Federal Ministry of Health





NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN (NSHDP) 2010 - 2015

November 2010

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Preface

Successive Governments have strived to improve the health status of Nigerians. Through a series of national development plans and annual budgets, modest progress was made, in the past. Over the past decade however, there have been major reversals on the gains of the health sector. Childhood immunization plummeted and life expectancy reportedly dropped to mid 40-years. Unfortunately, the strides in the sector has been much too slow. The country is largely challenged in achieving the Millennium Development Goals by 2015.

With the advent of a new decade, and a renewed leadership system of the Federal Ministry of Health, the health sector is poised to reposition itself to implement and institute result oriented programmes within the context of the MDG and national targets as enshrined in the National Vision 20:2020, and a new National Health Plan.

In an unprecedented collaborative and fully participatory national process, key stakeholders at all levels in the health sector – Federal, States, LGAs, partners both international and domestic, civil society organizations, etc, - have evolved a uniform national health development framework thereby putting in place the first ever truly National Health Plan through an associated Results (Targets/Indicators) Framework, that is consistent and elaborate on the Vision 20:2020 Human Capital Development aspirations. This is hoped will serve as a standard against which the progress from 2010 to 2015 will be measured- in the first instance- and beyond, as we match towards Vision 20:2020.

The National Strategic Health Development Plan (or NSHDP) - reflects shared aspiration to strengthen the national health system and to vastly improve the health status of Nigerians. The Plan is the overarching reference health development document for all actors towards delivery on a shared Results Framework, to which each and everyone will be held accountable for achieving the goals and targets as contained in the Results Framework. The Health Plan, which was also developed in tandem with the guidelines of the National Planning Commission – Vision 20:2020 process (including the NV20:2020 Implementation Plan), is the compass or reference for the health sector Medium Term Sector Strategy (MTSS) and annual operational plans and budgets at all levels.

The development of the NSHDP involved inputs from a vast number of people and agencies. Public health experts from the Government and academia took the lead in preparing evidence-based background studies for the work of the NSHDP Technical Working Group (TWG) in drafting a framework for the plan's focus areas and objectives. The NSHDP Steering Committee provided guidance to steer the process. The Department of Health Planning, Research & Statistics at the Federal Ministry of Health in conjunction with the NSHDP Reference Group expertly managed the process. It is note-worthy that the success of this effort is due to the overwhelming and enthusiastic engagement of the nationwide contributory and consultative public meetings.

The knowledge, commitment, and collaboration of these groups combined, in the first instance, to produce the NSHDP Framework. It was then formalized, for use, by the National Council on Health (the highest health policy advisory body in Nigeria), to develop the National Health Plan and its Results Framework. The emerging plan was endorsed by the National Council on Health on March 16, 2010, during the tenure of Professor Babatunde Osotimehin as Minister of

Health. The Plan was subsequently approved by the Federal Executive Council on November 10, 2010.

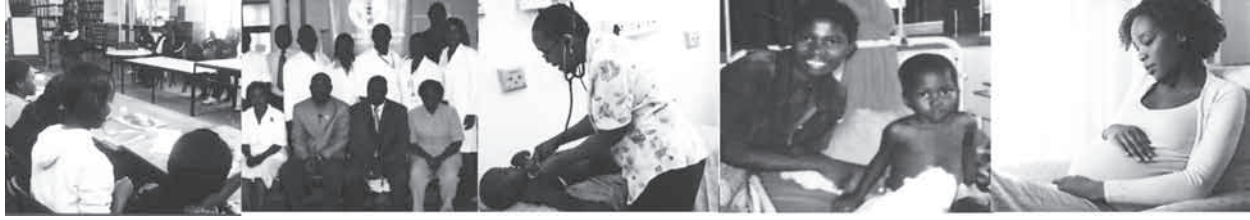
The emerging plan is more comprehensive than previous attempts. There are Eight (8) Priority Areas of Focus for the National Health Plan, divided into goals (8); strategic objectives/programmes (33); strategic interventions (70); and translation into various activities for implementation by different levels of stakeholders, including partners, thus making the National Health Plan 2010 – 2015 an encyclopaedic compilation of health investments and improvement opportunities with result oriented short and long term focal view addressing the noble ideals of the nation's Vision 20:2020.

Our health-demography suggests that we are faced with several epidemiological profiles: massive but preventable communicable infectious disease, side-by-side a growing life-style induced worsening health conditions, with excessive mortality at younger ages, and impacting negatively on the average life expectancy of Nigerians' average life expectancy at birth, and even at older ages. There is also a staggering health inequalities and disparities among different groups, hence the need to take measures to eliminate these disparities. So, for the first time a set of shared health indicators in the NSHDP Results Framework are aimed to help all actors focus on the required actions to improve health in Nigeria by strengthening the primary health care approach.

On behalf of the Federal Ministry of Health, I appreciate and congratulate all the numerous individuals, institutions, and our development partners that have worked so hard together to create this National Health Plan document. But this is just the beginning of our march towards delivering, investing and financing RESULTS to change our national health fortune for better health in Nigeria. I implore us all, including our development partners, to remain guided by this plan in meeting the aspirations of the health component of the National Vision 20:2020 to achieve better health in Nigeria.

On its part, the Federal Ministry of Health is committed to the faithful implementation of this National Health Plan.

Professor C. O. Onyebuchi Chukwu
Minister of Health
November 11, 2010



Acknowledgement

The National Strategic Health Development Plan – NSHDP - has emerged as a Federal Ministry of Health lead process, mandated by the National Council on Health, to develop a National Health Plan, which later formed part of an elaboration of the health component of the National Vision 20:2020.

The Plan was prepared through an elaborate collaborative process involving all major stakeholders; Federal Government agencies and individuals from the Federal Ministry of Health, National Planning Commission, Federal Ministry of Finance, the Budget Office of the Federation, Office of the Senior Special Assistant to the President on Millennium Development Goals; the National Assembly Senate and House Committees on Health, and other relevant Sub-Committees of the National Assembly, such as the House and Senate Sub-Committees on MDGs; all the States Ministries of Health and the FCT Department of Health Services and Local Governments Health Departments; academia and public health experts, development partners, including the UN agencies, HHA (Harmonization for Health in Africa) partnership – WHO, UNICEF, UNFPA, UNAIDS, African Development Bank, the World Bank; USAID, IHP+ partnership, DFID through PATHS2, CIDA, JICA, and many other Bilateral organizations; Foundations, Funds, Civil Society organizations etc.

Managerially, the production of the Plan was coordinated by the Department of Health Planning, Research & Statistics of the Federal Ministry of Health in close collaboration with the NSHDP Reference Group, the NSHDP Technical Working Group (TWG) and the health sector Vision20:2020 National Technical Working Group.

Finally, commendation must go to the National Council on Health for its foresight in mandating the preparation of this ONE Health Plan for the country and to Mr. President and the State Governors for adopting a National Partnership on Health Declaration on Mutual Accountability for Improved and Measurable Health Results in Nigeria based on the implementation of the National Health Plan.

Dr. Muhammed M. Lecky
Director, Health Planning, Research & Statistics,
Federal Ministry of Health
Chair, NSHDP Reference Group

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
ART	Anti-Retroviral Therapy
AU	African Union
B-EOC	Basic Emergency Obstetric Care
CBN	Central Bank of Nigeria
CBSHIP	Community-Based Social Health Insurance Programme
CCTs	Conditional Cash Transfers
C-EOC	Comprehensive Emergency Obstetric Care
CHO	Community Health Officer
CHW	Community Health Worker
CSO	Civil Society Organization
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment Short-course
DP	Development Partner
DPRS	Department of Planning Research and Statistics
DRG	Debt Relief Gains
FCT	Federal Capital Territory
FIRS	Federal Inland Revenue Service
FMF	Federal Ministry of Finance
FMOH	Federal Ministry of Health
FP	Family Planning
FRSC	Federal Road Safety Commission
GDP	Gross Domestic Product
HDCC	Health Data Consultative Committee
HF	Health Facility
HHA	Harmonization for Health, Africa
HHHE	House-hold Health Expenditure
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMB	Hospital Management Board
HRH	Human Resources for Health
ICT	Information Communications Technology
IHP+	International Health Partnerships
IMCI	Integrated Management of Childhood Illnesses
IPTp	Intermittent Preventive Treatment
ISS	Integrated Supportive Supervision
ITN	Insecticide Treated Net
LGA	Local Government Area
LGHE	Local Government Health Expenditure
MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
MDGs	Millennium Development Goals
MDR	Multi Drug Resistant
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Cluster Survey
MRCN	Medical Research Council of Nigeria
MTSS	Medium Term Sector Strategy
NACA	National Action for Control of AIDs
NAFDAC	National Agency for Food and Drug Administration and Control
NARHS	National AIDS and Reproductive Health Survey
NCDs	Non-Communicable Diseases
NCH	National Council on Health
NDHS	National Demographic and Health Survey
NDP	National Development Plan

NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NIMR	Nigeria Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NPHCDA	National Primary Healthcare Development Agency
NSHDP	National Strategic Health Development Plan
NSTDA	National Science and Technology Development Agency
ODA	Official Development Assistance
OOPE	Out-Of-Pocket Expenditure
OPS	Organised Private Sector
ORT	Oral Rehydration Therapy
OSSAP	Office of the Senior Special Assistant to the President
PBF	Performance Based Financing
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PITC	Provider Initiated Testing and Counseling
PMTCT	Preventing Mother to Child Transmission
PPP	Public Private Partnerships
P/PROM	Preterm/Prelabour Rupture of Membrane
QALY	Quality Adjusted Life Years
RBF	Results Based Financing
SHDP	Strategic Health Development Plan
SHI	Social Health Insurance
SMOH	State Ministry of Health
SSA	Sub-Saharan Africa
SGHE	State Government Health Expenditure
STHE	State Total Health Expenditure
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
THE	Total Government Health Expenditure
THE	Total Health Expenditure
USD	United State Dollars
USAID	United States Agency for International Development
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAT	Value Added Tax
VLBW	Very Low Birth Weight
VOC	Vote-Of-Charge
VPD	Vaccine Preventable Diseases
WDI	World Development Index
WHO	World Health Organization

Presidential Summit Health Declaration

NATIONAL PARTNERSHIP ON HEALTH: DECLARATION ON MUTUAL ACCOUNTABILITY FOR IMPROVED AND MEASURABLE HEALTH RESULTS IN NIGERIA BY THE PRESIDENT OF THE FEDERAL REPUBLIC OF NIGERIA, EXECUTIVE GOVERNORS OF THE 36 STATES AND FCT MINISTER AT THE PRESIDENTIAL SUMMIT ON HEALTH IN NIGERIA: IMPLEMENTING THE HEALTH SECTOR COMPONENT OF VISION 20:2020

ABUJA, 10th November 2009

WE, the President, Vice-President, Executive Governors and FCT Minister of the Federal Republic of Nigeria, met in Abuja this 10th day of November 2009 on the occasion of the first Presidential Summit on Health Care in Nigeria, held under the theme ***"Accepting collective responsibility for improving our health in Nigeria"***;

2. **RECOGNIZING** that a healthy and economically productive population that is growing at a sustainable pace, supported by a health care system that caters for all, sustains a life expectancy of not less 70 years and reduces to the barest minimum the burden of infectious and other debilitating diseases, and emphasizing that the Nigerian health sector is vital to sustainable socio-economic development for achieving the goal of Vision 20:2020;

3. **DEEPLY CONCERNED** that Nigeria is not on track towards significant improvement in meeting the health expectations of its people, inclusive of achieving the health MDGs;

4. **RECOGNIZING** that the key challenges for achieving national health objectives are related to the weak health system characterized by constrained governance systems and structures, low levels of health care financing and poor predictability and release of funds with inadequate financial protection for the poor, shortage and mal-distribution of human resources for health, poor quality service delivery, inadequate and untimely availability of quality health commodities, lack of routine health services data, low levels of research for health, weak partnership and coordination, as well as poor community participation and poor utilization of health services, particularly child and maternal services, to mention a few;

5. **RE-AFFIRMING** the principles of health as a basic human right and the leadership role of government in the health of its people;

6. **AWARE** of the cross-cutting nature of health and the importance of inter-sectoral collaboration in the achievement of improved health outcomes through equitable access to health services;

7. **WELCOMING** the significant progress made towards the interruption of wild polio virus transmission following renewed commitments to the Abuja declaration to eradicate poliomyelitis and engagement of political, traditional and religious leadership with stakeholders; believing that such levels of commitments would be sustained, increased and deployed to other health interventions at community, LGA and State levels.

8. **APPRECIATING** the support of all partners active in the Nigerian health sector, civil society organizations, particularly women and youth focused groups, Private Sector, Traditional and Religious

Institutions, and the communities inclusive of multilateral and bilateral organizations;

WE HEREBY COMMIT OURSELVES TO SIGNIFICANTLY IMPROVE THE HEALTH STATUS OF NIGERIANS THROUGH THE DEVELOPMENT OF A STRENGTHENED AND SUSTAINABLE PRIMARY HEALTH CARE DELIVERY SYSTEM BY:

9. **ESTABLISHING** National and State level Partnerships led by Mr. President and the Governors respectively for accelerating the annual progress towards improvement of health outcomes for Nigerians irrespective of location, gender, age, or socio-economic status;

10. **COMMITTING** to the results oriented National Strategic Health Development Plan, State Strategic Health Development Plan and their attendant annual operational plans with appropriate costs and budgets as part of the continued implementation of the health sector component of Vision 20:2020;

11. **LAUNCHING** with a call to action at state and LGA levels, the State Strategic Health Development Plans (SHDPs) in our respective states for timely and integrated implementation of interventions and activities, as well as laying emphasis on achieving improved health results;

12. **REAFFIRMING** our commitment to the Primary Health Care (PHC) approach and henceforth adopting effective governance and coordination including establishment of state primary health care agencies/ boards or its equivalent;

13. **INCREASING** budget allocations to health at the Federal, State and LGAs from the present level by at least 25% each year towards achieving the Abuja Declaration target of 15%; committing to at least 90% budget release and 100% utilization by the end of the year;

14. **ESTABLISHING** pro-poor financial protection systems, including provider incentives to implement fee exemptions for the poor and vulnerable groups and appropriate risk pooling mechanism such as social and community health insurance;

15. **COMMITTING t**o effective implementation of integrated, high impact interventions, and to deliver for our respective states on the following results and targets:

    i. *Reducing infant and under-five mortality* from present levels (75/1,000 Live-Births and 157/1,000 Live-Births respectively) by half by 2015;

    j. To have decreased prevalence of underweight children under 5 (U 5) years of age to 18% by 2015;

    k. Interrupt wild polio virus transmission by 2010

    l. Increase percentage of Children aged 12-23 months who are fully immunized by at least 25% annually and to have attained 80% by 2015

    m. Achieve 80% of 1 year olds immunized against measles by 2015

    n. *Reducing Maternal mortality ratio* by a third from present level (545/100,000 Live-Births) by 2015;

    o. Increase by at least 10% annually (from present level of 37%), the proportion of births attended by skilled health

personnel and to have achieved at least 80% Nationally by 2015;

p. Increase by at least 10% annually the percentage of pregnant women with four antenatal care visits by 2015;

q. Achieve universal access to reproductive health by 2015;

r. To have halted by 2015 and begun to reverse *the spread of HIV/AIDS,*

s. *To have halted by 2015 and begun to reverse incidence of malaria and other diseases*;

t. To have reduced the prevalence of Malaria in children under the age of five (5) years by at least 25% annually from present level (198/10,000) and to achieve 75% reduction by 2015 using an integrated approach;

16. **ADDRESSING** all the human resources for health challenges, including incentives-based deployment to rural and underserved locations, direct implementation of the Midwifery Services Scheme, as well as up-scaling the production of human resources for health;

17. **IMPROVING** infrastructure planning and investments targeted at underserved populations, inclusive of maintenance and operational costs;

18. **ESTABLISHING AND STRENGTHENING** partnerships with the private sector and other health service providers such as non governmental organizations, military, etc towards improved access and service coverage;

19. **ACHIEVING** timely availability of quality health commodities and supplies at all levels within federal, state and Local Government owned facilities, as applicable;

20. **DIRECTING** our principal officers at federal, state and Local Government levels to forge inter-sectoral collaborations for an integrated, well-coordinated and comprehensive response to the health challenges of our state and the nation, including events that may constitute public health emergencies of national and international concerns, such as Human Influenza and other diseases that have potential to spread rapidly across international boundaries;

21. **ENSURING** effective coordination and collaboration with development partners in the health sector at federal, State and Local Government levels, as well as private sector, CSOs, Traditional and Religious Institutions, and the communities, particularly on demand creation for health services;

22. **COMMITTING** to strengthening the National Health Information System to serve as the backbone for managing for results;

23. **ENDORSING** the establishment of a joint monitoring mechanism based on the National Monitoring and Evaluation/Results Framework, with an enabling Fund, database and scorecard, to chart the progress of implementation on a regular basis (annual, semi-annual, and quarterly for federal, state and LGA respectively) of the decisions reflected in this declaration and as stated within the National and State Strategic Health Development Plans;

24. **ENSURING** the provision of periodic reports on the status of implementation to the National Economic Council and the hosting

of an annual review of performance by Federal, States and Local Government Areas along the benchmarks set out in our state and national plans' results indicators framework; and

25. **IMPLEMENTING** the decisions and recommendations of this first Presidential Summit on Health Care in Nigeria.

