership and participation, Partnership for health and research for Health.

Appropriate interventions, targets and activities have been developed to actualize the national priorities enumerated above. They are targeted towards accelerating the attainment of the health related MDGs and therefore reducing the worsening state health indices. They address key issues of health service delivery among which is the implementation of the minimum service package, various intervention modes of the integrated maternal, newborn and child health strategy and community ownership of health service delivery at state and Local Government Levels. They have been appropriately costed and assigned specific timelines for implementation.

Annex 1: Detailed activities in the Benue Strategic Health Development Plan

BENUE STATE STRATEGIC HEALTH DEVELOPMENT PLAN (2010 - 2015)						
PRIORITY						
Goals				**BASELINE YEAR 2009**	**RISKS AND ASSUMPTIONS**	**TOTAL COST 2010-2015**
	Strategic Objectives			**Targets**		
		Interventions		**Indicators**		
LEADERSHIP AND GOVERNANCE FOR HEALTH						
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria						383,627,350.01
	1.1	**To provide clear policy directions for health development**		**All stakeholders are informed regarding health development policy directives by 2011**		50,651,794.42
		1.1.1	Improved Strategic Planning at State and LGA levels	1. Availability of one State SHDP and 23 LGA SHDPs by end of 2009. 2. Availability of Annual Operational Plan for the state from 2010-2015		50,651,794.42
			1.1.1.1 SMOH and LGA will be strengthened through an integrated organizational change and development programme.		Political will	42,705,240.63
			1.1.1.2 Institutionalize intergovernmental and inter-sectoral collaborating mechanisms for improving determinants of health.		Political will	2,423,534.61
			1.1.1.3 Develop evidence –based, costed, and prioritized Operational health plans at State and LGAs, through participatory approaches.		Political will	773,047.13
			1.1.1.4 Dissemination and advocacy on state policy makers to encourage annual operational plans/policy support and implementation.		Political will	2,358,803.45
			1.1.1.5 Implementation of agreed plans		Frequent changes in leadership of the varous depts/units in the health sector	2,391,169.03
		1.1.4	Improving and maintaining Sectoral Information base to enhance the performance.			
	1.2	**To facilitate legislation and a regulatory framework for health development**		**Health Bill signed into law by end of 2009**		20,667,130.28
		1.2.1	Strengthen regulatory functions of government	Availability of public and private partnership policy document and operating procedures		20,667,130.28
			1.2.1.1 State to develop public /private partnership policies and plans in line with the national policy on ppp.	Enactment of health legislation , health acts and	Inability of the State to develop its policies	2,197,132.63

					laws by State assembly		
			1.2.1.2	Adapt standard operating procedures with agreed quality standards to guide service delivery and supportive supervision		Willingness of stakeholders to cooperate	2,504,360.96
			1.2.1.3	Foster public sector collaboration with the private sector to improve health delivery systems through joint professional development and generation of public health information		Willingness of stakeholders to cooperate	**12,697,664.25**
			1.2.1.4	Enforce health legislation and public health acts and laws through State assembly		Inability of the State assembly to enact health legislations	1,407,744.34
			1.2.1.5	Adapt and implement the revised and streamlined roles and responsibilities of regulatory institutions to align with National Health Bill.		Adherence to stream lined roles and reaponsibilities	1,860,228.53
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**			**80% of States and the Federal level have an active health sector 'watch dog' by 2013**		307,506,667.89
		1.3.1	To improve accountability and transparency		No of State Council on Health (SCH) held		307,506,667.89
			1.3.1.1	Institutionalisation of annual State Council on Health (SCH) to build stakeholder consenus on health matters		Lack fund to hold the SCH meeting	300,352,580.14
			1.3.1.2	Create platforms for interaction with health sector advocacy groups		Existence of conflicts in the community	2,423,534.61
			1.3.1.3	Sensitization of benefiting communities to empower them to manage and oversee health projects and programmes “watch dogs”.		Lack of political will	2,391,169.03
			1.3.1.4	Decentralize decision making process in health sector.		Decision making process will be decentralized.	2,339,384.10
	1.4	**To enhance the performance of the national health system**			**1. 50% of States (and their LGAs) updating SHDP annually 2. 50% of States (and LGAs) with costed SHDP by end 2011**	**Various levels of government have capacity to update sectoral SHDP States may not respond in a uniform and timely manner**	4,801,757.41
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance		Availability of reports		4,801,757.41
			1.4.1.1	Establishment of effective collaboration with revelant health system research units of Universities and other research institutes to broaden evidence based decision making	No of studies conducted as a result of the colloboration	Capacity to carry out reaseach studies	2,391,169.03
			1.4.1.2	Establish priorities list of areas of further analytical work inconjunction with development partners		List of areas for further analytical work available	2,410,588.38

HEALTH SERVICE DELIVERY							**40,787,715,590.67**
2. To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare							28,903,289,888.28
	2.1	**To ensure universal access to an essential package of care**			**Essential Package of Care adopted by all States by 2011**		15,524,849,906.31
		2.1.1	To review, cost, disseminate and implement the minimum package of care in an integrated manner		1. Proportion of facilities implementing the costed minimum helath package inline with the operating standards and guidelines		7,466,450,469.02
			2.1.1.1	Strengthen specific disease control programmes & development of an emergency preparadness and response to curtail outbreaks of diseases		Availability of funds	24,933,185.51
			2.1.1.2	Review Cost and implement the minimum health package of care		Capacity of staff to implement the package	7,430,998,486.59
			2.1.1.3	Provide standard operating procedures (SOP) and guidelines for minimum health care package for service delivery at State and LGA level.		Availability of standard operating procedures for MHP	5,171,974.95
			2.1.1.4	Proper coordination using the integrated approach to training, service delivery, supervision and monitoring.		Favourable political will	5,346,821.97
		2.1.2	Strengthen immunization services		1. Decline in the incidence of vaccine preventable diseases & deaths 2. No. of cold chain equipment procured and functional		456,213,475.68
			2.1.2.1	Strengthen routine immuniztion services and improve access to immunization at State and LGAs levels		Non availability of vaccines or cold chain equipment	32,157,864.51
			2.1.2.2	Provide cold chain equipment and logistic supply to ensure quality of vaccines		Un willingness to change habits formed	409,418,292.62
			2.1.2.3	Adopt mechnisms for supportive suppervision		Non release of budgeted funds	4,752,342.09
			2.1.2.4	Conduct evidence based advocacy, social mobilization programmes to create demand of polio vacination and create mechnism for supportive suppervision		Non release of budgeted funds	4,909,704.41
			2.1.2.5	Use of updated standard manuals & tools to enhance the knowledge & skills of health workers		Non release of budgeted funds	4,975,272.05

		2.1.3	Scale -up Integrated Maternal, Newborn & Child Health (IMNCH)		1. Propotion of birth assisted by skilled birth attendance 2. Availability of IMNCH plans for implementation		2,210,253,459.74
			2.1.3.1	Develop and implement evidence based IMNCH plans endorsed by policy makers at State & LGA level		State & LGAs have capacity to develop IMNCH plans	2,189,958,965.76
			2.1.3.2	Conduct advocacy for allocation of budget , increased community resources & promote partnership for IMNCH		Favourable political will	5,040,839.68
			2.1.3.3	Assess training needs, train and retrain HW & community care givers to have appropriate skills, provider attitudes & ethics		Favourable political will	5,106,407.31
			2.1.3.4	Develop tools and guidelines to stregthen the systems capacity for supportive suppervision & regular reporting		Availability of IMNCH guidelines and tools for supportive suppervision	4,975,272.05
			2.1.3.5	Access to skilled care during pregnancy, childbirth, intrapartum & postnatal period at State and LGA levels		Inadequate skilled staff	5,171,974.95
		2.1.4	Prevention and management of malaria, TB & HIV/AIDS at State and LGA levels		1. No. of Pregnant women and children using ITN 2. Proportion of people accessing TB/malaria & HIV/AIDS care		5,279,278,564.82
			2.1.4.1	Alignment of State and LGA operational plans with the adopted State RBM/ TB/HIV plans		Availability of operational plans	4,713,001.51
			2.1.4.2	Procurement & distribution of ITN, LLIN, SP, IPT,ACT RDT & diagnostic equipment /Kits for RBM/ TB/HIV		Avalibility of commodities	5,250,713,806.63
			2.1.4.3	Production and distribution of IEC materials on TB, HIV / malaria & provide VCT, councelling on infant option & prevention of HIV infection		Inadequate funds to produce IEC materials and prucure drugs	13,809,417.89
			2.1.4.4	Strengthen TB/HIV collaboration and procure TB, HIV / Malaria drugs and other commodities		Willigness of development partners to cooperate	5,014,612.63
			2.1.4.5	Training of health workers on proper diagonistic procedures and establish quality control service		Quality of diagnostic procedures improved	5,027,726.15
		2.1.5	Maternal and Child Nutrition		1. No. of acute malnutrition in under 5 children identified and manage 2. Availability of plas for securing & distibution of		112,653,937.06

					micronutrients supplement		
			2.1.5.1	Develop plans for securing ,distributing and monitoring supplies of micronutrients supplements		Avialability of plans	4,804,796.20
			2.1.5.2	Prevention and management of severe and acute malnutrition in children aged under 5 years at facility and community levels		Capacity to prevent and manage cases well	92,280,761.91
			2.1.5.3	Adopts a comprehensive system for monitoring and correcting micronutrients defficencies (iodine, vitamin A, & iron) in children and women		Capacity to conduct proper supervision	4,962,158.52
			2.1.5.4	Promotion of optimal child & infant feeding at household level			5,171,974.95
			2.1.5.5	Provision of adequate and appropriate nutrition as per the office EPRP to children and pregnant women affected by rapid onset emergencies		Acceptance of the women to take appropriate nutrition as per EPRP	5,434,245.48
	2.2	**To increase access to health care services**			**50% of the population is within 30mins walk or 5km of a health service by end 2011**		9,139,125,681.08
		2.2.1	To improve geographical equity and access to health services		No. of facilities rehabilitated & upgraded at State & LGA levels		8,634,924,517.57
			2.2.1.1	Health facility mapping by location and services provision at state and LGA levels	List of Health facilities established	Existence and budgetary provision	11,314,350.87
			2.2.1.2	Construction and or rehabilitation of dilapidated health facilities using appropriate guidelines at State and LGA levels.		Existence and budgetary provision	8,307,178,616.69
			2.2.1.3	Develop criteria for citing new health facilities at State and LGA levels		Lack of political will	1,016,298.32
			2.2.1.4	Adapt and implement guidelines for outreach services and task shifting.		Non functionality of PHC system	315,415,251.68
			2.2.1.5	Advocacy to promote, implement, scale-up and allocate resources to increase access to health care services		Political commitment	
		2.2.2	To ensure availability of drugs and equipment at all levels		Availability of essential druglist and equipment list		308,937,642.43
			2.2.2.1	Review of essential drugs list, disseminate and ensure compliance with the essential drug list at state and LGAs levels	No. & types of drugs and equipment procured based on the establish lists	Availability of essential drug lists	1,972,711.54
			2.2.2.2	Establish and strengthen effective procurement systems (forecasting, orders, procurement, inventory, distribution etc) on a sustainable basis to ensure availability of		Lack of political will	176,595,493.45

				essential health commodities on sustainable basis.			
			2.2.2.3	Adopt the updated equipment list for secondary and PHC facilities in line with the essential package of care.		Availability of equipment lists for all levels of care	123,267,151.37
			2.2.2.4	Procurement and distribution of equipment and drugs at all levels of health facilities in the state		Willingness of stakeholders to cooperate	7,102,286.08
			2.2.2.5	Revatilize drug revolving fund (DRF) scheme and strengthen its management at State and LGA levels			
		2.2.3	To establish a system for the maintenance of equipment at all levels		Functional equipment and hospital furniture workshop established		13,985,755.49
			2.2.3.1	Adaption, dissemination and implementation of National Health Equipment policy at the state and LGAs.	No. of staff trained on equipment & furniture maintenance	Availability of National Health Equipment Policy at State level	1,045,585.20
			2.2.3.2	Creation of budget line for maintenance of medical equipment and hospital furniture at all levels		Favourable political will	7,973,024.26
			2.2.3.3	Refurbishment of State & Hospital medical maintenance units for effective performance		Favourable political will	4,196,328.56
			2.2.3.4	Capacity building on medical equipment & Furniture maintenace at State & LGA levels		Lack of funds	770,817.47
			2.2.3.5	Outsourcing of medical equipment maintenance to private institutions and entering into post warranty maintence agreement with suppliers		Acceptance and implementation of PPP policy in Benue State	
		2.2.4	To strengthen referral system		No. of PHC facilities linked to secondary facilities for emergency obstetric care		170,294,667.65
			2.2.4.1	Mapping of referral centers		Existence of functional PHC system	140,213,493.58
			2.2.4.2	Develop a network of PHC centers linked to secondary referral facilities for emergency obstetric care.		Lack of political will	2,588,228.14
			2.2.4.3	Provide adequate logistic and communication facilities for referrals (ambulances, motorcycles / tricycles, radios, mobile phones etc.)		Lack of funds	4,822,280.90
			2.2.4.4	Establish and implement guidelines for two-way referrals		Willigness of stakeholders	17,586,113.59
			2.2.4.5	Monitor and document the effectiveness and outcome of referrals		Willigness of stakeholders	5,084,551.44
		2.2.5	To foster collaboration with the private sector		Availability of a comprehensive list of private health facilities		10,983,098.82

			2.2.5.1	Mapping of all categories of private health care providers by operational level and location in the state and LGAs		Unwillingness of private health providers to register their outfits	2,220,557.19
			2.2.5.2	Development of guidelines and standards for regulation of their operations and registration in the state and LGAs		Availability of approved guidelines	2,596,463.43
			2.2.5.3	Development of guidelines for partnership, training and outsourcing of health services to private sector		Availability of approved guidelines	244,769.22
			2.2.5.4	Development of joint performance monitoring mechanism for private sector in the state		Willingness of private practitioners to cooperate	661,910.51
			2.2.5.5	Adapt and implement the national policy on traditional medicine.			5,259,398.46
	2.3	**To improve the quality of health care services**			**50% of health facilities participate in a Quality Improvement programme by end of 2012**		93,066,176.49
		2.3.1	To strengthen professional regulatory bodies and institutions		Availability of standard guidelines for regulatory bodies		21,308,328.71
			2.3.1.1	Adaptation of guidelines and standards for regulatory bodies		Availability of approved guidelines	13,260,398.24
			2.3.1.2	Built capacity of staff to monitor compliance of providers to regulatory guidelines		Availability of approved guidelines	1,753,437.64
			2.3.1.3	Create budget lines and necessary resources to conduct regular monitoring exercises with apropriate documentation and feedback		Inability to release the budget	6,294,492.84
		2.3.2	To develop and institutionalise quality assurance models		No. of quality control unit established		34,416,285.70
			2.3.2.1	Review available models and build consenus on the models to be adopted in the state		Availability of approved quality assurance models	769,749.16
			2.3.2.2	Development of quality assurnance training models and implemented to build capacity of staff in the state and LGA levels		Availability of training plan on quality assurance models	13,260,398.24
			2.3.2.3	Adoption and implementation of SERVICOM guidelines in all health establishments in the state		Availability of SERICOM guidelines	8,031,447.64
			2.3.2.4	capacity building to implement SERVICOM guidelines at all levels in the state		Availability of train plan on SERVICOM	5,958,786.55
			2.3.2.5	Develop and implement strategies for monitoring the implementation of quality of health care		Favourable political will	6,395,904.11
		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms		No. of staff trained on integrated supportive supervision 2. No. of		37,341,562.07

					supportive supervision team constituted		
			2.3.3.1	Training of health managers on leadership development programmes at State and LGA levels to build their capacity on Integrated Supportive Supervision (ISS).		Availability of ISS guidelines	1,541,634.07
			2.3.3.2	Development and implementation of ISS tools and guidelines for all levels of health care in the state		Availability of ISS guidelines/tools	13,260,398.24
			2.3.3.3	Constitute supportive supervision teams and agree on modalities of operation State and LGA level			4,778,569.14
			2.3.3.4	Provision of budget lines and sustainable funding for comprehensive ISS activities			15,527,255.47
	2.4	**To increase demand for health care services**			**Average demand rises to 2 visits per person per annum by end 2011**		2,652,233,843.95
		2.4.1	To create effective demand for services		% increase in the no. of persons seeking health care		51,521,628.56
			2.4.1.1	Adoption, dissemination and implementation of national health promotion communication strategy to promote health care seeking behaviuor		Availability of communication strategy	2,877,982.00
			2.4.1.2	Provision of budget lines for health promtion, behavioural change communications (BCC) at State and LGA levels		Favourable political will	26,235,252.06
			2.4.1.3	Develop monitoring mechanism to assess implementation of health promotion strategy at all levels		Favourable political will	12,588,985.67
			2.4.1.4	Support local adoptation of the national strategy to reflect local realities		Lack of polical will	5,040,839.68
			2.4.1.5	Adapt, disseminate and implement the health promotion policy		Availability of the policy	4,778,569.14
		2.4.2	Revitalize the Management of Primary Health s Care Systems		Primary Health Board established		787,384,228.46
			2.4.2.1	Formation of Primary Health Care Board (PHCB) in line with the national health act.		Acceptance and willingness of the government .	83,284,882.57
			2.4.2.2	Establishment of PHC service delivery fund		Acceptance and willingness of the government .	555,415,557.00
			2.4.2.3	Conduct advocacy for sustainable allocation of budget line for PHC services		Acceptance and willingness of the government .	5,303,110.21
			2.4.2.4	Establishment of zonal structures with the appointment of governing councils		Acceptance and willingness of the government .	138,405,406.64
			2.4.2.5	Capacity building of management & health facility staff		Acceptance and willingness of the government .	4,975,272.05