Commitments made in Abuja, Nigeria on 10th of November 2009 by the Federal and State Governments. Signed by the thirty six (36) State Governors and FCT Minister. Endorsed by the President and the Vice President on 19th August 2010

S/N	DESIGNATION	NAME	SIGNATURE
1	President of the Federal Republic of Nigeria	Goodluck E. Jonathan	
2	Vice President of the Federal Republic of Nigeria	Arc: SAMBO M.N.	
3	Executive Governor, Abia State	ORJI, T.A	
4	Executive Governor, Adamawa State	Murtala H. Nyako	
5	Executive Governor, Akwa Ibom State	Godswill Akpabio	
6	Executive Governor, Anambra State	MR PETER OBI	
7	Executive Governor, Bauchi State	Isa Yuguda	
8	Executive Governor, Bayelsa State	Chief Timipre Sylva	
9	Executive Governor, Benue State	Suswam Torwua	
10	Executive Governor, Borno State	Senator Ali SHARIF	
11	Executive Governor, Cross River State	LIYEL IMOKE	
12	Executive Governor, Delta State	DR. E.E. UDUAGHAN	
13	Executive Governor, Ebonyi State	Chief MARTIN N. ELECHI	
14	Executive Governor, Edo State		
15	Executive Governor, Ekiti State	SEGUN ONI	
16	Executive Governor, Enugu State	Chime	
17	Executive Governor, Gombe State	M.D. Goje	
18	Executive Governor, Imo State		
19	Executive Governor, Jigawa State	Ahmed M. Gumel	
20	Executive Governor, Kaduna State	Arc: Sambo M.N.	
21	Executive Governor, Kano State	A. T. Mohd	
22	Executive Governor, Katsina State		
23	Executive Governor, Kebbi State		
24	Executive Governor, Kogi State		
25	Executive Governor, Kwara State		
26	Executive Governor, Lagos State		
27	Executive Governor, Nasarawa State		
28	Executive Governor, Niger State		
29	Executive Governor, Ogun State		
30	Executive Governor, Ondo State		
31	Executive Governor, Osun State		
32	Executive Governor, Oyo State		
33	Executive Governor, Plateau State		
34	Executive Governor, Rivers State		
35	Executive Governor, Sokoto State		
36	Executive Governor, Taraba State		
37	Executive Governor, Yobe State		
38	Executive Governor, Zamfara State		
39	Honourable Minister, FCT Abuja		

Executive Summary

Background: Nigeria is a country on the West Coast of Africa that operates a Federal System of Government with three levels: the Federal, the State and the Local Government Areas/Councils (LGAs). The country has a population of about 150 million[1] making it the most populous African country in the world.

Nigeria recognizes that a healthy population is important for socio-economic development. This has been underscored in the Vision20:2020, and the National Development Plan. Consequently, the government is committed to reduce the morbidity and mortality rates and significantly increase the life expectancy and quality of life of its people. There are therefore concerted efforts to develop and implement appropriate policies and programmes that will strengthen the National Health System based on the principle of primary Health Care in line with the Ouagadougou and Abuja declarations.[2]

Situation Analysis: The health indicators for Nigeria are among the worst in the world. Nigeria shoulders 10% of the global disease burden and is making slow progress towards achieving the 2015 targets for the health related MDGs. The health indicators in Nigeria have largely remained below country targets and internationally-set benchmarks due to weaknesses inherent its health system.

The Federal Government of Nigeria, through the Federal Ministry of Health is convinced that a purposeful reform of the National Health Care Delivery System is necessary for strengthening the weak and fragile National Health Care Delivery System and improving its performance. The government, thus, initiated a process that led to the development of the National Strategic Health Development Plan: 2010-2015 (NSHDP) which was developed in a highly participatory manner.

The NSHDP will also serve as the overarching framework for health development in Nigeria. It draws inspiration from 36 State and the FCT Health Development Plans (SHDP). It has the following eight strategic priority areas:

- Leadership and Governance for Health;
- Health Service Delivery;
- Human Resources for Health;
- Financing for Health;
- National Health Management Information System;
- Partnerships for Health;
- Community Participation and Ownership; and
- Research for Health.

Highly cost effective services in dealing with the major health challenges in Nigeria will be made available. As such a set of specific “high impact services” would constitute a core part of the service delivery to the Nigerian population. These services are specified in the NSHDP and will be implemented in an integrated manner.

The final NSHDP was approved by the National Council on Health (NCH) during its 53rd session which took place in Asaba, Delta State

[1]Projected from. Nigeria National Population Commission 2006 population census figures. NPC 2006.

[2]Ouagadougou Declaration on Primary Health Care And Health Systems In Africa: Achieving Better Health For Africa In The New Millennium. Available at [http://www.afro.who.int/en/divisions-a-programmes/dsd/health-policy-a-service-delivery/hps-publications/doc_details/2135-ouagadougou-declaration-on-primaire-health-care-and-health-system-in-africa-2008.html].

from March 11-16, 2010. The NCH is the highest policy advisory body in the Nigerian Health Care Service Delivery System.

Results Matrix: A Framework has been developed to serve as a guide to the Federal, State and LGAs in the selection of evidenced-based priority interventions that will contribute to achieving the desired health outcomes for Nigerians.

The Federal, States and LGAs have used this framework to respectively develop their estimated budget plans through participatory approaches to reflect their context and prevailing issues**.**

1. **Monitoring and Evaluation:** The NHSDP Results Matrix provides an excellent summary of key performance indicators to assess the progress of the National Plan. It has a total of 52 indicators covering an essential combination of indicators on impact, outcomes, outputs, process and inputs. A Monitoring and Evaluation (M&E) Framework for the National Strategic Health was developed to encourage the participation of different actors (within the public sector, private-for-profit, private-not-for-profit, NGOs, faith-based organizations, etc.) in harmonizing their data and to be mutually accountable for results at their respective levels.

   In order to complement the National M&E Framework, a generic sub-national M&E framework was developed which the States and LGAs adapted to their own contexts, although indicators selected for sub-national are different from those of the national level.

2. **Estimated costs of the National Strategic Health Development Plan:** The total estimated costs of the NSHDP for the six year period 2010-2015 is NGN3.997 trillion (USD 26.653 billion) with an annual cost and investment requirement of NGN666.3 billion (USD4.442 billion). This gives an annual cost per capita of NGN 4,745 (USD 31.63)[2]. Details of the specific earmarks of each priority area are in the table below.

3. **Financing the Plan:** The interplay of the funding sources and financing agents in the Nigerian health system is critical in ensuring adequate and timely resourcing of the National Strategic Health Development Plan. It will ensure the delivery of high impact and cost effective health services within an enabling environment, and invariably promote universal access to health services. The NSHDP (2010 – 2015) projects significant financial resource needs from the public sector at the Federal, State and LGA levels for each of the eight (8) priority areas. This underscores the importance of predictable and sufficient investments by these tiers of government to achieve the targeted measurable results.

Priority Area	NGN	US$	Percent
Leadership And Governance For Health	27,587,202,750	183,914,685	0.69%
Health Service Delivery	1,946,257,153,350	12,975,047,689	48.68%
Human Resources For Health	1,664,676,299,550	11,097,841,997	41.64%
Financing For Health	218,976,510,300	1,459,843,402	5.48%
National Health Information System	41,605,199,400	277,367,996	1.04%
Community Participation And Ownership	23,913,081,450	159,420,543	0.60%
Partnerships For Health	25,502,477,700	170,016,518	0.64%
Research For Health	49,448,161,050	329,654,407	1.24%
Sum	**3,997,966,085,850**	**26,653,107,239**	**100.00%**

[3]Source: Costing workshop January Abuja

4. **Strategy:** The strategy for financing the NSHDP is not solely dependent on increases in the Federal, State and LGA government spending. It will also require corresponding reactions by all actors in the health sector – Development Partners, CSOs, Private sector and philanthropists. On an annual basis, expenditure plans and budgets need to match available resources to meet the priorities identified by the yearly operational plans. Government and Development partners should ensure flexibility in funding, on a yearly basis, to allow for necessary budget reviews.

5. **Implementation Modalities:** Health authorities at the Federal, State and LGA will implement the NSHDP in collaboration with all stakeholders. The Medium Term Sector Strategy (MTSS) will serve as important tools for implementing the NSHDP through annual operational plans for all planning entities at the Federal, States and LGAs.

   The leadership for the Implementation of the NSHDP will be provided by the Federal Ministry of Health (FMoH) at the Federal Level, State Ministry of Health (SMoH) at the State Level, and Local Government Health Authority.

   The State Health Development Planning level, (SHDP) Steering committees will be established at the Federal and State levels, to monitor the implementation of the plan. The steering committees will be chaired by the Permanent Secretary of the FMoH, at the Federal level, while the Honourable Commissioner for Health and the Chairman of the Local Government Area or the Supervisory Councillor for Health (LHGA) will chair the committees at the State and Local Government levels respectively.

   It will have representatives from the relevant departments/ Units at the FMoH, SMoH and LGA Health Management Team, representatives of the Planning Commission Ministries at all levels, and relevant development Partner Agencies. The committees will be responsible for catalysing the implementation of the plans at each of the levels; mobilising government support for engagement of all stakeholders that are crucial to the implementation of the plans; through advocacy, planning, resource mobilisation and awareness creation.

   Based on peculiar priorities, the Federal, State and LGAs will extract strategic activities from their SHDPs, to develop their MTSS and annual operational plans. These plans will show detailed activities that are linked to key deliverables towards the achievement of the targets of the plans. Technical assistance will be made available to the Federal, State and LGAs, to develop plans with realistic costing and stakeholders' participation in facilitating the implementation. It is the responsibility of the Departments of Planning Research and Statistics at all levels to ensure that these plans are developed annually and to monitor their implementation using a suitable tool that ties deliverables to the results/targets of their respective SHDPs. To this effect, the FMOH will prepare and disseminate specific guidelines on how to operationalise the NSHDP into MTSS and annual operational plans.

6. **Human Resources:** The NSHDP will have a direct influence on resource requirements, mobilization and allocation to the health sector. Core technical staff will be identified in the DPRS at each level; they will be empowered with necessary skills in planning, monitoring and evaluating the tools necessary to facilitate their work. The SHDP implementation steering committee is responsible for identifying resource needs and mobilisation from governments and development partner agencies. Resource mobilization and allocation will be directed towards addressing the health sector priority interventions to achieve the vision and goal of the NSHDP.

7. **Managing Implementation**: The SHDP implementation steering committee and the DPRS at each level will be responsible for

managing the implementation of the SHDPs. This will require provision of TA for development of operational plans; orientation of all stakeholders on the plan and required actions and responsibilities for achieving the targets of the plan; progress review and feedback.

8. **Strategic Partners:** The FMOH will periodically review the overall progress of the implementation of the NSHDP. It will make available a feedback mechanism wherein all the states will highlight their progress towards achieving set targets in the Presidential Health Summit Declaration. Since all State governments have signed onto this declaration, which has committed them to delivering on key results and targets of the NSHDP, this activity will facilitate accountability and provide information that will enable healthy competition among the States. The development partner agencies, CSOs and media will be closely involved in this process.

   The Country Compact on the NSHDP requires Development Partner Agencies to align with and support the implementation of the NSHDP while engaging with the responsible authority at all levels.

Vision

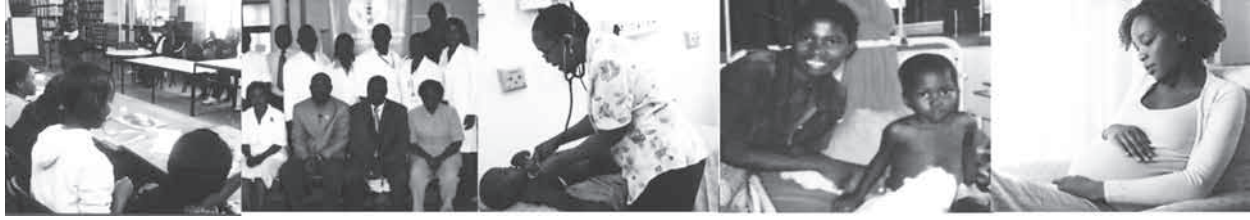
"To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Nigerians".

Mission Statement

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

The overarching goal of the NSHDP is "to significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system".

Key NSHDP Indicators and Targets					
S/N	Indicator	Baseline	Targets		
			2011	2013	2015
1.	Life expectancy at birth	47 years	55 years	63 years	70 years
2.	Under-five mortality rate	157/1000 LBs (NDHS, 2008)	130/1000 LBs	103/1000 LBs	75/1000 LBs
3.	Infant mortality rate	75 (NDHS, 2008)	60/1000 LBs	45/1000 LBs	30/1000 LBs
4.	Proportion of 1 year old immunized against measles	41.4 (NDHS 2008)	60%	80%	95%
5.	Prevalence of children under five years of age who are underweight	27.1 (NDHS, 2008)	24%	20%	17.90%
6.	Percentage of children under 5 sleeping under insecticide-treated bed nets	5.5 (NDHS, 2008)	24%	42%	60%
7.	Maternal mortality ratio	545/100,000 LBs (NDHS 2008)	409/100,000 LBs	273/100,000 LBs	136/100,000 LBs
8.	Adolescents Birth Rates	126 per 1000	114/r 1000	102/1000	90/1000
9.	HIV prevalence among population aged 15-24 years	4.2% (ANC Sentinel Survey)	3.2%	2.1%	1%



Chapter 1

Background

1.1 Geography and Demography

Nigeria is a country on the West Coast of Africa; lying 5º North of the Equator and between 3º and 4º East of the Greenwich Meridian. It is bordered on the South by the Bight of Benin and the Atlantic Ocean, on the North by the Republics of Niger and Chad, on the East by the Republic of Cameroon and on the West by the Republic of Benin. Nigeria has a land mass of 923,768 Km^2 and a projected 2009 population of 149,107,132 million[4], and an annual growth rate of 3.2%, making it the most populous black country in the world.

A gender disaggregated distribution reveals 51% male and 49% female. Women of child bearing age and children under five constitute 22% and 20% of the population respectively. Adolescents aged 10-24 years accounting for 32% of the population while children under 15 years account for 42% of the population.

1.2 Political Administration

Nigeria operates a Federal System of Government with three levels; the Federal, the State and the Local Government Areas/Councils (LGAs). There are 774 LGAs within the 36 states and Federal Capital Territory (FCT) Abuja. The 774 LGAs are further sub-divided into 9,565 wards. The states and FCT are grouped into six geo-political zones, namely: the South-South, the South-East, the South-West, the North-East, the North-West and the North Central zones.

Fig. 1. Political Map of Nigeria[5]

[4]Projected from. Nigeria National Population Commission 2006 population census figures. NPC 2006.

[5]Source: Wikimedia. Available at http://upload.wikimedia.org/wikipedia/commons/d/d2/Nigeria_political.png [accessed March 30, 2010]

1.3 National Development Initiatives

Nigeria is endowed with relatively good access to skills, capital and technology, fertile land, mineral resources and a favourable geographic location. Recent improvements in development policy and performance also mean that the country can now benefits from a positive medium-term economic outlook. Despite these signs of progress, however, Nigeria's dependence on oil and gas – and its wider social, political and economic ramifications - have contributed to significant development shortfalls: for example, the country is presently on track towards achieving, in part or in whole, only targets for three of the eight MDGs, namely, basic education, HIV/AIDS prevalence and the global partnership for development.[6] The Federal Government, in particular, is keenly aware of this challenge and is developing a policy framework to address key shortfalls. The main point of reference is Nigeria's Poverty Reduction and Strategy Paper, the National Economic Empowerment and Development Strategy (NEEDS), 2003-2007 and now its successor, the 7-Point Agenda which will be implemented through two main instruments: the Vision 20:2020 document, focused on transforming Nigeria into one of the top 20 global economies by 2020, and the National Development Plan (NDP).

1.4 National Health Development Initiative(s)

The importance of human capital development, with health, being one of the cardinal factors, has been underscored in the Vision20:2020, and the National Development Plan. However, Nigeria is said to shoulder 10% of the global disease burden due to high disease burdens and its relative large population in the continent. For example, Nigeria is making slow progress towards achieving the 2015 targets for the Health Related MDGs, especially goals 4, 5 and 6 which are to:

- Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate;
- Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio;
- Target 5.B: Achieve, by 2015, universal access to reproductive health;
- Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS
- Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it; and
- Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

The health indicators in Nigeria have remained below country targets and internationally-set benchmarks. The MDGs, have also recorded very slow progress over the years. Currently, the health sector is characterized by a lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, weak health information system with low quality of data and limited use and understanding of evidence in planning as well as mal-distribution of health work force with poor coordination amongst key players.