		2.4.3	Establishment of PHC facilities for outreach services and training of medical student from Benue State University		1. No. of Facilities & hostels built 2. Proportional increase in attendance		156,033,483.52
			2.4.3.1	Construction and rehabilitation of 3 PHC centers & Hostels for medical student community experience.		Acceptance and willingness of the government .	136,044,971.82
			2.4.3.2	Procurement of drugs, furniture and equipments for the PHC centers & hostels		Acceptance and willingness of the government .	5,084,551.44
			2.4.3.3	Recruitment of staff for the centers		Acceptance and willingness of the government .	4,822,280.90
			2.4.3.4	Baseline survey for community diagnosis and mobilization		Acceptance and willingness of the government .	5,171,974.95
			2.4.3.5	Continues field training of medical students		Acceptance and willingness of the government .	4,909,704.41
		2.4.4	Enhance development of permanent site for HMB headquarters and sucessful take off of 7 new hospitals in the State		1,HMB permanent site occupied 2. Quality health services rendered at 7 new hospitals		1,642,102,045.57
			2.4.4.1	Construction,equiping and furnishing of permanent site for HMB headquarters	,	Acceptance and willingness of the government .	310,891,995.04
			2.4.4.2	Build new structures, upgrade and refurbish all substandard facilities		Acceptance and willingness of the government .	1,316,087,531.49
			2.4.4.3	Procurement of drugs, furniture and equipments for the 7 new hospitals		Acceptance and willingness of the government .	4,865,992.66
			2.4.4.4	Recruitment of staff for the 7 new hospitals in Benue State		Acceptance and willingness of the government .	5,040,839.68
			2.4.4.5	Community mobilization advocacy and awareness to promote ownership and participation in management affairs		Willingness of governmen and community members	5,215,686.70
		2.4.5	Strategic promotion of quality services at the HMB headquarters and its hospitals		Improved quality services using standard measureable tools		15,192,457.85
			2.4.5.1	Review the HMB workshop and statelite units towards improved service delivery		Acceptance and willingness of the government .	5,346,821.97
			2.4.5.2	Set up drug information centers at the north bank hospital and 3 zonal hospitals for effective services to health providers and the public		Availability of standard and concrete proposal	4,844,136.78
			2.4.5.3	Revitalization of all health systems earlier set up by developmental partners (1996-2005) to enhance optimal performance and effective impacts		Availability of standard and concrete proposal .	4,372,486.15

	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**		1,494,014,280.45
		2.5.1	To improve financial access especially for the vulnerable groups		No. of vulnerable groups accessing any form financial protection scheme		1,494,014,280.45
			2.5.1.1	Explore models for financial protection like voucher's, pre-payment schemes, health cards etc		Favourable political will	2,559,415.97
			2.5.1.2	Scale up coverage of existing finacial protection schemes		Willingness of stakeholders to participate	46,214,859.67
			2.5.1.3	Implement free MHC services		Favourable political will	1,445,240,003.94
HUMAN RESOURCES FOR HEALTH							**24,495,062,180.71**
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							20,025,665,289.42
	3.1	**To formulate comprehensive policies and plans for HRH for health development**			**States and LGAs are actively using adaptations of the National HRH policy and Plan by end of 2015**		15,556,268,390.48
		3.1.1	To develop and institutionalize the Human Resources Policy framework		Availability of HRH plans at State and LGA level		15,556,268,390.48
			3.1.1.1	Adaptation of the national HRH policy and plans to guide human resource development at state & LGA level		Availability of national HRH policy	6,239,308.65
			3.1.1.2	Implementation of HRH policies on training & recruitment of health personnel		Availability of national HRH policy	15,544,201,189.24
			3.1.1.3	Develop, introduce and utilise staffing norms based on workload		Availability of framework	2,495,168.84
			3.1.1.4	Establish a fora to instutionalized HRH policy review, supervision and monitoring of frameworks		Availability of the framework	1,590,415.06
			3.1.1.5	Stregthening of capacities to access and implement federal government circulars , guidelines and policies related to HRH		Funds to develop various capacities	1,742,308.69
	3.2	**To provide a framework for objective analysis, implementation and monitoring of HRH performance**			**The HR for Health Crisis in the State has stabilised and begun to improve by end of 2012**		23,098,521.38
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels		Document on staffing norms based on workload developed by State & LGAs		23,098,521.38

			3.2.1.1	Adoption of national career pathways for all groups of health professional in the state		Availability of approved national career pathways	1,552,921.83
			3.2.1.2	Development or adoption of staff norms base on workload, service availability and health sector priorities to guide planning		Low capacity of staff and LGAs to deveop staff norms	1,494,685.20
			3.2.1.3	Establishment of a coordination mechanism for consistency in HRH planning and budgeting by relevant bodies in the state		Adoption of national HRH policy in the state	4,652,568.15
			3.2.1.4	Orientate State and LGA to increase their capacities to monitor, guidelines, HRH circulars and policies		Unwillingness to cooperate	12,202,454.66
			3.2.1.5	Mapping of health sector priorities and service availability to determine staffing needs.		Difficult terrains	3,195,891.54
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**			**1. 50% of States have functional HRH Units by end 2010 2. 10% of LGAs have functional HRH Units by end 2010**		67,679,252.13
		3.3.1	To establish and strengthen the HRH Units		1. A functional HRH Unit created at State level 2. 50% Unitof LGAs have functional HRH		67,679,252.13
			3.3.1.1	Creation of HRH units in DPRS and LGA health departments to perform HRH functions		Challenge of acceptance of HRH Unit in DPRS	13,995,096.25
			3.3.1.2	State & LGAs HRH unit to adapt guidelines and training materials from FMOH			13,495,916.22
			3.3.1.3	Training and retraining of managers in human resource planning and mangement			13,595,752.55
			3.3.1.4	Conduct a need assessment			13,196,408.86
			3.3.1.5	Monitor training courses output on HRH planning & management			13,396,079.89
	3.4	**To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers**			**One major training institution per Zone producing health workforce graduates with multipurpose skills and mid-level health workers by 2015**		4,085,552,815.49
		3.4.1	To review and adapt relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities		No. of training programmes of health related institution adapted to national priorities		4,085,552,815.49

			3.4.1.1	Expansion of training of community health workers and other supportive staff through accreditation of SHT		All the necessary courses to be offered by SHT are accredited	35,688,671.10
			3.4.1.2	Promotion and participation in the national Midwives Services Scheme and community programme at the state & LGA level		Continue existence of the service	913,652,230.41
			3.4.1.3	Development of monitoring and supervision mechanism to check health training institutions' performance		Favourable political will	15,768,195.29
			3.4.1.4	Construction/rehabilitation/upgrading of infrustructures and equipping of training institutions in the State.		Ability of the training institution to create quality assurance units	2,956,348,471.98
			3.4.1.5	Promote human capital capacity building and continuing professional development.		Lack of funds	164,095,246.70
		3.4.2	To strengthen health workforce training capacity and output based on service demand		No. of HRH produced by the identified health institutions by 2011		6,701,303,033.84
			3.4.2.1	Facilitate accreditation of eligible public and private health institutions and facilities to increase training opportunities for internship and post basic training of all health professionals.		Availability of accredited health training institutions	5,782,579,065.99
			3.4.2.2	Implementation of policy of health workers training sponsorship to bonding to mitigate migration in the state and LGAs		Availability of approved guidelines	749,452,276.87
			3.4.2.3	Provide minimum levels of infrastructure, teaching and learning materials as incentive for retention		Lack of funds	44,644,377.79
			3.4.2.4	Establish educational quality assurance units in all training institutions.		Ability of the training institution to create quality assurance units	56,423,896.99
			3.4.2.5	Map the capacity of production of health care providers by training institutions in the State.		Lack of funds	68,203,416.20
	3	**To improve organizational and performance-based management systems for human resources for health**			**50% of States have implemented performance management systems by end 2012**		284,231,668.91
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health		1. Proportion of staff deployed to institutions that show equit, right mix and geographical space at State and LGA level 2. No. of retired health professionals enaged		82,121,366.41