The Federal Government of Nigeria, through the Federal Ministry of Health (FMOH) recognizes that to improve the health and wellbeing of Nigerians, there would be a need to scale-up, strengthen the health systems including additional financing for health, build and strengthen the Primary Health Care System in line with the principles in the Ouagadougou and Abuja declarations.[7]

[6] Nigeria. Office of the Senior Special Adviser on MDGs. Mid-Point Assessment of the Millennium Development Goals in Nigeria 2000-2007. Accessed [02/02/2009]. Available online [http://www.ng.undp.org/mdgs/Mid-Point%20Assessment2000-7.pdf]

[7] Ouagadougou Declaration on Primary Health Care And Health Systems In Africa: Achieving Better Health For Africa In The New Millennium. Available at [http://www.afro.who.int/en/divisions-a-programmes/dsd/health-policy-a-service-delivery/hps-publications/doc_details/2135-ouagadougou-declaration-on-primaire-health-care-and-health-system-in-africa-2008.html Accessed [03/02/2010]

The Federal Government of Nigeria, through the Federal Ministry of Health is convinced that a purposeful reform of the National Health Care Delivery System was necessary for strengthening the weak and fragile National Health Care Delivery System and improving its performance to achieve the goals of the local and international health development agendas. Therefore in 2003, a sectoral response to the NEEDS document, the Health Sector Reform Programme (HSRP), 2003-2007 document was developed to kick-start this reform. At the end of the period, it was noted that the HSRP was successful in helping the system to develop the required policy basis upon which strategic agenda could be built. This led to the development of the National Strategic Health Investment Plan in 2007/08 to succeed the HSRP and to serve as the tool to articulate a strategic health development agenda geared towards achieving the MDGs new international commitments for improved efficiency in health systems including the Paris Declarations and the International Health Partnerships and other related issues (IHP+) Global Compact. The process for developing a National Strategic Health Investment Plan were initiated in 2007 and endorsed by the National Council on Health (NCH) in November 2007. However, considering the need to align the initiatives of the Federal Ministry of Health, with the National Development initiatives including the 7 point agenda, Vision20:2020, and National Development Plan, the NSHIP was expanded and later developed into a National Strategic Health Development Plan.

The National Strategic Health Development Plan is the first of its kind in the history of the development of the Nigerian Health Care Delivery System which will serve as **the overarching**, all encompassing, reference document for actions in health by all stakeholders to ensure transparency, mutual accountability for results in the health sector. It is a developed using a participatory bottom-up approach to ensure ownership by all the three tiers of government. In developing the NSHDP, studies in 10 different thematic areas were commissioned to provide the evidence base for the context of the plan. A framework to guide the development of the SHDPs at the different levels of government (through a participatory consultative process and approved by an emergency NCH in 2009) was developed; a toolkit that will guide the development of the plans was also developed, which served as a log frame and template to ensure uniformity of Federal, State, FCT and LGA plans. Capacity building for States and Federal technical officers to apply the framework to develop their SHDPs was built.

The Federal, 36 States and the FCT each, have an SHDP which seeks to address their respective priorities. Furthermore a harmonised NSHDP was developed to provide stakeholders with a global picture of the plan, its components, cost of implementation and mechanisms for monitoring progress and ensuring successful implementation. In the end, the final NSHDP therefore must be seen as comprising of the harmonised NSHDP and the individual Federal, State and LGA level SHDPs.

The NSHDP has eight strategic priority areas including:

- Leadership and Governance for Health;
- Health Service Delivery;
- Human Resources for Health;
- Financing for Health;
- National Health Management Information System;
- Partnerships for Health;
- Community Participation and Ownership; and
- Research for Health.

It is within these areas that the Federal, States and LGAs have developed and will implement strategic activities aimed at achieving the goals and objectives of each priority area. These are captured in both the SHDPs and operational plans at the Federal, State and LGA levels.

The final NSHDP has been approved for adoption and implementation by the National Council on Health (NCH) during its 53rd session which took place in Asaba, Delta State. The NCH is the highest policy advisory making body in the Nigerian Health Care Service Delivery System

1.5 Linkages with IHP+ and HHA Partners Strategic Orientations

Nigeria is a signatory to the International Health Partnerships Global Compact (May 28, 2008) and is committed to the achievement of the principles of the Paris Declaration on Aids Effectiveness. The NSHDP development process has received tremendous support from all the Harmonization for Health, Africa (HHA) partners in Nigeria. The country is committed to signing a country IHP+ compact which will have the NSHDP as its basis. This will facilitate the achievement of the goals of the Global IHP+ compact and the Paris declaration in the Country. The collaboration and support of the HHA partners in the development of the NSHDP has already been applauded as a best practice example in the region.

The successful implementation of the NSHDP will require the commitment of all the responsible agencies at the three tiers of government; Federal, State and LGAs; development partners, civil society organizations, private sector and communities.

The International Health Partnership and Related Initiatives (IHP+)

The International Health Partnership and Related Initiatives (IHP+) was launched in September 2007 in order to accelerate progress towards the achievement of the health-related MDG challenges in a manner consistent with the Paris Declaration on Aid Effectiveness. Signatories to the IHP+ sign a 'compact' that commits them to provide sustainable, predictable funding and more harmonized and aligned support to robust results-oriented national plans and strategies that also tackle health system constraints. In each IHP+ country, the initial focus of the IHP+ is on existing national health plans and strategies, their link to broader development plans (PRS, MTEF, etc.) and the existing structures and processes (e.g., joint reviews and assessments) in each country. While the details of each country 'compact' vary, they are expected to have common elements.

The IHP+ is primarily a structure to improve the coordination of existing initiatives and resources. Precisely, the objectives of the IHP+ are:

1. to develop 'country compacts' that commit development partners to provide sustained and predictable funding and increase harmonization and alignment in support of results orientated national plans and strategies that also tackle health system constraints;
2. to generate and disseminate knowledge, guidance, and tools in specific technical areas related to strengthening health systems and services;
3. to enhance coordination and efficiency as well as leverage predicable and sustained aid delivery for health;
4. and to ensure mutual accountability and monitoring of performance.

Chapter 2
Situation Analysis

2.1 Health Status of the Population

The health status indicators for Nigeria are among the worst in the world. *On average, the health status of the population has declined, compared with the indicators of a decade earlier*. Some of the Nigerian health indicators also fare poorly when compared to other countries with similar income per capita. Inequalities in health outcomes also exist between rural and urban areas, between northern and southern regions, and across income groups. These poor outcomes are not only due to the high increase in the poverty level but also to the weaknesses in the health sector, especially in the delivery of primary health care services for immunize - able diseases. Routine immunization is still the most cost effective intervention to reduce child survival. With the introduction of new vaccines (Hib and Rotavirus vaccines) pneumonia and diarrheal diseases can be reduced by routine immunization.

In spite of the above, some care interventions have been resilient to the general deterioration of the system. Some even improved during the last decade, such as certain nutritional programs and child health services such as treatment of diarrhea and ARI symptoms. Maternal, newborn, child mortality as well as malnutrition rates remain high in the country, indeed the latter has remained relatively unchanged and rate of wasting has actually increased especially in the northern regions of the country as evidenced in the DHS 2008.

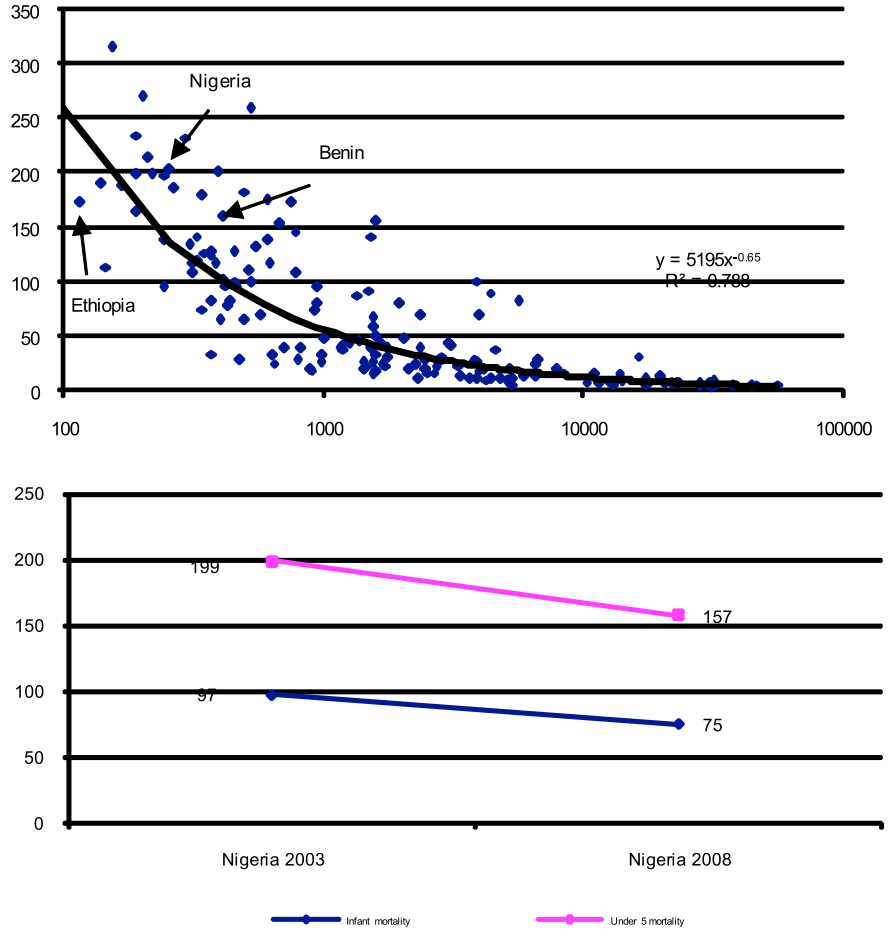
Nigeria is still one of the few Polio endemic countries though and has been a site for reinfection of neighbouring countries. There are clear indications on the effect of the ongoing program for polio eradication. This year (2010) by February only one virus of type 3 is confirmed. However there is still a need to strengthen the routine immunization system at state and local government area/district levels, and to highlight current political commitment and national efforts to ensure interruption of transmission of wild polio.

The life expectancy at birth has been reported to be 47 years according to the 2008 NDHS report. This is below the least developed countries (LDC) average age of 53 years. The disability adjusted life expectancy at birth is 38.3years. Vaccine-preventable diseases along with infectious and parasitic diseases continue to exact their toll on the health and survival of Nigerians. They remain the leading causes of morbidity and mortality. Nigeria has the highest number of HIV infected persons in the African continent and the fourth highest TB burden in the world. Faced with these facts, non communicable diseases are increasingly becoming public health problems, especially among the affluent urban population.

Infant and child mortality rates are high, though decreasing. At present, one out of every 7 to 8 children dies before his first birthday and one out of 6 before his fifth birthday. As seen in the level of child mortality rate in the country is slightly higher than what its income per capita would suggest. In the case of infant mortality, however, it is still lower than many countries with similar income. In the last decade, many SSA countries have experienced improvements in both infant and under five mortality rates[8].

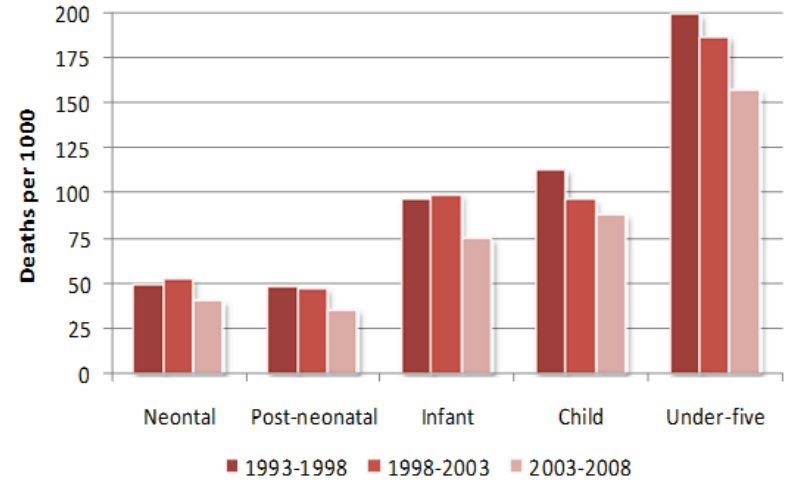
[8]Among the countries with two years of DHS data on infant mortality, Benin, Ghana, Malawi, Mali, Niger, and Togo experienced a decrease in this indicator. Most of the countries that saw this indicator increase have high HIV/AIDS infection rates or experienced conflicts such as Cameroon, Kenya, Rwanda, Tanzania, Uganda, Zambia, and Zimbabwe.

Figure 2:1. World Tendency in Child Mortality and GDP per capita and trends in infant and child mortality in the last decade



Source: WDI and NDHS 2003 and 2008

Figure 2:2. Mortality Trends



Source: NDHS, 2008

There are also large differences in infant and child mortality rates across population sub-groups and zones. The 2008 NDHS give reliable data on infant and child mortality disaggregated across regions, income groups, or type of residence. These indicators present a rather bleak picture of the situation. Poor children, children living in rural areas, and children living in the north are more likely to die before they reach their fifth birthday than their richer, urban, and southern counterparts. Infants and children under 5 years are more likely to die in the northern region of the country than in the southern region, this trend has remained unchanged in the past decade.

Children and infants among the poorest 20% of the population are about three times more likely to die than those among the richest 20%. The poor living in rural areas and in the Northern regions, fare considerably worse than the rest of the population. The disparity is

even greater for under-5 mortality where the mortality rate is 87 per 1,000 among the wealthiest population and a staggering 219 per 1,000 amongst the poorest (DHS 2008). In Nigeria therefore, the poor have more than twice more under-5 children dying than the rich. To progressively reduce infant and child mortality rates, there needs to be stronger emphasis on routine immunization as still the most cost effective intervention in child survival. With the introduction of new vaccines (hib and Rotavirus vaccines), pneumonia and diarrhoeal diseases (which are the major causes of childhood morbidity and mortality) can also be reduced with the routine immunization.

Table 1: Childhood mortality rates by socio-economic characteristics

Neonatal, post-neonatal, infant, child, and under-five mortality rates for the 10-year period preceding the survey, by background characteristic, Nigeria 2008

Background characteristic	Neonatal mortality (NN)	Post-neonatal mortality[1] (PNN)	Infant mortality ($_1q_0$)	Child mortality ($_4q_1$)	Under-five mortality ($_5q_0$)
Residence					
Urban	38	29	67	58	121
Rural	49	46	95	106	191
Zone					
North Central	41	37	77	62	135
North East	53	56	109	126	222
North West	47	44	91	139	217
South East	51	44	95	64	153
South South	48	37	84	58	138
South West	37	22	59	32	89
Mother's education					
No education	49	49	97	124	209
Primary	48	40	89	77	159
Secondary	40	30	70	49	116
More than secondary	33	15	48	22	68
Wealth quintile					
Lowest	50	49	100	132	219
Second	51	52	103	121	212
Middle	45	40	86	87	165
Fourth	40	34	73	60	129
Highest	39	20	58	31	87
Total	46	41	87	92	171

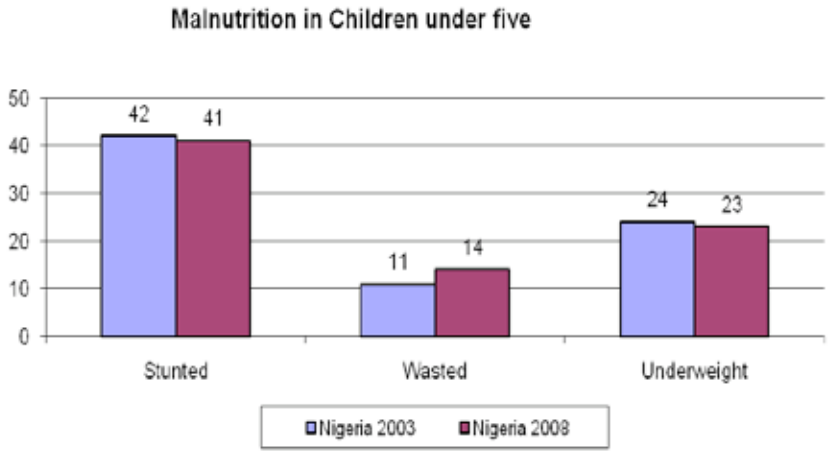
Note: Estimates are for deaths per 1,000 live births except for child mortality, which is deaths per 1,000 children age 12-59 months.
[1] Computed as the difference between the infant and neonatal mortality rates

Source: NDHS, 2008

Similarly, the nutritional status of Nigerian children is poor, showing little improvement compared to 2003. The 2008 NDHS found that 41% of under-five children suffer from chronic malnutrition (stunting) and 14% from acute malnutrition (wasting), rates which are consistent

with other poor countries in Sub-Saharan Africa. In addition, women and children among the poorest 20% are about three times more likely to be stunted and underweight than children among the richest 20%.