			3.5.1.1	Creation of database for HRH at all levels in the state		Availability of HRH unit	48,211,242.38
			3.5.1.2	Develop and/or adapt job description and specifications for all categories of health workers in the state and LGAs		Favourable political will	6,097,370.36
			3.5.1.3	Redistritution of health workers based on need at all levels in the state		Favourable political will	5,726,155.17
			3.5.1.4	Engagement of retired trained health professionals to meet HRH gaps & ensure rural posting incentives for health workers at all levels in the state		Favourable political will	19,632,532.01
			3.5.1.5	Establish mechnisms to minimized work place hazards through management of mental stress and physical risks			2,454,066.50
		3.5.2	To establish mechanisms to strengthen and monitor performance of health workers at all levels				202,110,302.50
			3.5.2.1	Training and retraining of health workers in interpersonal communication skills and ethics at state &LGA levels		Availability of training plan	30,755,433.00
			3.5.2.2	Sustainable systems of recognition, reward and sanctions for health workers at state & LGA levels		Availability of approved guidelines	113,890,448.31
			3.5.2.3	Establishment of supportive supervision mechanism for all health care providers in the state		Availability of approved guidelines	57,464,421.19
	3	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**			**50% of States have regular HRH stakeholder forums by end 2011**		8,834,639.40
		3.6.1	To strengthen communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system		No. of meetings held between management & staff of public and private sectors as well as professional bodies and associations at State and LGA levels.		8,834,639.40
			3.6.1.1	Establishment of effective dialogue and complaint resolution channels between management and staff of public and private health sectors as well as intra and inter-professions at state & LGA levels		Unwillingness to cooperate by professional groups	3,926,506.40
			3.6.1.2	Ensure involvement of workers and professional groups in the management teams, design and monitoring of services to enhance cooperation		Availability of professional bodies to initiate and sustain collaboration among professional associations	1,963,253.20
			3.6.1.3	In line with the HRH policy, promote intra and inter- professional respect, harmony and team work among all disciplines of health		Unwillingness to cooperate by professional groups	2,944,879.80

				care workers for optimum health service delivery.			
FINANCING FOR HEALTH							**1,719,593,895.80**
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							916,184,304.60
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**			**50% of States have a documented Health Financing Strategy by end 2012**		112,774,713.31
		4.1.1	To develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy		State and 30% of LGAs with developed costed health financing strategic plans and implementing it by 2012		112,774,713.31
			4.1.1.1	Setting up of Technical Working Groups for development of Health Care Financing plan in line with the National health financing policy at the state		Favourable political will	13,628,154.84
			4.1.1.2	Training of health workers on the implementation of health financing plan at all levels in the state		Availability of health financing plan	77,576,223.89
			4.1.1.3	Adapt and disseminate the costed and prioritized health financing strategic plans, in line with the National Health Financing Policy.		capacity of governments at State & LGA to manage reforms.	21,570,328.05
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**			**NHIS protects all Nigerians by end 2015**		275,411,479.43
		4.2.1	To strengthen systems for financial risk health protection		50% coverage of vulnerable groups by end of 2015		275,411,479.43
			4.2.1.1	Senitisation of Benue people to participate in the NHIS and other forms of social risk protection models at State and LGA levels		Willingness of stakeholders to participate	7,238,317.20
			4.2.1.2	Implementation of social health protection models inline with the National Health acts		The Bill to signed into law by the President	6,907,581.10
			4.2.1.3	Scale up successful health financing approaches (such as pre-paid schemes, and community based health insurance scheme) to cover wider populations		Willingness of stakeholders to participate	261,265,581.12
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**			**Allocated Federal, State and LGA health funding increased by an average of 5% pa every year until 2015**		154,359,199.75
		4.3.1	To improve financing of the Health Sector		State and 40% of LGAs allocating 15% of the budget to health		78,038,846.85

			4.3.1.1	Advocacy on the Governor, State and LG assemblies on the need to increase budgetary allocation to health to at least 15% .		Favourable political will	28,659,652.02
			4.3.1.2	Exploration and effective coordination of other sources of financial flow to health sector at all levels in the state.		Willingness by the stakeholders	16,459,731.61
			4.3.1.3	Strengthen financial and management systems for effective and efficient use of resources in the sector			20,378,715.33
			4.3.1.4	Ensure that 100% of the budget is timely released inline with the annual budgets		Political commitment	12,540,747.89
		4.3.2	To improve coordination of donor funding mechanisms		Availbility of functional donor corodinating mechanism		76,320,352.90
			4.3.2.1	Adaption and implementation of an effective donor agencies coordinating mechanism developed by FMOH eg common basket funding, joint funding Agreement and sector-wide approaches in the state		Availability of developed coordinating mechanism for donors	27,095,912.20
			4.3.2.2	Establishment of budget lines (Counterpart funds) for donor support programmes at state & LGA levels.		No significant substitution of government resources with donoer funds.	25,108,961.33
			4.3.2.3	Conduct a detailed joint assessment of existing government and development partner coordination structures and functions with appropriate strategies to improve effective coordination		A list of existing government and developement partners coordinating structures	24,115,479.36
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**			**1. Federal, 60% States and LGA levels have transparent budgeting and financial management systems in place by end of 2015 2. 60% of States and LGAs have supportive supervision and monitoring systems developed and operational by Dec 2012**		373,638,912.11
		4.4.1	To improve Health Budget execution, monitoring and reporting		State and LGA levels have transparent budgeting and financial		264,926,303.81

					management systems in place		
			4.4.1.1	Develelopment of costed annual operational plans at all levels in the state		Availability of state Health plan	132,361,238.73
			4.4.1.2	Deveopment of State Health Account (SHA) and public expenditure review (PER) to increase financial transparency		Favourable political will	75,139,981.13
			4.4.1.3	Monitor and evaluate the use of health accounts at State and LGAs on annual basis		Availability of M & E mechanism	57,425,083.95
		4.4.2	To strengthen financial management skills		No. of staff trained on finacila management		108,712,608.30
			4.4.2.1	Training of health workers on proper financial management skills and auditing to improve internal recording, timely accounting of expenditures and submission of periodic & comprehensive financial management reports.		Availability of funds to conduct various trainings	59,646,932.17
			4.4.2.2	On the job training and competency transfer to support financial management systems.		Willigness of staff to learn on the job	49,065,676.13
NATIONAL HEALTH INFORMATION SYSTEM							**1,074,904,358.29**
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							1,074,904,358.29
	5.1	**To improve data collection and transmission**			**1. 50% of LGAs making routine NHMIS returns to State level by end 2010** **2. 60% of States making routine NHMIS returns to Federal level by end 2010**		393,494,218.32
		5.1.1	To ensure that NHMIS forms are available at all health service delivery points at all levels		Adequacy of NHMIS forms at State and LGA health facilities		35,779,194.40
			5.1.1.1	Establishment of budget lines for HMIS at state and LGA levels		Non implementation of budget	3,729,054.43
			5.1.1.2	Printing and distribution of HMIS forms to all health establishments at state and LGA levels		Non release of approved budget	5,515,742.95
			5.1.1.3	Training and retraining of health staff on the use of HMIS forms		Non release of approved budget	3,138,078.38
		5.1.2	To periodically review of NHMIS data collection forms		NHMIS data collection forms and tools are reviewed and updated annully		72,124,727.54
			5.1.2.1	Establishment of a mechanism to ensure feed back annually on the appropriateness and user friendliness of data collection tools at all levels in the state		Feedback will be use for reviews other wise users will	6,584,777.08