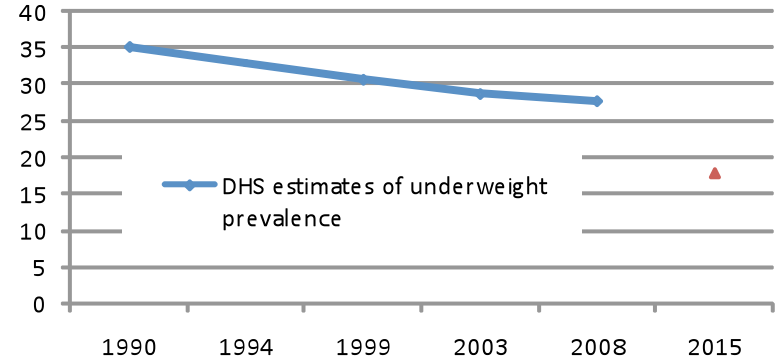
Figure 2:3 Malnutrition in Children under five



Large regional and rural/urban differences in children's malnutrition persist. There is also a wide geographical variation, with the highest rate in the dry savannah areas of the northern part of the country; and lowest in the humid forest areas of the South as shown in the figures above. Similarly, the figures are also higher in the rural than urban areas.

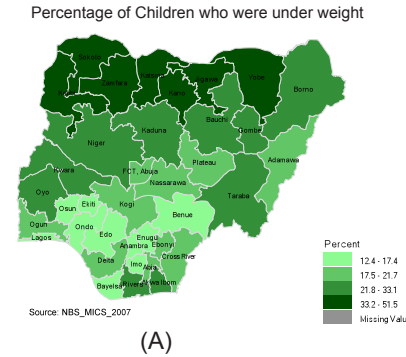
According to the NDHS report of 2008, no significant improvement has been recorded in the overall prevalence of stunting or chronic under-nutrition (height for age) among Nigerian children under-5 years in the past decade and indication that there may have been little or no action taken to address this. Similarly, prevalence of underweight has dropped insignificantly from 35% in 1990 to 23% in 2008, keeping the country on track in achieving the MDG target one out of goal 4 by 2015.

Figure 2:4 Underweight trends & MDG target

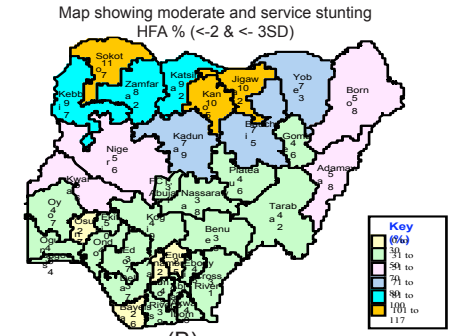


Figures 2:4 illustrate the gradual decline in the instances of malnutrition in children over a considerable period time while figure 2:5 indicate that children in the North are more likely to be undernourished and suffer from its multiple, often irreversible attendant consequences on physical and mental development.

Fig 2:5 Regional variation in underweight (A) and Stunting (B)



(A)

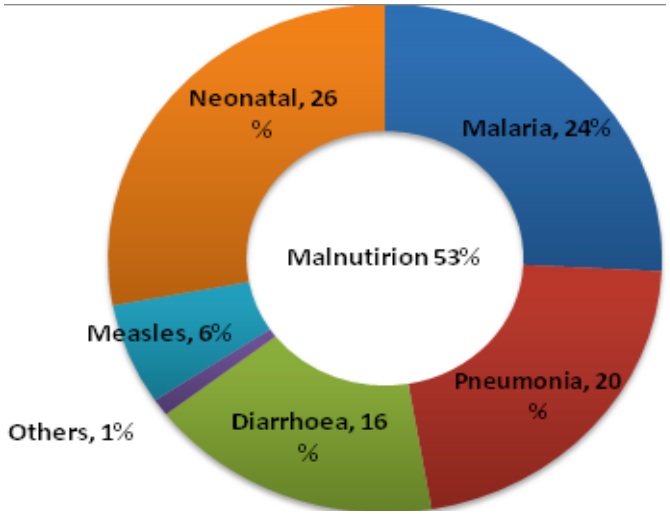


(B)

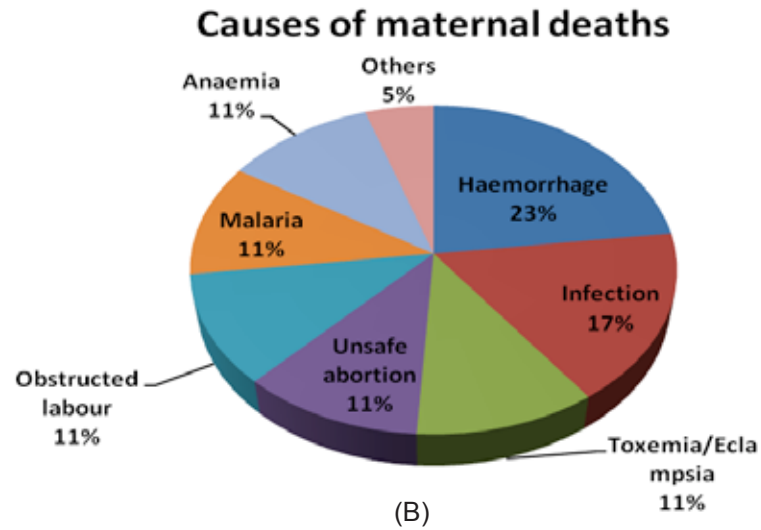
Although the regional desegregations in the two years of the data (NDHS 2003 and 2008) are not comparable, in general, there are more malnourished children living in the northern areas of the country than in the southern ones. Similarly, although the percentage of malnourished children has decreased in both rural and urban areas, the difference between the two areas remained the same. Children in rural areas are 1:2 times more likely to be underweight than children living in the cities.

Nigeria is still in the first stages of the epidemiological transition; communicable diseases are the major causes of mortality and morbidity in the country. In children, the major causes of mortality and morbidity are malaria, diarrhoea, acute respiratory infections (ARI), measles and other vaccine preventable diseases (VPD), and the exacerbating effect of children's malnutrition. These diseases, are however preventable and/or can be treated at small cost.

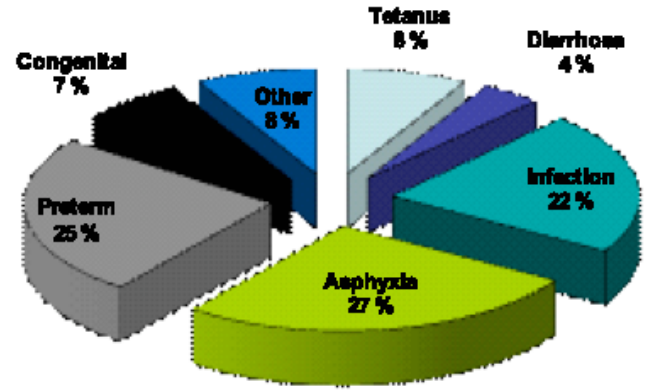
Figure 2. 6 Causes of under five, maternal and newborn mortality



(A)



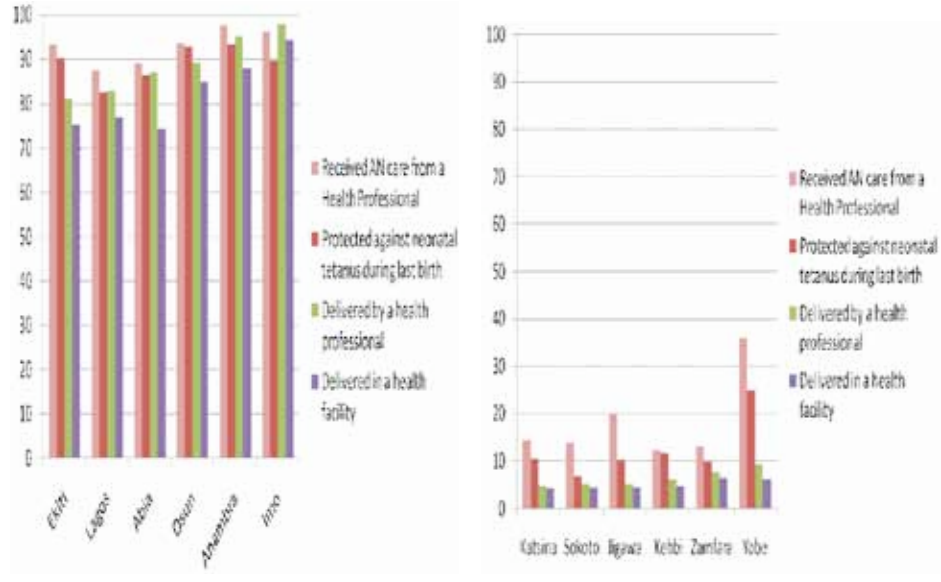
(B)



(C)

With the current estimated maternal mortality ratio of 545 per 100, 000 live births (DHS2008), Nigeria still has one of the highest rates in the world. With the new 2008 DHS information, about 4 maternal deaths occur in Nigeria per hour, 90 per day, and 2,800 per month totalling about 34,000 deaths annually, with wide regional and local variations. 57.7% of pregnant women aged between 15-49 years received antenatal care from skilled providers, while skilled attendance at birth remains low at 39% as shown in **figure 2:7 (a) and (b).** These charts are illustrative of Nigeria's diversity – with Imo State showing 98% skilled attendants at birth to only 5% in Jigawa State. The 2008 NDHS puts delivery in health facilities at 35% while home deliveries was rated at 62.1% underscoring the need for improved access and utilization for maternal health services It is also estimated that for every maternal death, at least 30 women suffer short to long term disabilities such as vesico -vaginal fistula (VVF). Each year, some 50,000-100,000 women in Nigeria sustain obstetric fistulae. Over 600,000 induced abortions are also estimated to be taking place in Nigeria annually. Abortions take place often under unsafe conditions, with an estimated 40% performed in privately owned health facilities.

Figure 2. 7 Coverage for Maternal Health Services

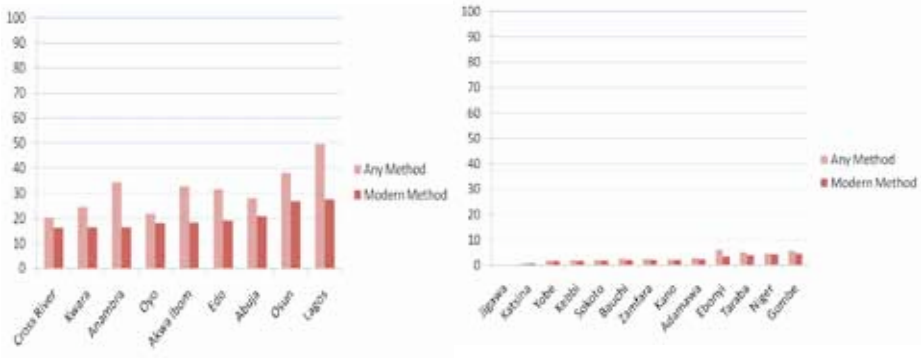


(A) (B)

In achieving universal access to sexual reproductive health services and its attendant linkages to maternal morbidity and mortality, the contraceptive prevalent rates in the country are a point of focus following the findings of the recent NDHS. The Contraceptive Prevalence Rate (CPR) increased from 6% in 1990 to 13% in 2003 and to 15% in 2008, with differentials in utilization by place of residence, wealth, education, etc. as illustrated in Figure 2:8 below. Although the trends in the use of modern contraception methods seem to have increased from 4% in 1990 to 10% in 2008, it still remains quite low in proportion to time lapse vis-à-vis population growth.

The 2008 NDHS also put unmet family planning needs at 21%, while Total fertility rate is 5.7, revealing critical factors for programming in the health sector. Considering the annual growth rate and the age structure of the population, where 42% are children below age 15, the continued limited access to and utilization of family planning information and services by this age group has significant consequences on national development. Despite the implications of these indices, particularly on maternal mortality and morbidity, Nigeria has continued to record stock-out of family planning commodities arising from unavailability of commodities in-country and logistics bottlenecks.

Figure 2. 8 Current use of contraception focus required on promoting the use of modern methods

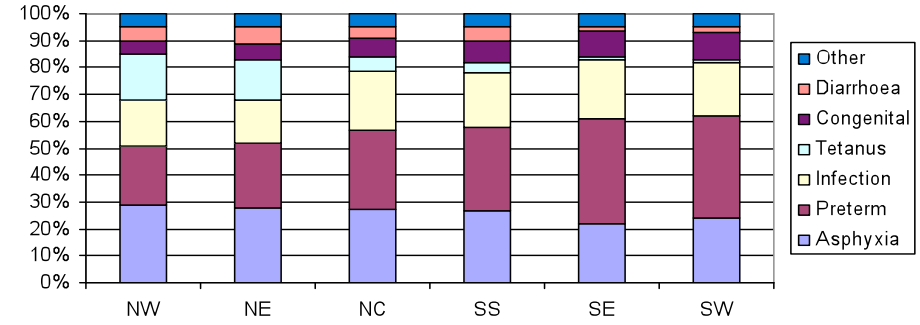


Causes of deaths in newborn babies

Birth asphyxia or intra-partum-related neonatal deaths remain a major cause of newborn deaths and disabilities in Nigeria, constituting more than one quarter of all causes. For each asphyxia-related newborn death, many more babies are left with permanent disabilities.

Low birth weight and preterm babies form another bulk of babies who die daily. Infections including neonatal tetanus, diarrhoea and pneumonia account for about 34% although contributions from each of these vary by region.(fig 6). The World Health Organization (WHO) estimates stillbirth rate for the year 2000 as 30 per 1,000 total births for Nigeria, resulting in an estimated 183,000 stillborn babies each year.

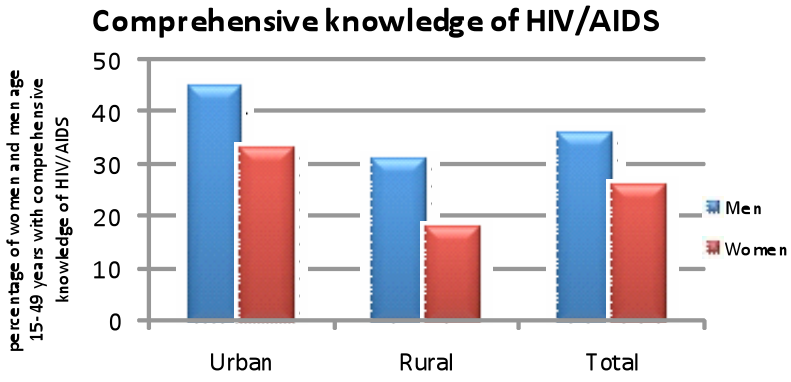
Figure 2:9 Causes of newborn deaths by region



Source: Save the children Nigeria NCRSA, 2009

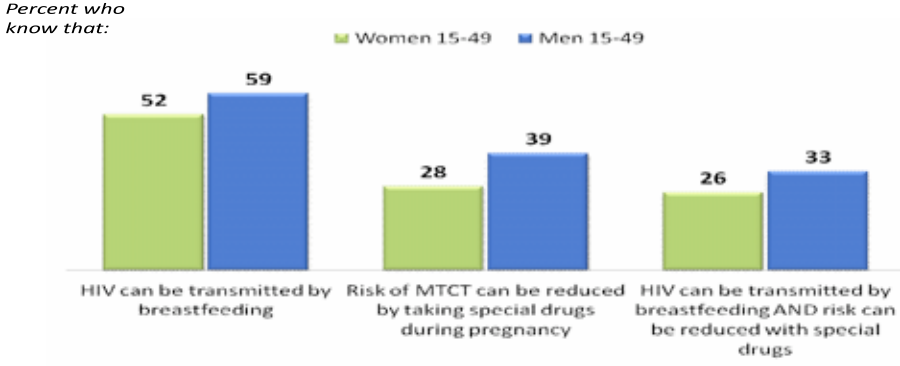
Adult HIV prevalence is estimated at 4.6%, so that Nigeria has the one of the highest number of infected people in the world – an estimated 3.5 million. The 2008 sentinel survey found that adult HIV prevalence was 4.6%. This is partially encouraging, since it is an apparent decrease from the 2001 estimate of 5.8%. Estimated prevalence in 1992 was 1.8%. State-level estimates from the 2008 NDHS survey do show a broad regional pattern. Comprehensive knowledge of HIV for men and women aged 15-49 years and disaggregated by place of residence revealed the existing knowledge base of the effect of use of condoms and limiting sex to one uninfected partner to reduce the chances of getting HIV, knowing that a healthy looking person may also be HIV positive, and rejecting the two most common local misconceptions about HIV prevention and transmission.

Figure 2:10



Equally, the provision of Prevention of Mother to Child Transmission (PMTCT) services, a high impact intervention to prevent maternal and neonatal mortality remains low with varied levels of information as illustrated in Figure 2:11 below.

Figure 2:11 Understanding Mother-to-Child Transmission of HIV

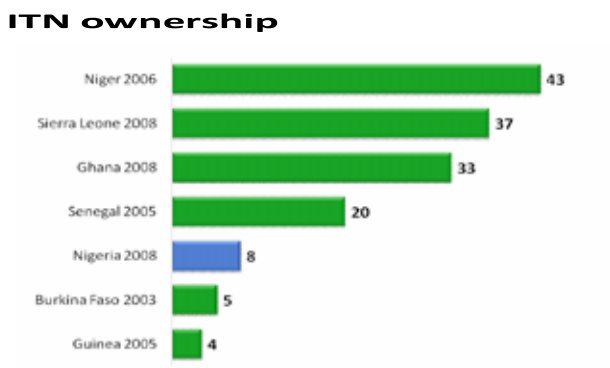


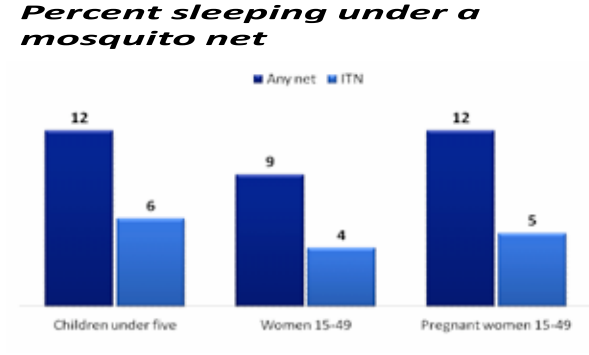
Nigeria has the fourth highest number of tuberculosis (TB) cases in the world, while other infectious diseases, such as meningitis, also represent a considerable health burden. Estimated annual TB incidence is 293 new cases per 100,000 persons; estimated prevalence (both new and old cases) of 546 per 100,000 implies that over 700,000 people have TB in the country. Nigeria experiences periodic epidemics of meningitis and suffers from numerous other endemic communicable diseases.

Malaria is a leading cause of death of children under five years in Nigeria. Indeed it affects all ages, however its burden of mortality and disability is felt more acutely in children ages 0 to 4 years. A slight increased burden exists in children between 5 and 15 years than the older age groups. (Nigeria BOD Study 2008) Chronic repeated malaria also contributes to anaemia in children.

Diarrhoea and pneumonia cause almost 400,000 child deaths annually in Nigeria. ***Diarrhoea*** is a major cause of child morbidity, and is both a cause and an effect of malnutrition. Acute di***arrhoea*** can lead to linear growth retardation, causing more than 176,000 deaths of children under-5 in the country. ***Pneumonia,*** the most serious Acute Respiratory Infection (ARI), is another major cause of mortality among children; it is responsible for an estimated 200,000 deaths each year. Many of these deaths can be avoided, as both diarrhoea and ARI, like malaria, can be treated at low cost, yet these diseases continue to be the leading cause of the high incidences of under-5 mortality rate. This can mainly be attributed to very poor responses at the household level, and low quality of health service delivery at the facility level.

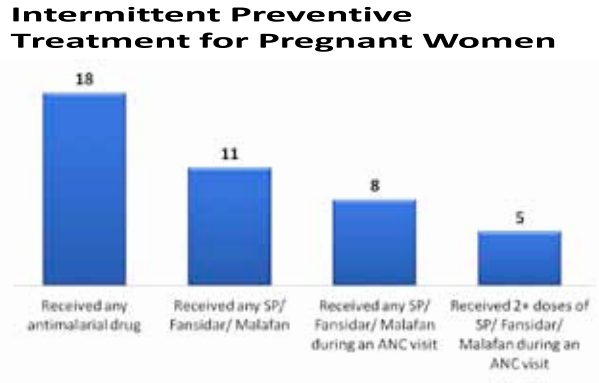
Figure 2:12 Use of Insecticide Treated Nets (ITNs)

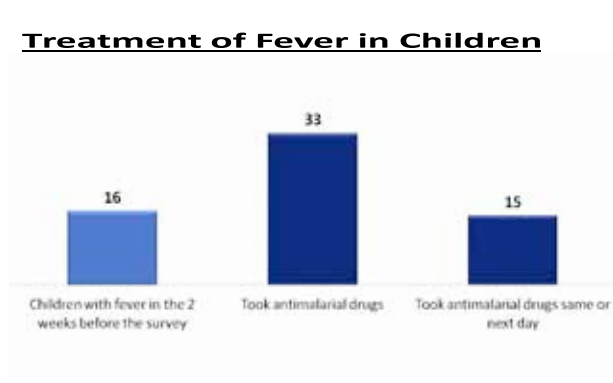




Source: DHS 2008

Figure 2:13 **Malaria treatment**





Figures 2:12 and 2:13 show ITN ownership and utilization, IPT for pregnant women and treatment of fever in children

Other Non-Communicable Diseases

There are reasons to believe that non-communicable diseases (NCDs) such as hypertension, diabetes mellitus, coronary heart disease, sickle cell disease, cancers, G6PD deficiency anaemia, mental health, road traffic injuries and violence, oral health, blindness, rheumatic heart disease, stroke, osteoporosis *represent an increasing share of Nigerians' burden of disease.* Therefore even *though communicable diseases also constitute major causes of mortality and morbidity in the country, incidences of these* NCDs is increasing alarmingly. *As at 2007, Nigeria ranked second on the weighted scale of countries with very high road traffic crashes. (WHO. Nigeria publication on Road safety 2008).* Similarly, according to data from the Federal Road Safety Commission (FRSC), over 7,000 Nigerians die every year from road traffic crashes, while over 26,000 injuries are recorded.

2.2 Health Services - Provision and Utilization

Despite considerable investment in the health sector over the years, available evidence suggests that health services throughout Nigeria are delivered through a weak health care system. The latter is characterized by

inequitable distribution of resources, decaying infrastructure, poor management of human resources for health, negative attitude of health care providers, weak referral systems; poor coverage with high impact cost-effective interventions, unavailability of essential drugs and other health commodities, lack of integration and poor supportive supervision.

Consequently, the health care system is unable to provide basic, cost-effective services for the prevention and management of common health problems especially at the LGA and Ward levels. For example;

- The proportion of PHC facilities providing immunisation services range from 0.5% in the North-West zone to 90% in the South West and South East Zones.

- The capacity to provide basic emergency obstetric services is very limited as only 20% of facilities are able to provide these services[1]. This limited coverage of basic health services, which results from poor access to information and services results in under utilisation of services. Only 58% of pregnant women receive antenatal care from a professional, with coverage levels ranging from 31% to 87%, while

- Deliveries under the supervision of a trained birth attendant ranging from 9.8% to 81.8%. The lowest figures are from the North East and North West zones10.

Availability and distribution of functional health facilities and other health infrastructure vary across the country for example;

- Many new PHC facilities being built are not strategically sited.

- Majority of the public health facilities especially PHC centres are in a state of disrepair. Although every State currently has at least one tertiary health facility, nonetheless, most are not functioning at optimal capacities in the providing quality specialist care.

- *Most public health facilities across the country are poorly equipped as indicated in findings from a 2001 survey of public PHC facilities*[2]. The report shows that only a quarter of health facilities had more than 50% of the minimum equipment package and 40% had less than a quarter. However, in the past few years a significant level of capital investment has been made to improve the medical equipment and infrastructure of a cohort of federal teaching hospitals and 350 model PHC facilities have been constructed and equipped. In 2005 FMOH estimated a total of 23,640 health facilities in Nigeria of which 85.5% are primary health care facilities, 14% secondary and 0.2% tertiary. 38% of these facilities are owned by the private sector.

- The Essential Drugs Programme, including the first national essential drug list in the country was developed in 1988. The Bamako Initiative aimed at strengthening PHC through ensuring sustainable quality drug supply systems was re-invigorated in all LGAs in 1998 under the Petroleum Trust Fund. These initiatives are now moribund due to poor commitment to the establishment of systemic procurement systems for health commodities resulting in loss of confidence and decreased utilization of public sector health facilities due to drug stock-outs.

- One of the consequences of these is the proliferation of patent medicine vendors and drug hawkers who compound the problem of irrational drug use. As a result, the market is replete with

[1]FMOH/UNFPA study on essential obstetric care in Nigeria (2002-2003)

[2]Adeniyi. J, Ejembi CL, et al (2001) The Status of Primary Health Care in Nigeria: Report of a Needs Assessment Survey. National Primary Health Care Development Agency.

substandard fake drugs. In recent years however, there has been a growing confidence in the drug regulatory framework operated by the National Agency for Food and Drug Administration and Control (NAFDAC). A significant and concerted effort need is required to address the weak and fragmented logistics and supply chain system for drugs and health commodities in the country.

- *Available services by private and public providers are clinic-based, with minimal outreach, home and community-based services*. In spite of the 60% private sector health care delivery capacity, private-public partnership is still very weak. The services are fragmented, with many vertical disease control programs. Referral systems are weak and often tertiary facilities are used for provision of primary care thus diminishing the continuum of care and making the system inefficient.

- *The NPHCDA has defined a ward health care minimum package for PHC, but dissemination and implementation remain very limited*. At higher levels - except for a few disease control programs, like PMTCT, TB, Malaria, Family planning and Essential Obstetric care - there are no standard operating procedures and treatment protocols. These should emphasis provider-initiated rather than client-centered delivery of care/ services

Other confounding factors that further limit quality of care include dearth in the competence of health providers, poor attitude of health care providers as well as the number *of available human resources for health care delivery.* In addition the country is confronted with a lack of emergency preparedness to respond to epidemics.

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 is needed. This would of necessity require interventions that would transform the way the health care system is resourced, organized, managed and services delivered.[3]

2.3 Health Care Financing

The National Health Accounts (NHA) for Nigeria over the period 2003 to 2005[4] estimate that the Total Health Expenditure (THE) in Nigeria has grown from N661.662 billion in 2003 to N976.69 billion in 2005. While the THE has grown in absolute terms by nearly a third during this period, THE as a share of Gross Domestic Product (GDP) has actually declined from 12.25% in 2003 to 8.56% in 2005. Federal government health expenditure was estimated to have grown three fold from N47.02billion in 2003 to N130.76billion in 2005, while the estimated expenditures for the same period by states grew from N48billion to N78.8billion and that of LGAs nearly doubled from N28.63 billion to N44.64billion.

This trend is supported by figures from the Central Bank of Nigeria which reveals that the proportion of the Federal Government's total expenditure on the social sector between 2001 and 2005 ranged between 12% and 19%[5]. The other sources also confirm that absolute expenditure on health over the period 2001 – 2005, has increased by more than 150%.[6]

Household out of pocket expenditure remains by far the largest source of health expenditure in Nigeria (about 69%) and in absolute terms increased from N489.79 billion in 2003 to N656.55 billion in 2005. The estimated health expenditure of private firms grew from N20.32 billion in 2003 to N29.67billion in 2005. The contributions from the

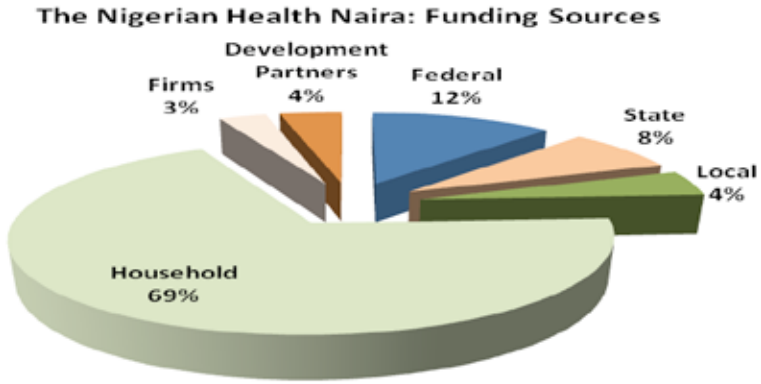
[3] 2003 – 2005 NHA Estimation, Final Report, 2009
[4] CBN Report 2006
[5] Macroeconomics and Health background study, commissioned by the FMOH, 2009
[6] 2003 – 2003 NHA Estimation, Final Report, 2009

development partners to health sector in Nigeria is estimated to have increased from N48.02billion in 2003 to N78,78 billion in 2005.

In terms of contribution from different levels of Government, the NHA 2003-05 estimates that the Federal Government contributes above a tenth of the total sum (12.1%), State Governments, about 7.6%, and LGAs about 4.5%. The Household Out-Of-Pocket Expenditure (OOPE), by far remains the largest source contributing to over two thirds (68.6%) while Private Firms contribute (3.1%) and Development Partners (4.1%) as illustrated in Fig 2:14 below[14]

It appears that the share of OOPE has been steadily increasing and stands at about 68.6% of THE by the recent NHA (2003-05) indicating an increase from the 64.25% estimated over the period 1998 to 2002. There are however notable differences in share of OOPE across the states and with some states in the northern zones estimated to have household share as high as 86%. This underscores the huge economic burden of health care expenditure on households, especially the poorer households. The responsibility to lessen this burden therefore rests with the Government playing a stewardship role to ensure provision of quality and affordable health services to Nigerians.

Figure 2.14 Funding Sources in the Nigerian Health system, 2003-2005



[7]2.4 Public Expenditure on Health

Average share of Total Government Expenditure on health over the period 2003 to 2005 was about a quarter of THE (24.1%). This has increased from an average of about a fifth of THE (20.65%) between 1998 and 2002. State level analysis show that the contribution of States and LGAs to STHE is generally very low. State Government Health Expenditure (SGHE) as a proportion of STHE averaged less than 10% over the study period. The contribution of LGHE during the same period averaged less than 7%. However, it is gratifying to note that all levels of government have the capacity to subsidize the health expenditure of poor families through the social health insurance scheme, incentives or cash transfer approaches. This is currently true of the formal sector, where employees receive medical re-imbursements within specified rates, or are enrolled in the formal sector National Health Insurance Scheme. Some of the recent initiatives by States to reduce OOPE include the establishment of targeted exemption schemes or free health services for vulnerable populations such as pregnant women, children under five years, elderly, etc.

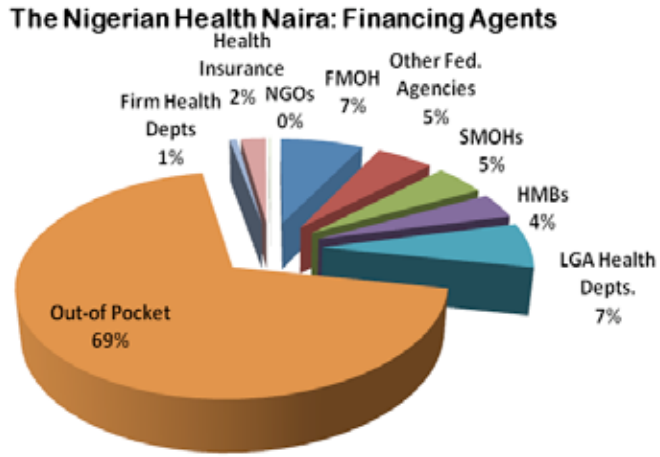
The financing agents of health care in Nigeria, through whom funds are channelled to providers include public agents (Federal ministries and agencies, SMOHs, Hospital management boards, LGAs health departments), National Health Insurance for the formal sector and pilot community health insurance schemes, NGOs and Faith based

[7]2003 – 2005 Nigeria NHA Estimation, Final Report, 2009

organizations, private firms' medical units and direct expenditure by households. Their financing contribution to providers is as illustrated in Figure 2:15 below.

The poor performance of Nigeria's health system can therefore also be primarily attributed to poor financial resourcing of health services. The bulk of the nation's resources come from oil revenues, which are deposited into the federation account and shared among federal, state and local governments according to an allocation formula. The federal

Figure 2.15. Financing Agents in the Nigerian health system, 2003 - 2005



government is currently unable to monitor the expenditure of funds allocated for secondary and primary health services, while Local and state governments also demonstrate a critical lack of accountability, as local governments allocate funds with little influence from the states. A National Health Bill, is reported to have been passed by the 2 houses of the National Assembly, but is yet to be signed into law by the President of the Federal Republic of Nigeria. When signed, the National Health Act is expected to help streamline the responsibilities of the different levels of care and enhance health care financing, especially to the PHC level. The Bill proposed that two percent of the national budget should contribute towards a PHC Fund, which will finance MNCH and other PHC activities through the National Primary Health Care Development Agency (NPHCDA). The Bill also states that the management and accountability of this fund should be completely transparent, with expected changes in implementation of community based programming.