						cease sending feedback	
			5.1.2.2	Attendance of HMIS annual review meetings with stakeholders both in the state and at FMOH		Non release of approved budget	34,612,918.94
			5.1.2.3	Review and update health facility list annually		Non release of approved budget	30,927,034.56
		5.1.3	To coordinate data collection from vertical programmes		1.Functioan coordinating committees in place by end of 2010 2. M&E ofvertical programmes integrated into NHMIS by 2011		33,682,051.45
			5.1.3.1	Establish a committee for collaboration of agencies and partners in data management		Willigness of development partners to mainstream their data into NHMIS	5,365,458.41
			5.1.3.2	Revitalization of HDCC at state level in collaboration with development partners, private practitioners and other government agencies to streamline and strengthen data collection.		Lack of cooperation among committee members	17,074,680.19
			5.1.3.3	Integration of HMIS with M&E to ensure coherence and complementarities		Avoidance of duplication of data captured by partners and HMIS	5,493,207.42
			5.1.3.4	Ensure harmonization and use of HMIS tools by all levels including Development partners		Willigness of development partners to mainstream their data into NHMIS	5,748,705.44
		5.1.4	To build capacity of health workers for data management		No. of staff trained on HMIS		39,616,148.08
			5.1.4.1	Training and retraining of health care providers on data collection tools, analysis and utilisation at all levels in the state		Adequate funds to conduct the trainings	1,188,029.29
			5.1.4.2	Monitor the delivery of training workshop to ensure quality of trainings		Lack of logistic for monitoring	15,208.22
			5.1.4.3	Advocate State to training and recruitf health information personnel and /or re-allocate other staff to support the system.		Lack of political will	38,412,910.57
		5.1.5	To provide a legal framework for activities of the NHMIS programme		Appropriate NHMIS laws and bye laws permulgated 2013		161,354,119.79
			5.1.5.1	Enforcement of National Health Act sanction for refusal to submit data to health authorities		Availability of signed National Health Act	3,607,337.00
			5.1.5.2	Development of state legislation on the compulsory submission of health data by all health establishments in the state		Favourable political will	

			5.1.5.3	Advocacy and senistisation of stakeholders on the HMIS legislations at State & LGA level		Availability of approved legislation	157,746,782.79
		5.1.6	To improve coverage of data collection		50% of public and private health facilities reporting		25,585,185.38
			5.1.6.1	Increase advocacies to private health care providers on their involvement in the imlemenation of HMIS in the state		Willingness to participate	10,949,915.12
			5.1.6.2	Provision of data collection tools at all health establishments in the state and LGAs		Non availability of data collection tools	10,949,915.12
			5.1.6.3	Regular supportive supervisions and monitoring of all health care providers to ensure data returns		Release of budgeted funds	1,249,555.65
			5.1.6.4	Advocacy on the National Population Commission in the State to strengthen vital registration system in order to capture birth and death statistics required for health planning and programmes		Willingness of NPC to partner with health sector	1,207,346.77
			5.1.6.5	Strengthen community based data collection system at State and LGA levels		Willingness to participate	1,228,452.73
		5.1.7	To ensure supportive supervision of data collection at all levels		No. of supportive supervision carried out at State & LGAs levels		25,352,788.64
			5.1.7.1	Provide adequate logistics to enhance the performance of relevant officials in supervising data collection at lower levels (vehicles, motorcycles, tricycles and bicycles)		Availability of logistic support for supervision	8,055,514.93
			5.1.7.2	Create a budget for for routine supportive supervision at State and LGA levels		Availability of funds	17,297,273.71
	5.2	**To provide infrastructural support and ICT of health databases and staff training**			**ICT infrastructure and staff capable of using HMIS in 50% of States by 2012**		67,506,226.72
		5.2.1	To strengthen the use of information technology in HIS		1. No of staff trained and using software for data collection 2. Level of PPP in data management		30,440,764.03
			5.2.1.1	Training of data collectors on the use software for data collection and utilisation		Availability of training plan	
			5.2.1.2	Encourage public private partner in the managemnet of data warehouse		Sustenance of PPP with emerging ecomic policies	29,090,274.50
			5.2.1.3	Promote the use of e-health data such as electronic management intelligence information system websites, patient information system etc		Stablity of power supply to sustainable e-health	1,350,489.53
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management		1. Basic infrustructures provided 2. No. of technical staff trained on use of software		37,065,462.68

			5.2.2.1	Advocate to State and LGAs health managers to provide vehicles, computers, photocopiers, binding machines, calculators and provision of power supply and internet services etc to meet HIS minimum package at all levels in the state		Misuse of computers, vehicles etc. for activites unrelated to HIS	6,040,703.17
			5.2.2.2	Training of health staff on database software at all levels in the state and LGAs		Tendency to move trained HMIS staff to other areas where the training will not be relevant	12,902,649.98
			5.2.2.3	Provision of adequate office space for HMIS units at all levels in the state and LGAs		Lack of political will	3,576,972.27
			5.2.2.4	Monitor appropriate use of computer hardware system and ensure regular mainteniance			14,545,137.25
	5.3	**To strengthen sub-systems in the Health Information System**			**1. NHMIS modules strengthened by end 2010** **2. NHMIS annually reviewed and new versions released**		94,576,850.21
		5.3.1	To strengthen the Hospital Information System		1. No. of hospitals with effective patient information system 2. Availability of disease mapping at State and LGA levels		43,306,914.30
			5.3.1.1	Computerisation of medical record unit at all hospitals in the state		Favourable political will	14,545,137.25
			5.3.1.2	Training of medical record officers in hospitals on computer application to data management in the state		No. of record staff trained	15,037,883.43
			5.3.1.3	Adapt guidelines and specification for disease mapping at State and LGA levels		Availability of disease mapping	13,723,893.62
		5.3.2	To strengthen the Disease Surveillance System		1. Completeness & timeliness of disease notifcation. 2. Availability of community based surveillance volunteers		51,269,935.91
			5.3.2.1	Provision of data collection tools at all health establishments in the state and LGAs for regular reporting of notifiable diseases		Early response to reported epidemics stimulate early reporting.	10,949,915.12
			5.3.2.2	Establishment of community based surveillance to strengthen disease surveillance system in the state and LGAs			9,660,258.45
			5.3.2.3	Capacity building of HW on Integrated Disease Surviellance and Response (IDSR)			8,759,932.10

			5.3.2.4	Sensitization of clinicians on case management and surveillance			9,854,923.61
			5.3.2.5	Awareness creation and health education through radio, IEC material and television.			12,044,906.63
	5.4	**To monitor and evaluate the NHMIS**			**NHMIS evaluated annually**		53,167,921.20
		5.4.1	To establish monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs		No. of review meetings hels at LGA and State		32,326,582.75
			5.4.1.1	Provision of vehicles or motorcycles for HMIS officers for regular monitoring of HMIS activities in the state and LGAs	No. of support vehicles purchased.	Lack of funds to purchase the needed vehicles	10,572,751.38
			5.4.1.2	Establish quarterly HIS review meetings at LGA level and bi-annual review meetings at state level (where HFs present data at LGA level while LGA presnt data at State level)		Data presentation and review meetings will stimulate data collectors	10,268,587.07
			5.4.1.3	Adapt and utilize HIS quality assurance (QA) manual to monitor quality of data generated.		Quality data processed	11,485,244.30
		5.4.2	To strengthen data transmission		1. Timely transmission of data 2. No. of HMIS trained on use of internet for transmission of data		20,841,338.45
			5.4.2.1	Establishment of internet connectivity in HMIS units at State & LGA levels to ease transmission of data to relevant stakeholders within and outside the state		Availability of of internet conectivity and power supply	11,181,080.00
			5.4.2.2	Training of HMIS officers on the use of internet for data transmission at State & LGA levels		Lack of funds can delay training .	9,660,258.45
	5	**To strengthen analysis of data and dissemination of health information**			**1 State MOH have Unit capable of analysing health information by end 2010 2. State MOH disseminate available results regularly**		489,555,460.32
		5.5.1	To institutionalize data analysis and dissemination at all levels		1. No. of health facilities with analyzed data 2. No. of bulletin produced		489,555,460.32
			5.5.1.1	Adapt guidelines and training programmes on data analysis and dissemination at state & LGAs levels		Availability of capcity to analyze data at lower levels	443,930,813.98
			5.5.1.2	Production of annual health bulletin by Department of Health Planning in the state			
			5.5.1.3	Promote the use of data for informed decision making , using pilot LGAs			45,624,646.34