The 2006 appropriations also include N21bn Virtual Poverty fund (VPF) resources deployed to achieving the Health related MDGs from the Debt Relief Gains. An analysis of the aforementioned resource flow in the health sector shows that health budgetary allocation is far below the 15% Abuja declaration, which was signed by the Nigerian government. A renewed commitment by the Executive arms of government at federal and state levels towards meeting the 15% allocation to health is as stipulated in the 2009 National Partnership on Health Declaration, targeting a yearly 25% increase from present levels and a 90% budget release.

National Health Insurance Scheme

The Government of Nigeria (GON) has, made concerted efforts to improve access to quality of health for the Nigerian people. In 1999, the government established the National Health Insurance Scheme (NHIS) which is a federally funded social health insurance scheme.

The scheme is designed to facilitate fair financing of health care costs through risk pooling and cost- sharing arrangements for individuals. The scheme was officially launched in 2005 and to date; over 1.2 million identity cards have been issued. This covers mainly civil servants in public sector.

Given that alternative mechanisms for health care financing such as user fees, have failed to meet desired goals, the option of health insurance seems to be a promising alternative. Through risk pooling and transferring unforeseeable healthcare costs to fixed premiums, there is the possibility of improving poor people's access to healthcare that is of acceptable quality. Several attempts in the past have focused on community-based schemes that were unsustainable. The challenge is to emphasize large scale implementation that can reach a significant proportion of the poor. The focus should be overall population coverage by a multiple of schemes looking at those same issues as those of more sophisticated social and private health insurance schemes. The programs of the NHIS seek to cover those in the formal and informal sectors and additional special needs groups. The majority of the coverage however for now reaches mainly individuals working in the formal sector leaving large gaps among the poor and informally employed. For most people leaving in poor rural or urban slums in Nigeria, ill health still represents a permanent threat to their ability to earn income and continues to impoverish them. Apart from the direct cost for treatment and drugs, indirect costs such as loss of productive man-hours, and transport still have to be borne by the households.

Community Health Insurance Scheme

In an effort to address challenges related to financial barriers to health services towards achieving universal coverage and improvement in Nigeria's health indicators community based insurance schemes are currently being piloted by both the public and private sector in states selected due to the poor health indices. The National Health Insurance Scheme is currently piloting Community Based Health Insurance Scheme in 12 states of the country with similar pilots on-going in the private sector. In particular, Pharm Access, in collaboration with the Health Insurance Fund (HIF) and Hygeia Health Maintenance Organization, have sought to increase access to health care through private risk sharing arrangements. The pilot program, Hygeia Community Health Plan (HCHP) subsidizes insurance premiums for low income previously uninsured people and targets approximately 75.000 farmers in Kwara State and 40.000 local market women in Lagos have been recruited.

Human Resources for Health

Human resources for health are the cornerstone of the health system. No health intervention can be successful without an effective workforce. Every country should therefore have a national workforce plan to build sustainable health systems to address national health needs. These plans should aim at;

- Providing access for every family to a motivated, skilled and supported health worker, and
- Optimizing health system performance, workers should be recruited from, accountable to and supported for work in their community where feasible.

The main categories of human resource in the Nigerian health care system are doctors, nurses, midwives, laboratory staff, public health nurses, public health nutritionists and the community health and nutrition workers (community health officers, community health extension workers, community health assistants – etc.). Government health workers are employed and paid by the level of government responsible for their facilities. That means federal for tertiary hospitals, states for secondary hospitals and local government authorities for

PHC facility staff. However, there are a few exceptions, in some states, professionals working in PHC facilities may be employed by the state government, while some skilled health staff employed by the federal parastatals or vertical programmes may also work at the secondary and primary levels.

The planning and management of HRH still poses a major challenge to health development in the country for several reasons. These include migration within and outside the country, mal-distribution, poor skill mix and limited production capacity. In addition, poor motivation, differential conditions of service, remuneration and work environment; negative attitude to work and poor supervision are added challenges. The planning and management of HRH should also reflect the intended changes in the service delivery.

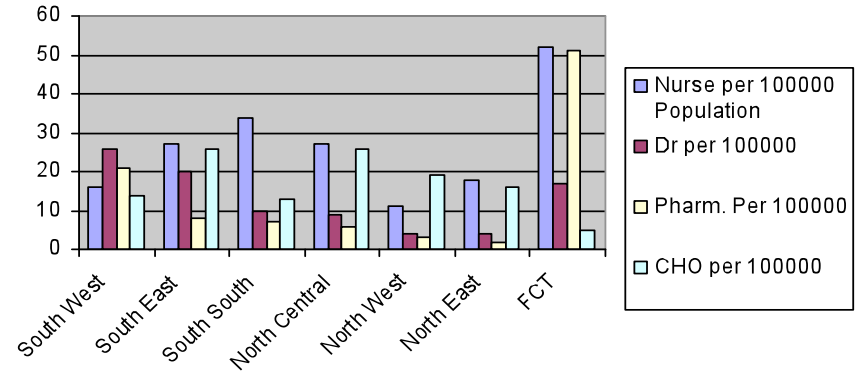
There are presently 14 professional regulatory bodies charged with the responsibility of regulating and maintaining standards of training and practice for various health professionals. However, they are limited by weak structures and institutional capacities to carry out statutory functions of effective monitoring and accreditation of training institution programmes

There are about 39,210 doctors, 124,629 nurses and 88, 796 midwives registered in Nigeria. It is difficult to judge these numbers alone. The aggregated numbers hides a large variation between areas and States/Zones.

The density of health workforce varies between rural and urban areas. Figure 2: 16[8] above also shows that availability of various staff category varies from one geopolitical zone to the other. This suggests that any strategy to ensure equitable distribution of doctors and nurse-midwives must be sensitive to the needs of the affected zones.

[8]Source Federal Ministry of Health. Human Resources for Health Strategic Plan 2008 2012. FMoH 2007

Figure 2:16 Health workforce/100,000 Population by Geo-Political Zone



Most doctors and nurses work in higher level and private practices. 88% of 26,361 doctors practising in the country work in hospitals, most of them (74%) in private hospitals. Only about 12% of practising doctors work in private or public sector PHC services[9].

About an average of 2,500 doctors, 5,500 nurses and 800 pharmacists graduate and enter the health sector every year. Except for nurses and midwives, there appears to be a positive net gain when rate of inflow of fresh graduates are compared with attrition rates. Intakes into health training institutions are however not influenced by evidence-based predetermined staff projections. Consequently, many of the health training institutions over-produce some cadres of staff who do not readily find employment within the state yet are not employed by other states where needs exist. At the same time, there is gross under-production of other cadres who are critically needed in the states.

Although available information is limited, there are indications that

[9]Dare et al,

better working conditions and remuneration draw skilled health personnel to urban areas and the private sector. Irregular or non payment of staff salaries were described as reasons why many health workers have a second source of income, sell drugs privately or provide services outside the facilities. Also, lack of supplies and equipment, poor remunerations, lack of training and supervision and lack of transportation are common reasons adduced for poor performance.

There is a need to integrate health services in Nigeria. Despite the epidemiological and programmatic link between HIV/AIDS, sexual reproductive health, TB and malaria, individual government programs and donor funded projects have continued to manage them vertically, thereby further fragmenting the weak health system, particularly at the PHC level. Efforts to integrate services can improve the efficiency of the total workforce. The emergence of Strategic Health Development plans at State and federal level with an overarching national framework and plan now provide the highest level of commitment and platform for the execution of the integration, harmonization and alignment of vertical programs within existing national systems and government policies.

There is also a need for a decentralization of certain health services and they must be accompanied by a redistribution of health workers. Most of the secondary and tertiary hospitals reaching their full capacity – health workers now complaining about HIV/AIDS client load and frequent equipment breakdown. Scaling up will require decongesting comprehensive sites and taking services closer to the people. PHCs constitute over 70% of all health facilities in the country. Guidelines for staffing different health facilities are available and will be further developed at the federal level according to a decentralization and integration strategy for important health services. There is evidence that lower cadre health workers can provide quality ART[10],[11]

[10]Fairall et al. *Trials* 2008;**9**:21. doi:10.1186/1745-6215-9-21
[11]Bolton-Moore et al. *JAMA* 2007;**298**(16):1888-1899

2.5 Way Forward

One of the main issues that needs to be addressed in the Nigerian health system is the weakness of government's primary health care services. This weakness is one of the causes of the stagnation and even deterioration of some of the population's health outcomes. As will be detailed in the following sections, the available data indicate that public PHC facilities:

(a) Do not have adequate stocks of pharmaceuticals and support services,

(b) Do not have properly maintained facilities,

(c) Do not regularly pay their staff's salaries, and

(d) Do not have adequate record-keeping, monitoring systems and capacities.

Consequently, PHC services are often bypassed in favour of higher level care facilities in both the public and the private sectors where both preventive and first level curative cares are provided. The services offered by higher public level facilities and the private sector ensured the availability of certain care interventions such as ORT. This was, however, not the case for all preventive and curative activities, and many of them such as immunization declined.

Organization and management difficulties that affect the entire health system are behind the weakness in the government's PHC services. Some of these difficulties, such as an unclear division of responsibilities, a fragmented and uncoordinated system, and weak governance are discussed below as well as one of the major opportunities the system counts with: the dynamic private sector.

Lack of clarity in the division of responsibilities across different

levels of government. The current (1999) Constitution mentions health only with regard to the responsibilities of local governments, implying that responsibility for health services is shared between the State and local levels.[12] In practice, the division of responsibilities is based on the 1979 Constitution, where health services were on the "concurrent list" of responsibilities shared between the Federal and State governments, and reflects a body of Federal directives, policies, and laws relating to the health sector. The diffusion of responsibility is particularly evident at the primary level, where services are managed by Local Governments, under the nominal supervision of the States, and involving Federal Ministry of Health (FMOH) Departments and Federal parastatals concerned with particular programs and diseases. In many ways, this seems to have led to a situation where government primary health care services are perceived as the responsibility of everyone and of no-one. The new National Health Act, currently under discussion, seeks to address this problem.

The health system is highly fragmented and the linkages across the different levels of government and stakeholders is weak. The health system is highly decentralized with the three levels of government having roles in the sector that are not well coordinated. Furthermore, the tendency to bypass both Federal and State health ministries through the creation of large numbers of parastatal and organizations to implement programs and manage services have added to the fragmentation of the system. For instance, at the Federal government level alone there are more than eighty of these parastatal organizations.

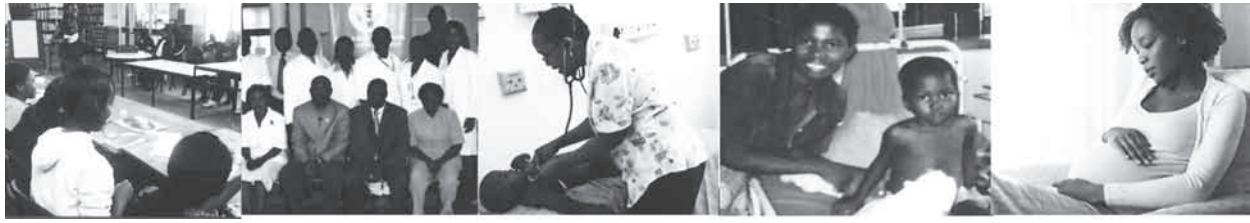
A *requirement for effective decentralization is that the lower-level political units have the capacity to meet their new responsibilities*. *In most cases, this requirement was not met* when responsibility for primary health care services was transferred from the States to Local Governments in the late 1980s, while some of the newly-created States also found themselves with insufficient capacity to manage their responsibility for secondary-level facilities.

Underlying many of the organizational problems described above are inadequate governance and accountability at all levels of the health system. A major justification for decentralizing responsibilities is to improve governance by bringing control of health services closer to the communities they serve. However, this was done in Nigeria in the context of a military government attempting to balance regional and ethnic divisions at the same time as retaining as much power centrally as possible. Since governments at all levels were poorly accountable to the population during this period, decentralization of the health system likely had little benefit in terms of improving governance. Fulfilling the promise of decentralization will now depend on the consolidation of democracy in Nigeria, particularly at the State and Local levels. Moreover, although accountability problems affect all levels of government, at the local level they presents a particular challenge and would entail improvements in commitment, governance, accountability, and institutional capacity. *A dynamic private sector offers an opportunity to fill part of the gap left by a weak PHC system.* The private sector represents an important share of the health care provision in Nigeria. This sector includes pharmacists and patent medicine dealers, outpatient clinics, private doctors, and hospitals. Despite their large numbers, these providers are not particularly available to the rural poor.

Despite the large role of the private sector in the provision of health care, information on their performance is very scarce. At present, little is known on the efficiency of these providers, their quality, their

12 The 1999 Constitution states: "The functions of a local government council shall include participation of such council in the Government of a State as respects the following matters: (a) the provision and maintenance of primary, adult and vocational education; (b) the development of agriculture and natural resources, other than the exploitation of minerals; (c) the provision and maintenance of health services; and (d) such other functions as may be conferred on local government councils by the House of Assembly of the State."

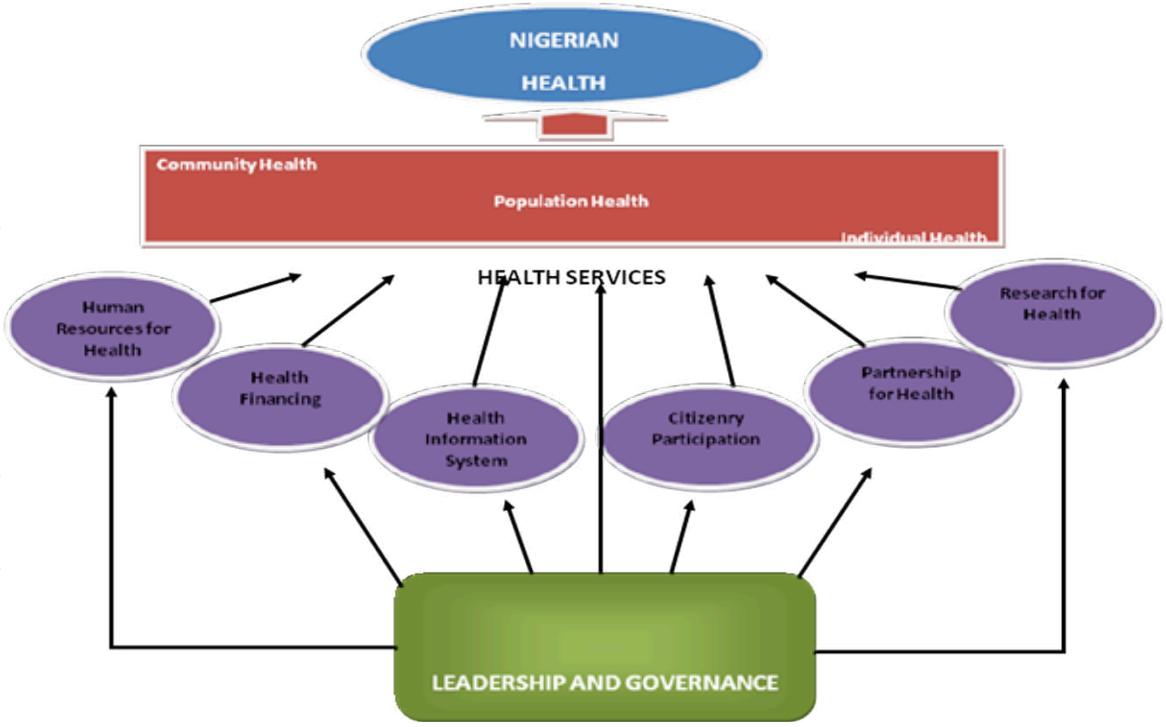
affordability, the type of services they offer, the characteristics of their health staff, their sources of financing, or whether these providers face any constraints in their development. These will be clarified with the enforcement of existing regulations and strengthening of the health regulatory agencies. An analysis of the characteristics of this sector will help identify strategies to ensure appropriate service standards and build better public/private partnerships in the provision of health care.



Chapter 3

NSHDP Priority Areas

Prority Areas to be strengthened for a revitalization of Nigerian Health System



3.0 Preamble

A Framework has been developed to serve as a guide to federal, state and LGAs in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians. Federal, States and LGAs have used this framework to respectively develop their costed plans through participatory approaches to reflect their context and prevailing issues.

What is presented below are National Strategic Health Objectives and Interventions based on the harmonization of the different Federal, States and FCT plans. Eight evidenced-based priority areas have been identified to improve the performance of the health sector, through a holistic approach at federal, state and LGA levels. They are: 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.

These serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria. Goals with strategic objectives, interventions and activities have been developed for each priority areas.

LEADERSHIP AND GOVERNANCE FOR HEALTH				
1. To create and sustain an enabling environment for the delivery of quality health care and development in Nigeria				
	1.1	**To provide clear policy directions for health development**		
		1.1.1	Improved Gender Responsive Strategic Planning at Federal and State levels	• FMoH will be strengthened through an integrated organizational change and development programme, which will incorporate the re-orientation and strengthening of the human resource capacities. • Increased emphasis will be placed on effective implementation of agreed plans and this will include advocacy at State level in support of policy development and implementation. • The highest priority will be to support States in the development of evidence-based, costed, and prioritized strategic health plans for the sector. • The development of strategic health plans will be undertaken in such a way as to optimize the contribution of the wider stakeholders at each level.
	1.2	**To facilitate gender sensitive legislation and a regulatory framework for health development**		
		1.2.1	Strengthen regulatory functions of government	• The FMoH will support the development of public/private partnership policies and plans in States in line with the national policy on PPP. • States will also be offered opportunities for technical support on implementation of their strategic plans to ensure that the regulatory function of government is strengthened and agreed quality standards are set, monitored, and delivered. • The public sector (government) will collaborate with the private sector to improve their health delivery system, for example through joint continuous professional development, supportive supervision and generation of public health information and intelligence. • Arrangements under which State governments may wish to outsource some components of health service delivery to the private sector will be explored and supported. • Efforts will be channeled into reviewing, updating and enforcing Public Health Acts and Laws as well as revising and streamlining roles and responsibilities of regulatory institutions to align with the National Health Bill that is due to be passed into law. • The various tiers of government will prioritize the review of public health legislations to ensure that gaps are filled in areas which need improvement, and relevant laws enacted through National and State Assemblies. • Review committees will be set up to review and align laws of regulatory bodies.
	1.3	**To strengthen accountability, transparency and responsiveness of the national health system**		
		1.3.1	To improve accountability and transparency	• Demand for accountability, transparency and responsiveness of the national health system will be institutionalized through effective decentralization of the decision making process in the health sector. • FMoH will support the States and the LGAs to institute stakeholders' dialogue and feedback forum for enlisting input into health sector decision making. • Platforms for interaction and collaboration with health sector advocacy groups will be created, • Empowerment of beneficiary communities through sensitization to manage and oversee their health projects and programmes, • Promotion of the emergence of independent health sector 'watch dogs'. • FMoH will lead a process for improved access to information required for yearly joint review of the health sector and put such information in the public domain and on demand by stakeholders.
	1.4	**To enhance the performance of the national health system**		
		1.4.1	Improving and maintaining Sectoral Information base to enhance performance	• Deepen and expand the analytical work at both Federal and State Government levels, • In conjunction with development partners a prioritized list of areas for further analytical work will be outsourced to Universities, private sector research firms and research institutes. An example is the Nigeria Demographic and Health Survey (DHS) which is conducted on a five yearly cycle and presently outsourced to Macro International with funding from several donors. • Linkage with the relevant activities in the research and health information system priority areas of this framework will contribute to achieving this intervention.

HEALTH SERVICE DELIVERY				
2.	**To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare**			
	2.1	**To ensure universal access to an essential package of care**		
		2.1.1	**To review, cost, disseminate and implement the minimum package of care in an integrated manner**	▪ Review, cost, disseminate and implement the minimum package of care in an integrated manner
				▪ Strengthen specific communicable and non communicable disease control programmes.
				▪ Standard Operating procedures (SOPs) and guidelines are to be made available for delivery of services at all levels
	2.2	**To increase access to health care services**		
		2.2.1	**To improve geographical equity and access to health services**	▪ Mapping of health facilities, establishing GIS for all health facilities in the country
				▪ Developing criteria for sitting of new health facilities at all levels.
				▪ Upgrade and refurbish all substandard facilities especially at PHC level.
				▪ To ensure adherence to guidelines that stipulate standards for access and linkages of the different levels of care.
				▪ Guidelines for outreach services will be developed and implemented, budget lines for the maintenance of health facilities provided and guidelines for task shifting established and implemented.
				▪ The use of telemedicine will be strengthened.
		2.2.2	To ensure availability of drugs and equipment at all levels	▪ Ensuring availability of drugs and equipment at all levels.
				▪ review of the essential drugs list and establishing a system to ensure procurement and distribution of essential drugs on a sustainable basis at all levels
				▪ develop/review an equipment list for different levels of health facilities in line with the essential package of care
				▪ Procure and distribute equipment based on need.
		2.2.3	To establish a system for the maintenance of equipment at all levels	• Adapt, disseminate and implement the National Health Equipment Policy; a
				• Create budget lines for the maintenance of equipment and furniture at all levels.
				• establishing medical equipment and hospital furniture maintenance workshops across the country
				• Exploring public private partnership in maintenance of medical equipment and hospital furniture.
		2.2.4	To strengthen referral system	• mapping network linkages for two-way referral systems in line with national standards, with implementation guidelines for all cases such as emergency obstetric care, complicated malaria, road traffic accidents, etc;
				• Transportation, communication and other logistics for referrals need to be put in place to ensure effective referrals
				• A system put in place to monitor referral outcomes.

		2.2.5	To foster collaboration with the private sector	• mapping of all categories of private health care providers by operational level and location,
				• Development of guidelines and standards for regulation of their practice and their registration.
				• guidelines for partnership, training and outsourcing of services will be developed
				• Performance monitoring mechanism for the private sector will be developed and implemented.
				• The national policy on traditional medicine will be adapted and implemented at all levels.
	2.3	**To improve the quality of health care services**		
		2.3.1	To strengthen professional regulatory bodies and institutions	• review, update and implement operational guidelines of all regulatory bodies at all levels and build capacity of regulatory staff t
				• Monitor compliance of providers to the regulatory guidelines.
				• Budget lines are to be created and necessary resources provided.
				• Regular monitoring exercises with appropriate documentation
				• feedback will be strengthened
				• regulators empowered through the provision of necessary security.
		2.3.2	To develop and institutionalise quality assurance models	• Reviewing available models and building consensus on the models to adopt.
				• quality assurance training modules will be developed to build capacity of both public and private health care providers,
				• Training of trainers (TOT) conducted and cascaded to other health workers.
				• Quality assurance and improvement initiatives will be institutionalised and implemented at all levels.
				• The quality of service delivery can be further assured by entrenching the ideals of SERVICOM at all levels of care.
				• Development of SERVICOM guidelines, building institutional capacity and training staff for its implementation at all levels.
				• Strategies will be put in place for monitoring implementation of quality of care.

		2.3.3	To institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms	• management capabilities of health managers and health teams especially at the LGA and Ward Levels will be strengthened through team building and leadership development programmes,
				• institutionalization of comprehensive ISS at all levels, development of capacities of programme managers at all levels on the ISS mechanism;
				• development of ISS tools and guidelines specifying modalities and frequencies of the ISS visits at all levels.
	2.4	**To increase demand for health care services**		
		2.4.1	To create effective demand for services	• necessary to develop, disseminate and implement a national health promotion communication strategy based on the National Health Promotion Policy, and its corresponding adaptation to reflect local realities.
				• Budget lines for health promotion through Behavioural Change Communication will be provided at all levels
				• a programme monitoring and evaluation system will be put in place.
				This intervention is further explored under Priority Area 7 of this framework.
	2.5	**To provide financial access especially for the vulnerable groups**		
		2.5.1	To improve financial access especially for the vulnerable groups	• Models for financial protection for the vulnerable groups (e.g. Pregnant women, under fives, orphans and the aged) such as exemption schemes vouchers, health cards, pre payment schemes will be explored and existing financial protection schemes scaled up.
				This intervention is further explored under Priority Area 4 of this framework.
HUMAN RESOURCES FOR HEALTH				
3.	**To plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care**			
	3.1	**To formulate comprehensive policies and plans for HRH for health development**		

		3.1.1	To develop and institutionalize a gender responsive Human Resources Policy framework	• States are to domesticate the National HRH Policy and Strategic Plan to guide human resource development at all levels. • Policies on training and recruitment of health personnel are to be updated across the country to make them non-restrictive and ensure non-discriminatory processes irrespective of states of origin and/or gender. • A policy framework to guide existence of private and public practitioners at all levels of health service delivery is to be developed; • develop and implement guidelines on task shifting and establish a fora for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks.
	3.2	**To provide a gender responsive framework for objective analysis, implementation and monitoring of HRH performance**		
		3.2.1	To reappraise the principles of health workforce requirements and recruitment at all levels	• Career pathways for all groups of health professionals critically needed to foster demand and supply creation in the health sector are to be developed and streamlined. • To guide HRH planning, it is necessary to develop, introduce and utilize staffing norms based on workload, service availability and health sector priorities. • To establish coordinating mechanisms for consistency in HRH planning and budgeting by Ministries of Health, Finance, Education, Civil Service Commission, Regulatory bodies, Private Sector Providers, NGOs in health, and other institutions. • State and LGA capacities will be strengthened to access and implement federal government circulars, guidelines and policies related to HRH. • Entry criteria and admission quotas of prospective health care providers into training institutions are to be reviewed.
	3.3	**Strengthen the institutional framework for human resources management practices in the health sector**		
		3.3.1	To establish and strengthen the HRH Units	• HRH units will be created / strengthened at all levels to perform HRH functions. • Training programmes in human resource for health planning and management at all levels will be established to enhance the HRH managers.
	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**		
		3.4.1	To review and adapt relevant training programmes for the production of adequate nb of CHW based on national priorities	• Training programmes of health related institutions in HRH will be reviewed in line with national priorities. • Special training programmes aimed at producing adequate cadres of health professionals in critical areas of need will be designed and implemented. • training for community health workers and other cadres of supportive personnel will also be established or expanded. • the national Midwives Service Scheme and the Community Midwifery Programme will be promoted. • admission criteria for relevant disciplines in response to the HRH crisis in disadvantaged areas of the country will be reviewed, • adequate production of qualified health professionals through appropriate accreditation and regulatory bodies will be strengthened. • Continuous assessments of training institutions and programmes will be institutionalised • curricula and programmes to reflect task shifting requirements will be developed and implemented. • Regular review of functions and mandates of HRH regulatory bodies will be conducted and public private partnership in HRH development and management strengthened

		3.4.2	To strengthen health workforce training capacity and output based on service demand	• To set up and strengthen training institutions for production of health care providers there is need to provide minimum levels as well as ensure the periodic upgrading of teaching and learning materials, infrastructure and financial support as incentives for retention of staff. • Quality assurance units and education review units are to be established in all training institutions with incentives for satisfactory performance. • Training curricula of identified training institutions will be reviewed to reflect the disease burden situation of the country • Accreditation systems for training institutions to ensure professional standards of health personnel will be strengthened • Accreditation of eligible private sector health facilities to increase training opportunities for internship and post-basic training for all sector health professionals will be facilitated. • Human capital capacity building and continuing professional development (CPD) by government and healthcare provider institutions will be promoted • coordination with professional regulatory bodies to link sponsorship to bonding of healthcare providers to mitigate migration across states and outside the country established.
	3.5	**To evolve a gender sensitive organizational and performance-based management systems models for human resources for health**		
		3.5.1	To achieve equitable distribution, right mix of the right quality and quantity of human resources for health	• Set up deployment processes that are equitable in terms of mix, needs and geographical space. • to create a database of HRH, • to develop and provide job descriptions and specifications for all categories of health workers. • Redeploy staff equitably between rural and urban areas and at the different levels of the health care system in relation to needs, paying attention to staff mix. • States MoH are to collaborate with Federal institutions located in their states to leverage available human resource so as to expand service coverage and quality. • Mandatory rotation of health workers to underserved rural areas, e. g through NYSC scheme for doctors, pharmacists and appropriate scheme for midwives and nurses is to be promoted. • The National Health Bill makes provision for a primary healthcare fund from the federation account; 10% of this fund should be deployed equitably for HRH. • Retention strategies including management of migration, through bilateral and multilateral agreements are to be developed and implemented to reverse and contain the crises. • The pool of professionals in Diaspora and the capacities of retired trained health professionals will be leveraged to strengthen the human resource availability in the country and meet HRH gaps respectively. • Use of intra or extra mural private practice services to improve services in underserved areas as well as provision of incentives for health workers in underserved areas will be instituted. • Mechanisms to minimize work place hazards through management of physical risks and mental stress, with full compliance with prevention and protection guidelines will be strengthened • To create an enabling environment that motivates staff. • Performance-based incentives will be established.
		3.5.2	To establish gender responsive mechanisms to strengthen and monitor performance of health workers at all levels	• Routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics are to be conducted for the promotion of client satisfaction and improvement of quality of care. • A system of recognition, reward and sanctions will be instituted. • to establish and institutionalize a framework for an integrated supportive supervision with adequate committed resources for all types and levels of care providers across public and private sectors. • Mechanisms will be established to monitor health worker performance, including use of client feedback (exit interviews).

	3.6	**To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda**		
		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	• The HRH policy (2007) states that government shall promote intra and inter-professional respect, harmony and team work among all disciplines of health care workers for optimum health service delivery. • Establishing effective dialogue and complaints channels between management and staff of public and private sectors as well as HRH regulatory bodies and associations. • involvement of workers and professional groups in management teams, design and monitoring of services is proposed to enhance cooperation amongst all actors
FINANCING FOR HEALTH				
4.	**To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at Local, State and Federal levels**			
	4.1	**To develop and implement health financing strategies at Federal, State and Local levels consistent with the National Health Financing Policy**		
		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	• 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. • setting up of technical working groups for health financing at each tier of government and capacity building for the development and implementation of the Strategic Plans at all levels. • Federal Ministry of Health to provide technical assistance to support this process.
	4.2	**To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services**		
		4.2.1	To evolve and strengthen gender responsive systems for financial risk health protection	• States and LGAs will be supported to explore existing and innovative social health protection approaches – social health insurance, other pre-paid schemes, community-based health insurance schemes, etc - for sustainable health financing with protective measures against the financial risks associated with ill health. • Technical support will be provided to States and LGAs to rapidly scale up successful approaches to achieve wider population coverage. • The capacity of the NHIS needs to be strengthened to provide effective regulatory framework for social health Insurance and protection programmes in the country. • Review and amendment of the current law establishing the NHIS to provide the legislative backing for its regulatory authority.
	4.3	**To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner**		

		4.3.1	To improve financing of the Health Sector	• Mechanisms will be put in place to get governments at all levels to increase the allocation of public resources to the health sector (apportion 15% of total budget on health in line with Abuja Declaration) and to assist them in the effective and efficient use of these resources. • States and LGAs will be supported by the FMoH to test and implement strategies for attracting alternative financial flows to the health sector and to share lessons learnt. • Existing and potential financing strategies that will be considered include pre-payment schemes, and health insurance schemes, grants from the Federal Government, proportion of Value Added Tax (VAT), "sin tax" from alcohol and cigarette and donations from corporations and charities. • Special funds for chronic and emerging diseases (e.g. mental health, cancers, diabetics etc.) may also need to be established. • The establishment of alternative financing sources will include careful consideration of the impact on poverty and gender • Financing safety nets will be established to protect the interests of the poor and vulnerable groups.
		4.3.2	To improve coordination of donor funding mechanisms	• The FMoH in collaboration with Development Partners will conduct a detailed assessment of coordination structures and functions which exist in the country • Appropriate models for more effective coordination will be established on a State by State basis and at the Federal level. • Mechanisms for coordinating donor resources with that of government for health development are expected to take the form of common basket funding through options such as joint funding agreements, sector-wide approaches (SWAps) and sectoral multi-donor budget support etc. • The implementation of Paris declaration on aid effectiveness with a follow up of the Accra agenda will be promoted.
	4.4	**To ensure efficiency and equity in the allocation and use of health sector resources at all levels**		
		4.4.1	To improve Health Budget execution, monitoring and reporting	• The FMoH will provide technical assistance to aid States and LGAs in developing costed, annual operational plans. • Additional capacity will be built to ensure that proper internal recording and accounting of expenditures are maintained and that timely and detailed financial management reports are produced periodically. • Credible mechanisms will be put in place to increase financial transparency through the development of National and State Health Accounts (NHA and SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets.
		4.4.2	To strengthen financial management skills	• Hands-on training and competency transfer will be conducted to enable the States and LGAs manage their financial management systems.
NATIONAL HEALTH INFORMATION SYSTEM				
5. To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care				
	5.1	**To improve data collection and transmission**		
		5.1.1	To ensure that NHMIS forms are gender responsive and available at all health service delivery points at all levels	• States and LGAs will make forms available by providing adequate budget and ensuring that funds are released for printing of the data collection forms. • The forms will be distributed to appropriate facilities to ensure their utilisation. • Forms will be produced 6 monthly.
		5.1.2	To periodically review of NHMIS data collection forms	• Health managers at States and LGAs will create mechanisms to ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools • To establish mechanisms for annual review.