COMMUNITY PARTICIPATION AND OWNERSHIP							**716,602,905.53**
6. To attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes							466,235,805.64
	6.1	**To strengthen community participation in health development**			**All LGAs have at least annual Fora to engage community leaders and CBOs on health matters by end 2012**		215,868,703.45
		6.1.1	To provide an enabling policy framework for community participation		Availability of updated policy		60,033,536.04
			6.1.1.1	Adoption and implementation of Community Development Policy by SMOH and LGA health departments		Availability of community Development policy	32,708,918.74
			6.1.1.2	Guidelines for engaging communities in health care development activities will be developed by SMOH and implemented at State and LGAs levels		Availability of guidelines for engaging community in health Development	27,324,617.31
		6.1.2	To provide an enabling implementation framework and environment for community participation		Proportion of communities participating in planning, management and monitoring		155,835,167.41
			6.1.2.1	Adapt and/or establish community structures using established guidelines to foster effective community participation in health activities at state and LGAs levels		Availability of guidelines for engaging community in health Development	79,578,034.93
			6.1.2.2	Training of established community organisations to enhance community involvement in planning, management, monitoring and evaluation of health interventions in the state and LGAs		Availability of guidelines for engaging community in health Development	68,107,237.46
			6.1.2.3	Establishment of inter-sectoral stakeholders committees involving community representatives to enhance collaboration		Willingness of community members to work together	4,074,947.51
			6.1.2.4	Identify and map out key community stakeholders and resources with community assessment of capacity needs		Willingness of community members to work together	4,074,947.51
	6.2	**To empower communities with skills for positive health actions**			**State MOH offer training to FBOs/CBOs and community leaders on engagement with the health system by end 2012**		161,927,866.78
		6.2.1	To build capacity within communities to 'own' their health services		1. Capacity needs of the stakeholds identified 2. No. of		161,927,866.78

					orientation activites conductes for development committes by 2011		
			6.2.1.1	Identification and mapping of key community stakeholders and their resources		Unwillingness of community stakeholders to work together	61,928,886.14
			6.2.1.2	Assess the capacity needs of community stakeholders		Unwillingness of community stakeholders to work together	32,153,900.63
			6.2.1.3	Re-orientate commnuity development committees and community resource persons (CORPS) on their roles and responsibilities		Unwillingness of community stakeholders to work together	2,417,716.07
			6.2.1.4	Sensitization of communities on resource mobilization for community level activities		Unwillingness of community stakeholders to work together	3,498,475.53
			6.2.1.5	Create a forum between communities and government structures for maximum impact		Unwillingness of community stakeholders to work together	61,928,886.14
	6.3	**To strengthen the community - health services linkages**			**50% of public health facilities in all States have active Committees that include community representatives by end 2011**		31,130,259.12
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points		Availability of guidelines on health service linkages		31,130,259.12
			6.3.1.1	Carrying out of an assessment of level of linkages of existing health delivery structures within communities		Availability of guidelines on health services linkages in LGA	45,429.05
			6.3.1.2	Devlopment of guidelines for community health services linkage and restructuring of health delivery structures		Availability of guidelines on health services linkages in LGA	1,442,372.46
			6.3.1.3	Review performance of community Development Committees at State and LGAs levels and facilitate exchage of expereiences among communities development committee		Existence of Community Dev. Committees in LGA	21,805,945.82
			6.3.1.4	Provide technical guidance and support the community stakeholders		Technical support provided	7,836,511.78
	6.4	**To increase state capacity for integrated multisectoral health promotion**			**State MOH have active intersectoral committees with other Ministries**		46,562,018.06

					and private sector by end 2011		
		6.4.1	To develop and implement multisectoral policies and actions that facilitate community involvement in health development		No. of communities involved in health development activites		46,562,018.06
			6.4.1.1	Undertake advocacy to community gate keepers to increase awareness and support for the use of health promotion to facilitate their involvement in health developments		Existence of conflicts in the community	3,745,134.85
			6.4.1.2	Formulation of action plan to facilitate the development of health promotion capacities and support at various level linking health wih other sectors.		Lack of political will	5,451,486.46
			6.4.1.3	Adapt health promotion guidelines or frameworks on community involvement		Promotion guidelines adapted and implemented	5,451,486.46
			6.4.1.4	Empower communities with health knowledge , behavioural communication change		willingness of communities to change behaviour	31,346,047.12
			6.4.1.5	Strengthen the health promotion component in priority health programmes and health related programmes.			567,863.17
	6	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**			**Health research policy adapted to include evidence-based community involvement guidelines by end 2010**		10,746,958.18
		6.5.1	To develop and implement systematic measurement of community involvement		Mechnisms for meauring community impact adapted.		10,746,958.18
			6.5.1.1	Adaption of mechanism to measure community impact in health development at LGAs level		Availability of measuring tools	3,755,574.45
			6.5.1.2	Dissemination of lessons learnt from community impact assessment to enhance knowledge sharing in the state		Availability of community health impact report	3,513,017.37
			6.5.1.3	Develop/adapt models that will be used to establish simple mechanisms to support communities to measure impact and document lessons learnt and best practices from specific community-level approaches, methods and initiatives			3,478,366.36
PARTNERSHIPS FOR HEALTH							**716,602,905.53**
7. To enhance harmonized implementation of essential health services in line with national health policy goals							716,602,905.53
	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**		716,602,905.53

					2010 2. SMOH has an active PPP forum that meets quarterly by end 2010 3. State and all LGAs have similar active committees by end 2011		
		7.1.1	To promote Public Private Partnerships (PPP)		1. Availability of National PPP policy 2. Functional partners coordinating for a by mid 2010		89,836,086.93
			7.1.1.1	Adoption and implementation of National PPP policy in the state		Availability of National PPP policy in Nigeria	6,833,647.61
			7.1.1.2	Development of strategies for implementing PPP initiatives in line with national policy in the state		Capacity to coordinate donor activities exist	31,102,610.63
			7.1.1.3	Establishment of PPP units to promote, oversee and monitor PPP initiatives in the state		Availability of PPP implementation framework in Nigeria	51,899,835.55
			7.1.1.4	Development of mechanism for engaging private sector in the state eg. Contracting, outsourcing, leases, etc.		Lack of political will	
			7.1.1.5	Establishment of joint monitoring mechanism by public and private health care providers with adequate feedback		Lack of political will	
		7.1.2	To institutionalize a framework for coordination of Development Partners		State and 50% of LGAs have functional resource cordination by 2012		41,478,456.43
			7.1.2.1	Establishment of Development partners Forum to enhance their coordination in the state		Benue State continues to make progress to attract development partners	1,614,355.40
			7.1.2.2	Establishment of Health Partners Coordinating Committee (HPCC) as a coordinating body of all health development partners in the state.		Unwillingness of development partners to work together	36,635,383.35
			7.1.2.3	Establishment of mechanism for resources coordination through common basket funding models such as Joint Funding Agreement (JFA), Sector-Wide Approaches and sector multi-donor budget support		Unwillingness of development partners to work together	1,614,355.40
			7.1.2.4	Conduct an inventory of development partners by service and location in the State		lack of cooperation from partners	1,614,355.40
			7.1.2.5				

		7.1.3	To facilitate inter-sectoral collaboration		State and 60% of LGAs have inter MDA for a for coordinating health		65,426,484.90
			7.1.3.1	Establishment of inter-sectoral ministerial forum at DPRS to facilitate inter-sectoral collaboration with relevant MDAs involved in implementing health related activities in the state		Willingness of ministries to collaborate	65,426,484.90
			7.1.3.2				
			7.1.3.3				
			7.1.3.4				
			7.1.3.5				
		7.1.4	To engage professional groups		No. professional involved in planning , implementation, monitoring and evaluation of health plans and programmes		68,013,162.05
			7.1.4.1	Engagement of professional groups in planning, implementation, monitoring and evauation of health plans and programmes in the state		Willingness of professional groups to work together	12,725,482.19
			7.1.4.2	Establish communication links to facilitate relationships between professional groups and Ministry of health		Willingness of professional groups to work together	16,457,830.02
			7.1.4.3	Strengthen collaboration between government and professional bodies to advocate for increase coverage of interventions			16,457,830.02
			7.1.4.4	Convene public lectures through a coordinated approach by professional associations to enhance the provision of skilled care by health professionals.			22,372,012.96
			7.1.4.5	Promote linkages with academic institutions to under take research, education and monitoring through existing networks.			
		7.1.5	To engage with communities		1. 50% of the population are aware of their rights and entitlements available within the health system by 2013 2. 50% of mothers of children under 5 who know and can follow the correct treatment for priority health conditions by Dec 2012		259,767,563.81

			7.1.5.1	Improve information to communities in a form that is accessible and useful/ gender sensitive		Readiness of communities to use information provided	17,006,424.36
			7.1.5.2	Development of indicators on health system performance in the state		Long -term political stability and communities re-engage in public management of health services	38,217,741.99
			7.1.5.3	Establishment of health Service Charters at all levels in the state to enforce citizen's rights to quality basic health services		Readiness to enforce citizens charters	
			7.1.5.4	Capacity building of communities to prevent and manage priority health conditions through appropriate self-medicated mechanisms such as behaviour change communication (BCC), social marketing, public awareness campaign, information, education and communication (IEC) resources etc.		Community involvement in health service has positive impact	12,343,372.52
			7.1.5.5	Organize quarterly sensitization meetings between senior SMOH officials and community leadership			192,200,024.94
		7.1.6	To engage with traditional health practitioners		1. Availability of traditional medicine practioner's policy 2. No of traditional health practioners trained and referring properly		192,081,151.41
			7.1.6.1	Registration of traditional health practitioners in the state		Unwillingness of the practitioners to be registered	33,592,248.29
			7.1.6.2	Adoption of traditional practices and technologies of proven value into state health care system and discouragement of harmful ones		Traditional health practitioners has positive health outcomes	
			7.1.6.3	Training of traditional health practitioners to improve their skills, to know their limitations and ensure the use of referral system.		Reduction of risks associated with harmful practices	54,475,417.37
			7.1.6.4	Adapt and implement the traditional medicine practitioner's policy.			52,006,742.87
			7.1.6.5	Strengthen traditional medicine practitioners bodies /originations for easy of regulating their practice			52,006,742.87
RESEARCH FOR HEALTH							**1,433,205,811.05**
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							1,028,721,824.55
	8.1	**To strengthen the stewardship role of governments at all levels for research and knowledge management systems**			**1. ENHR Committee established by end 2009 to guide health research**		624,237,837.93

					priorities **2. FMOH publishes an Essential Health Research agenda annually from 2010**		
		8.1.1	To develop health research policy at State level and health research strategies at State and LGA levels		Availabiliy of health research policy at the state level 2. Health resaerch technical and steering committees formed		19,056,035.09
			8.1.1.1	Adoption and implementation of National Health Research policy in the state		the political will and technical capacity exist to develop policies and strategies	14,896,043.10
			8.1.1.2	Establishment of Health research technical groups and steering committees to handle research activities at State and LGAs levels		Lack of cooperation among committee members	4,159,991.99
		8.1.2	To establish and or strengthen mechanisms for health research at all levels		Research units established at State and LGAs 2. SMOH and LGAs research units properly staffed by qualified people		78,893,724.78
			8.1.2.1	Provide guidelines for setting up steering committees and strengthen the research units at DPRS SMOH and create a research units in the Health Departments at LGAs		Availability of qualified staff to man the units	20,686,847.22
			8.1.2.2	Deployment and or training of health research officers at all levels		Lack of political will	58,206,877.56
		8.1.3	To institutionalize processes for setting health research agenda and priorities		ENHR under taken annually by State and LGAs		429,033,390.35
			8.1.3.1	Adoption of guidelines and implementation of essential health reseach (ENHR) programmes		Research capacity exist for ENHR	425,558,000.02
			8.1.3.2	Establish functional institutional structures for research			3,475,390.33
		8.1.4	To promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, development partners and other sectors		1. Availability of guidelines for collaborative research. 2. SMOH and LGAS researchunit have established crdible forums for research activities.		80,769,223.90
			8.1.4.1	Establishment of forum for research users such as policy makers and universities at state and LGAs levels		Willingness of different actors to form the forum	16,153,844.78

			8.1.4.2	Convening of annual stakeholders' meeting to identify research priorities and harmonise research efforts		Effective research coordination	16,153,844.78
			8.1.4.3	Establishment of budgetary allocation for health research activities in the state and LGAs		Existence of political and adminstrative will.	16,153,844.78
			8.1.4.4	Adapt and disseminate guidelines for collaborative research agenda		Capacity exist to develop guidelines	16,153,844.78
			8.1.4.5	Support development of research proposals and their implementation		Capacity exist to develop guidelines	16,153,844.78
		8.1.5	To mobilise adequate financial resources to support health research at all levels		SMOH and 50% of LGAs allocating 2% of health budget for research		8,831,481.05
			8.1.5.1	Allocation of at least 2% of health budget to health research at all levels		Existanceof political will by goverments and active cooperation of Ministry for Local Government	3,970,128.11
			8.1.5.2	Identification of alternate funding source for health research in the state		Existanceof political will by goverments and active cooperation of Ministry for Local Government	4,861,352.95
		8.1.6	To establish ethical standards and practise codes for health research at all levels		Functional ethical review committees established and strengthened		7,653,979.80
			8.1.6.1	Establishment of ethical review committees for health research in the state		Adequate qualified people will to undertake the role	2,266,152.50
			8.1.6.2	Strengtening of monitoring and evaluation mechanism to regulate research and use of research findings at all level		Researchers are willing to submit their studies.	3,121,677.75
			8.1.6.3	Provide 2% of health budget for health research at State and LGA levels.		Lack of capacity to promote guidelines on ethical standards.	2,266,152.50
	8.2	**To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels**			**FMOH has an active forum with all medical schools and research agencies by end 2010**		286,414,083.90
		8.2.1	To strengthen identified health research institutions at all levels		1. No. of health institutions strengthned 2. 10% increase in number of researches undertaken		30,028,238.37
			8.2.1.1	Conduct periodic capacity of health research organinzations and institutions		Avialability of funds to conduct periodic	945,684.44

						capacity of health research organizations	
			8.2.1.2	Develop and implement measures to address research capacity gaps/weaknesses at State and LGAs level		Resource availability to undertake the assessment	15,783,866.43
			8.2.1.3	Mobilize funds from the pravite sector, foundations and individuals for health research		Willigness pravite sector to participate.	13,298,687.50
		8.2.2	To create a critical mass of health researchers at all levels		50% increase in number of researchers undertaking research relevant to evidence based policy making		56,536,872.71
			8.2.2.1	Create a critical mass of researchers in conjunction with training institutions		Availability of resources	3,342,122.71
			8.2.2.2	Adapt appropriate training interventions for research based on the identified needs		Political will exist	53,194,750.00
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels		One research policy makers forum held annually at State and LGAs level 2. No. of researchers involved in policy making by 2011		17,930,948.39
			8.2.3.1	Development of evidence based policy mechanism for translating research findings into policies making process in the state		Existance of political will and capacity to to use research findings to aid evidence based policy making	7,127,951.69
			8.2.3.2	Involve wide range of actors including resaerch producers in policy- making consultations.		Willingness of all the actors to work together	10,802,999.65
		8.2.4	To undertake research on identified critical priority areas		Biennial HRH, financial risk protection, HIV & AIDS, health delivery systems, disease burden studies conducted		181,918,024.42
			8.2.4.1	Identification of priority areas for research in the state and LGA		Existance of resources and political will by the government and development partners	4,602,191.08
			8.2.4.2	Conduct research on HRH, financial risk protection, HIV & AIDS, health delivery systems, disease burden etc.			177,315,833.34
	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**			**1. All States have a Health Research**		90,572,927.67

					Unit by end 2010 2. FMOH and State Health Research Units manage an accessible repository by end 2012		
		8.3.1	To develop strategies for getting research findings into strategies and practices		50% of health strategies are informed by research findings.		
			8.3.1.1	Instituion of bi-annual health research-policy forums at all levels.		Readiness of research producers to openly share their findings.	
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system		Needs assessment conducted and operational research undertaken at State level		90,572,927.67
			8.3.2.1	Conduct needs assessment to identify research gaps		Aviability of resources	45,286,463.84
			8.3.2.2	Undertake operational research in collaboration with public and non public reseach organization, thereby addressing gaps in research capacity in government institutions.			45,286,463.84
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**			**A national health research communication strategy is in place by end 2012**		27,496,975.06
		8.4.1	To create a framework for sharing research knowledge and its applications				27,352,888.21
			8.4.1.1	Development of a framework for sharing research knowledge at all levels		Availability of framework for sharing research knowledge	720,050.05
			8.4.1.2	Institution of annual health conferences, seminars and workshops on key thermatic areas such as financing, MDGs, health research, etc.		Willingness of leadership in the state	26,632,838.17
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners				144,086.85
			8.4.2.1	Development of a framework for sharing research knowledge at all levels		Availability of framework for sharing research knowledge	144,086.85
Total cost							**71,660,290,553.11**

Annex 2: Results/M&E Matrix for the Strategic Health Development Plan

BENUE 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	40	75	100%
2. Improved Legislative and Regulatory Frameworks for Health Development	2. State implementing the National Health Bill? (Yes/No)	SMOH	0	25	50	75
	3. Number of Laws and by-laws regulating traditional medical practice at State and LGA levels	Laws and bye-Laws	0	25	40	65
3. Strengthened accountability, transparency and responsiveness of the State health system	4. % of LGAs which have established a Health Watch Group	LGA Annual Report	0	30	65	100
	5. % of recommendations from health watch groups being implemented	Health Watch Groups' Reports	No Baseline	25	50	75
	6. % LGAs aligning their health programmes to the SSHDP	LGA Annual Report	0	25	50	100
	7. % DPs aligning their health programmes to the SSHDP at the LGA level	LGA Annual Report	No Baseline	25	50	100
	8. % of LGAs with functional peer review mechanisms	SSHDP and LGA Annual Review Report	0	25	50	100%
	9. Number of LGA Health Watch Reports published	Health Watch Report	0	25	50	100

4. Enhanced performance of the State health system	10. % LGA public health facilities using the essential drug list	Facility Survey Report	0	40	70	100%
	11. % LGA health facilities not experiencing essential drug/commodity stockouts in the last three months	Facility Survey Report	TBD	25	50	100%
	12. 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	0	25	50	75
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
Outcome 3: Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographic areas						
Outcome 4: Improved quality of primary health care services						
Outcome 5: Increased use of primary health care services						
5. Improved access to essential package of Health care	13. % of LGAs with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	0	25	50	75%
	14. % health facilities implementing the complete package of essential health care	NPHCDA Survey Report	TBD	50	75	100%
	15. % of the population having access to an essential care package	MICS/NDHS	TBD	40	65	80%
	16. Contraceptive prevalence rate	NDHS	13	25%	50	75%
	17. Number of new users of modern contraceptive methods (male/female)	NDHS/HMIS	TBD	25%	50%	75%
	18. % women age 15-19 who have begun child rearing	NDHS/MICS	23%	18%	14%	5%
	19 . % of pregnant women with 4 ANC visits performed according to standards*	NDHS	45	60	75	80%
	20. Proportion of births attended by skilled health personnel	HMIS	52	65	75	90
	21. Proportion of women with complications treated	EmOC Sentinel Survey and	TBD	50	60	70%

	in an EmOC facility (Basic and/or comprehensive)	Health Facility Survey				
	22. Caesarean section rate	EmOC Sentinel Survey and Health Facility Survey	TBD	10%	20%	30%
	23. Case fertility rate among women with obstretic complications in EmOC facilities per complication	HMIS	TBD	40%	30%	25%
	24. % of children exclusively breastfed 0-6 months	NDHS/MICS	17%	35%	50%	60%
	25. Proportion of 12-23 months-old children fully immunized	NDHS/MICS	21.50%	40%	65%	80%
	26. % children <5 years stunted (height for age <2 SD)	NDHSMICS	37.00%	25%	20%	15%
	27. % of under-five that slept under LLINs the previous night	NDHS/MICS	2.00%	50%	75%	90%
	28. % of under-five children receiving appropriate malaria treatment within 24 hours	NDHS/MICS	36.50%	50%	65%	80%
	29. % of women who received intermittent preventive treatment for malaria during pregnancy	NDHS/MICS	2%	30	50	75
	30. HIV prevalence rate among adults 15 years and above	BENSACA	23.40%	15	10	5
	31. HIV prevalence in pregnant women	BENSACA	13.20%	8	6	4
	32. Proportion of population with advanced HIV infection with access to antiretroviral drugs	BENSACA	29.4	50	70	100
	33.Condom use at last high risk sex	NDHS/MICS	TBD	50	70	100
	34. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS	21	40	60	80
	34. Prevalence of tuberculosis	NARHS	2.50%	1.5	1	0.5
	35.Death rates associated with tuberculosis	NMIS	7	5	3	2

	37. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NMIS	72	80	90	100
Output 6. Improved quality of Health care services	38. % of staff with skills to deliver quality health care appropriate for their categories	Facility Survey Report	TBD	30%	50%	75%
	39. % of facilities with capacity to deliver quality health care	Facility Survey Report	TBD	30%	50%	75%
	40. % of health workers who received personal supervision in the last 6 months by type of facility	Facility Survey Report	TBD	25%	50%	75%
	41. % of health workers who received in-service training in the past 12 months by category of worker	HR survey Report	TBD	20%	40%	60%
	42. % of health facilities with all essential drugs available at all times	Facility Survey Report	TBD	40%	60%	80%
	43. % of health institutions with basic medical equipment and functional logistic system appropriate to their levels	Facility Survey Report	TBD	25%	40%	75%
Output 7. Increased demand for health services	44. Proportion of the population utilizing essential services package	MICS	TBD	30%	50%	75%
	45. % of the population adequately informed of the 5 most beneficial health practices	MICS	TBD	30%	60%	80%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH **NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care**						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
Outcome 6. The Federal government implements comprehensive HRH policies and plans for health development						
Outcome 7.All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015						
Output 8. Improved policies and Plans and strategies for HRH	46. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Facility Survey Report	TBD	25%	40%	60%
	47. % LGAs actively using adaptations of National/State HRH policy and plans	HR survey Report	TBD	25%	40%	60%

Output 8: Improved framework for objective analysis, implementation and monitoring of HRH performance	48. % LGAs making availabile consistent flow of HRH information	NHMIS	0	30	50%	100%
	49. CHEW/10,000 population density	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	50. Nurse density/10,000 population	MICS	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	51. Qualified registered midwives density per 10,000 population and per geographic area	NHIS/Facility survey report/EmOC Needs Assessment	TBD	1:8000 pop	1:6000 pop	1:4000 pop
	52. Medical doctor density per 10,000 population	MICS	TBD	1:8000 pop	1:7000 pop	1:5000 pop
	53. Other health service providers density/10,000 population	MICS	TBD	1:4000 pop	1:3000 pop	1:2000 pop
	54. HRH database mechanism in place at LGA level	HRH Database	TBD	50%	75%	100%
PRIORITY AREA 4: FINANCING FOR HEALTH **NSHDP GOAL 4 : To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal Levels**						
Outcome 8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy						
Outcome 9. The Nigerian people, particularly the most vulnerable socio-economic population groups, are protected from financial catastrophe and impoverishment as a result of using health services						
Output 11: Improved protection from financial catastrophy and impoversihment as a result of using health services in the State	55. % of LGAs implementing state specific safety nets	SSHDP review report	TBD	25%	50%	75%
	56. % of LGAs which allocate costed fund to fully implement essential care package at N5,000/capita (US$34)	State and LGA Budgets	TBD	25%	40%	60%
	57. LGAs allocating health funding increased by average of 5% every year	State and LGA Budgets	TBD	25%	50%	70%

Output 12: Improved efficiency and equity in the allocation and use of Health resources at State and LGA levels	58. % of LGA budget allocated to the health sector.	National Health Accounts 2003 - 2005	2%	10%	20%	30%
	59. % of LGAs having operational supportive supervision and monitoring systems	SSHDP review report	TBD	25%	40	50%
PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM						
NSHDP GOAL 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						
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	60. % of LGAs making routine NHMIS returns to states	NHMIS Report January to June 2008; March 2009	20%	50%	65%	85%
	61. % of LGAs receiving feedback on NHMIS from SMOH		TBD	25%	50%	75%
	62. % of health facility staff trained to use the NHMIS infrastructure	Training Reports	TBD	40%	60%	90%
	63. % of health facilities benefitting from HMIS supervisory visits from SMOH	NHMIS Report	TBD	25%	40%	60%
	64.% of HMIS operators at the LGA level trained in analysis of data using the operational manual	Training Reports	TBD	40%	75%	100%
	65. % of LGA plans using the HMIS data	NHMIS Report	TBD	40%	75%	100%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
Outcome 12. Strengthened community participation in health development						
Outcome 13. Increased capacity for integrated multi-sectoral health promotion						
Output 14: Strengthened Community Participation in Health Development	66. Proportion of public health facilities having active committees that include community representatives (with meeting reports and actions recommended)	SSHDP review report	TBD	25%	50%	75%

	67. % of wards holding quarterly health committee meetings	HDC Reports	TBD	25%	50%	75%
	68. % HDCs whose members have had training in community mobilization	HDC Reports	TBD	40%	75%	100%
	69. % increase in community health actions	HDC Reports	TBD	10%	25%	50%
	70. % of health actions jointly implemented with HDCs and other related committees	HDC Reports	TBD	25%	40%	60%
	105. % of LGAs implementing an Integrated Health Communication Plan	HPC Reports	TBD	25%	40%	60%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
Outcome 14. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the						
	71. % LGAs holding annual multi-sectoral development partner meetings	SSHDP Report	TBD	25%	50%	75%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
Outcome 15. Research and evaluation create knowledge base to inform health policy and programming.						
	72. % of State health budget spent on health research and evaluation	State budget	TBD	1%	1.50%	2%
	73 % of LGAs holding quarterly knowledge sharing on research, HMIS and best practices	LGA Annual SHDP Reports	TBD	10%	25%	50%
Output 17: Health research communication strategies developed and implemented	74. % LGAs aware of state health research communication strategy	Health Research Communication Strategy	TBD	40%	75%	100%