		5.1.3	To coordinate data collection from vertical programmes	• The Health Data Consultative Committee at Federal and State levels in collaboration with partners and other government agencies will be revitalised to streamline and strengthen data collection systems. • The FMoH will integrate the current HIS with M&E system in the country to ensure coherence and complementarity. • Linkages and harmonized data collection mechanism at State and LGA levels will be established and strengthened.
		5.1.4	To build capacity of health workers for data management	• Comprehensive training and re-training of service providers on data collection tools, analysis and utilisation of data for action in health programming and policy formulation will be conducted. A • dequate monitoring systems at Federal and State levels to ensure data quality will be established, • recruitment of health information personnel, where grossly inadequate, to support the system will be undertaken
		5.1.5	To provide a legal framework for activities of the NHMIS programme	• In order to make data collection and utilisation mandatory, the draft National Health Bill proposes sanction of private care providers that fail to submit health data to the relevant health authorities. • Mechanisms to enforce these sanctions will be put established. Additional legal framework for activities of the NHMIS programme will be put in place at State and LGA levels. • Systemic advocacy will be embarked upon to policy makers to make them understand the value and usefulness of • promulgate an enabling law and bye laws to make this mandatory. • The FMoH and SMoH will spearhead this advocacy both to the top government functionaries as well as National and State Assembly. • The vital registration system in the country will also be strengthened
		5.1.6	To improve coverage of data collection	• In order to have good database the national data collection process and coverage will be improved. • States will be encouraged to develop innovative strategies to collect data from all public and private health facilities and equally improve the collection of community based data. • Tthe National Population Commission will be supported to strengthen vital statistics of birth and death registration both by the federal and state government. • This will only be feasible if there are adequate data collection tools and follow up on defaulting facilities
		5.1.7	To ensure supportive supervision of data collection at all levels	• Supportive supervision of data collection at all levels will be carried out and provision for adequate logistics for officials to supervise data collection at lower levels will be ensured
	5.2	**To provide infrastructural support and ICT of health databases and staff training**		
		5.2.1	To strengthen the use of information technology in HIS	• Use of information technology on HIS will be strengthened, • Decentralized software-based systems for data collection and analysis will be promoted • Public-private partnerships in the management of data warehouses will be established • Establishment of mechanisms to enhance the wide use of e-health data, such as through electronic Management Intelligence Information System, websites, Patient information system, etc.
		5.2.2	To provide HMIS Minimum Package at the different levels (FMOH, SMOH, LGA) of data management	• An HIS Minimum Package at the different levels (FMoH, SMoH, and LGA) of data management will be defined. Subsequently, adequate and timely availability of the NHMIS Minimum Package at federal, state and LGA levels for data management, inclusive of basic infrastructure for data storage, analysis and transmission systems (computers, power supply, and internet) will be provided. • Appropriate use of computers hardware systems will be monitored while acquisition systems for database software at all levels will also be deployed. • capacity of relevant staff on the database will be built.

	5.3	**To strengthen sub-systems in the Health Information System**		
		5.3.1	To strengthen the Hospital Information System	• The Federal and State ministries of health will establish and strengthen patient information systems as well as systems for mapping disease
		5.3.2	To strengthen the Disease Surveillance System	• The Federal, State and LGAs will also ensure that regular reporting of notifiable diseases by all health facilities is carried out, • initiate and strengthen community based surveillance to strengthen disease Surveillance System.
	5.4	**To monitor and evaluate the NHMIS**		
		5.4.1	To establish gender inclusive monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs	• Timely availability of logistics materials (vehicles or motorcycles) will be provided • Use of NHMIS field monitoring instruments at all levels facilitated. • HIS Quality Assurance (QA) manual (Handbook) will be used at each level of health care delivery, • Quarterly HIS review meetings at LGA level, bi-annual review meetings at State level and annual meetings at National level instituted.
		5.4.2	To strengthen data transmission	• Institutional and human capacities for timely and complete transmission of data in line with relevant guidelines will be built
	5.5	**To strengthen analysis of data and dissemination of health information**		
		5.5.1	To institutionalize gender sensitive data analysis and dissemination at all levels	• Institutional and human capacities for appropriate data analysis and dissemination of information and data to inform decision making and programming will be strengthened. • Production of periodic health data bulletin and annual reports by Departments of Planning Research and Statistic at the Federal and States levels will be instituted.
COMMUNITY PARTICIPATION AND OWNERSHIP				
6.	**To attain effective gender inclusive community participation in health development and management, as well as community ownership of sustainable health outcomes**			
	6.1	**To strengthen community participation in health development**		
		6.1.1	To provide an enabling gender sensitive policy framework for community participation	• to create an enabling policy environment to foster effective community participation in health actions through the appropriate revision of community participation section of the National Health Policy and finalization of the Community Development Policy.
		6.1.2	To provide an enabling implementation framework and environment for community participation	▪ existing guidelines for establishing community development are to be updated and adapted and participatory tools ▪ approaches to enhance community involvement in planning, management, monitoring and evaluation of health interventions developed and utilised. ▪ establish inter-sectoral stakeholder committees involving community representatives at all levels so as to enhance collaboration.

	6.2	**To empower communities with skills for positive health actions**		
		6.2.1	To build capacity within communities to 'own' their health services	▪ To enable communities to actively participate in health actions, they need to be empowered with health knowledge and capacity in management, implementation, as well as basic interpretation of health data. ▪ The key roles and functions of community stakeholders and structures will be defined. ▪ To actualize the intervention, various processes will be followed, which starts with the development, upgrading or modification of existing participatory tools for mobilising communities in planning and management. ▪ Follow up actions to this will entail the identification and mapping out of key community stakeholders and resources with community assessment of capacity needs. ▪ Community development committees and community-based health care providers will be re-oriented on their roles and responsibilities and resources mobilized and allocated for funding for community level activities. ▪ Community dialogue between communities and government structures for maximum impact will be established and information, education and communication (IEC) activities and media used to enlighten and empower communities for positive action. ▪ Communities will be involved at all levels in program planning, implementation and monitoring of health activities.
	6.3	**To strengthen the community - health services linkages**		
		6.3.1	To restructure and strengthen the interface between the community and the health services delivery points	▪ Review and assessment of the level of linkages of the existing health delivery structures with the community. ▪ Technical guidance and support will be provided to community stakeholders for the development of guidelines for strengthening the community-health services linkage and ▪ Restructuring of health delivery structures to ensure adequate promotion of community participation in health development. ▪ Facilitation of exchange of experiences between community development committees will be promoted.
		6.4.1	To develop and implement gender equitable multisectoral policies and actions that facilitate community involvement in health development	• Advocacy to community gatekeepers to increase their awareness on community participation and health promotion will be undertaken • community health development programmes developed and implemented. • Action plans to facilitate the development of health promotion capacities at community levels will be formulated • support will be given to various levels to link health with other sectors using the health promotion guidelines.
	6.5	**To strengthen evidence-based community participation and ownership efforts in health activities through researches**		
		6.5.1	To develop and implement gender sensitive systematic measurement of community involvement	• Locally existing framework for measurement of community involvement efforts (methods, and impact, which showcases the various models that have been adopted, and opportunities to learn lessons) will be assessed. • Locally adapted models 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 • findings from such efforts will be disseminated to enhance knowledge sharing amongst stakeholders

PARTNERSHIPS FOR HEALTH				
7.	**To enhance harmonized implementation of essential health services in line with national health policy goals**			
	7.1	**To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector**		
		7.1.1	To promote Public Private Partnerships (PPP)	• The existing national PPP policy for the country will be updated with a view to leveraging technical and financial resources alongside improved management approaches for improved delivery of health care services. • Strategies for implementing PPP initiatives in line with this national policy will be developed a • PPP units at all levels to promote, oversee and monitor PPP initiatives will be established. • Mechanisms for engaging the private sector – such as contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism and provision incentives (e.g health commodities, or technical support at no cost) will be undertaken • Other options that encourage the private sector set up health facilities in rural and under-served areas will be explored. • Joint monitoring visits by public and private care providers with adequate feedback are to be established.
		7.1.2	To institutionalize a framework for coordination of Development Partners	• establishment of *Development Partners Forum* comprising only health development partners at Federal and State levels as single entry points for engaging with partners. • The Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners will be strengthened and similar mechanisms will be established at state level. • mechanisms for resource coordination through common basket funding models such as Joint funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support will be established.
		7.1.3	To facilitate inter-sectoral collaboration	• have to take specific actions within their spheres of influence that would synergize the key health specific actions that could in turn bring about health gains for the entire population. • an inter-sectoral ministerial forum at all levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes – such as Environment in Malaria control and prevention, Agriculture in nutrition programmes, Water Resources in control of water borne or related diseases, Women Affairs in Maternal, Newborn and Child Health, and Information in Behaviour Change Communication (BCC) programmes will be established.
		7.1.4	To engage professional groups	• Promote effective partnership with professional groups through jointly setting standards of training by health institutions, subsequent practice and professional competency assessments; • engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes; • Promote effective communication to facilitate relationships between professional groups and Ministries of Health; • strengthen collaboration between government and professional groups to advocate for increased coverage of essential interventions, particularly increased funding; • convene public lectures through a coordinated approach by professional associations to enhance the provision of skilled care by health professionals; • Promote linkages with academic institutions to undertake research, education and monitoring through existing networks; • influence regulation and legislation to allow for competency-based practice by all types of health professionals according to the principles of "continuum of care".

		7.1.5	To engage with communities	• Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels; • Information packages for community consumption should include rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services; • develop indicators on health system performance at States, LGAs and facilities to improve transparency and accountability of the government to its citizens; • institute mechanisms for competition between States, LGAs and facilities for satisfactory performance in delivery of community support programmes for health; • establish and empower Health Service Charters at all levels, with Civil Society Organisations, traditional and religious institutions to promote the concept of citizen's rights and entitlement to quality, accessible basic health services; • build the capacity of communities to prevent and manage priority health conditions through appropriate self-mediated mechanisms such as Behaviour Change Communication (BCC), Social marketing, Public Awareness Campaign, Information, Education and Communication resources (IEC), etc
		7.1.6	To engage with traditional health practitioners	• Seek to have better understanding of traditional health practices and support research activities to gain more insight and evaluate them; • organise traditional medicine practitioners into bodies/organisations that are easy to regulate and actually regulate their practice; • adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful; • train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system; • where applicable seek the cooperation of traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene, immunisation and family planning; and (• discourage traditional health practitioners from advertising themselves and making false claims in the public media.
RESEARCH FOR HEALTH				
8. To utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform				
	8.1	**To strengthen the stewardship role of governments at all levels for gender sensitive research and knowledge management systems**		
		8.1.1	To finalise the Health Research Policy at Federal level and develop gender sensitive health research policies at State levels and health research strategies at State and LGA levels	• Health research strategies will be developed at all levels. • These interventions can be facilitated by convening Technical working groups to finalise or develop health research policies and strategies at all levels. • Establishment of Health research steering committees at all levels to shepherd research activities at all levels.
		8.1.2	To establish and or strengthen gender responsive mechanisms for health research at all levels	• The capacities of health research divisions and units at all levels to coordinate and encourage research efforts are to be strengthened, linking researchers and creating communities of practice. • Departments of Planning Research and Statistics (DPRS) at all levels are also to be similarly strengthened • Creation of active research units in FMOH, SMOH and LGA to undertake operations research and other research-related activities. • The coordinated implementation of the Essential National Health Research (ENHR) guidelines is to be ensured.

		8.1.3	To institutionalize processes for setting health research agenda and priorities	• Functional institutional structures for research are to be established and or strengthened. • The health research agenda will be expanded to include broad and multidimensional determinants of health and ensure cross-linkages with areas beyond traditional boundaries and categories. • Guidelines for collaborative health research agenda are to be developed at all levels.
		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	• Strong links will be established between the users of research such as policy makers and the producers of research such as universities. • Governments at all levels will establish a forum of health research officers at the FMOH and SMOH plus LGA. • There will be annual convening of multi-stakeholders forum to identify research priorities and harmonize research efforts. • Governments at all levels will have to support the development of collaborative research proposals and their implementation between governments and public and private health research organisations.
		8.1.5	To mobilise adequate financial resources to support health research at all levels	• At least 2% of health budget will be allocated for health research at all levels. • Funds for health research will be deployed in a targeted manner while expanding beneficiaries of funding to researchers from both public and non-public health research organizations and individuals. • Opportunities for accessing funds from bilateral and multilateral organizations, research funding agencies and through north-south and south-south collaboration will be explored. • To attract additional funds, a credible and transparent independent national research funding agency will be established
		8.1.6	To establish ethical standards and practise codes for health research at all levels	• Health research ethical mechanisms, guidelines and ethical review committees at federal and state levels will be established and or strengthened. • similar mechanisms in tertiary health and education institutions will be strengthened • monitoring and evaluation system to regulate research and use of research findings at all levels also established
	8.2	**To build institutional capacities to promote, undertake and utilize research for evidence-based policy making in health at all levels**		
		8.2.1	To strengthen identified health research institutions at all levels	• To mitigate this, Governments at all levels should strengthen identified health research institutions identified by inventory of all public and private institutions and organizations undertaking health research. • Periodic capacity assessment of health research organizations and institutions will be conducted. • Governments at all levels and development partners in conjunction with health research organizations/institutions are to develop and implement measures to address identified research capacity gaps and weaknesses. • The development and implementation of resource mobilization strategies targeting the private sector, foundations and individuals for health research are to be ensured.
		8.2.2	To create a critical mass of health researchers at all levels	• a critical mass of researchers in conjunction with training institutions will be created while developing appropriate training interventions for research, based on the identified needs at all level. • Governments will regularly provide competitive research grants for prospective researchers while motivating increased PhD training in health in tertiary institutions through award of PhD studentship scholarships
		8.2.3	To develop transparent approaches for using research findings to aid evidence-based policy making at all levels	• Mechanisms for translating research findings into policies will be evolved. • Close liaison and linkages between research users (e.g. policy makers, development partners) and researchers will be established. • A wide range of actors including research producers will be involved in policy-making consultations

		8.2.4	To undertake research on identified critical priority areas	• systematic researches on a number of topical areas such as:
				  • Estimating the burden of different diseases biennially,
				  • undertaking biennial Human Resources for Health studies;
				  • studies on health system governance (HSG);
				  • biennial studies on health delivery systems;
				  • studies on financial risk protection, equity, efficiency and value of different health financing mechanisms biennially,
				as may be determined by policy makers and other key stakeholders will be undertaken.

	8.3	**To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)**		
		8.3.1	To develop strategies for getting research findings into strategies and practices	• Deliberate efforts will be made to utilize research outputs in the short to medium term to improve strategies and practices in the health sector by establishing getting research into strategies (GRISP) units at all levels and instituting bi-annual Health Research-Policy forums at all levels.
		8.3.2	To enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system	• To conduct needs assessment to identify required health research gaps at all levels • Undertaking operations research by all government Health Ministries, Departments and Agencies at all levels. • Public and non-public research organizations/institutes will be contracted to collaborate with government in the conduct of operations research thereby addressing gaps in research capacity in government institutions.
	8.4	**To develop, implement and institutionalize health research communication strategies at all levels**		
		8.4.1	To create a framework for sharing research knowledge and its applications	• to publish the research findings in academic journals, involve the development of a framework for sharing research knowledge at all levels. • Annual health conferences, seminars and workshops at Federal and State levels on key thematic areas (financing, human resources, MDGs, health research, etc) will be convened. • Opportunities for international collaboration on national research agenda, both in terms of ensuring research findings from Nigeria are published and presented in other countries and that Nigerians receive research updates from other countries will be pursued. • Participation in international conferences on health and mainstream best practices at National, State and LGAs will be ensured.
		8.4.2	To establish channels for sharing of research findings between researchers, policy makers and development practitioners	• Governments and donors will develop the capacity of researchers to effectively produce policy briefs targeted at informing policy-makers, as well as the broad scientific and non-scientific audiences. • An inventory of national journals according to areas of focus will be conducted. • Selection of national journals to be supported on the basis of their ability to address issues related to Essential National Health Research (ENHR) principles. • Governments and donors will support the publication of high quality national journals, following a review of editorial boards, establishing appropriate linkages between editors of national journals and reputable publishers (especially online, free web-based access publishers) and international collaborators, to improve the quality of national journals. • Wide dissemination of selected national journals to all stakeholders at federal, state and LGA levels will be vigorously pursued.

Key	
Code	**Corresponding Colour**
Strategic Priority Area	
Goal of Strategic Priority Area (one for each priority area)	
Strategic Objective(s)	
Strategic Interventions	
Strategic Tasks/Activities	

3.1 Essential Package of Care

*The package is grouped according to three "service delivery modes", namely **family-oriented, community-based services** that can be delivered on a daily basis by trained community health, nutrition or sanitation promoters with periodic supervision from skilled health staff; **population-oriented, schedulable services** that require health workers with basic skills (e.g. auxiliary nurses/midwives and other paramedical staff) and that can be delivered either by outreach or in health facilities in a scheduled way; and **individually oriented clinical services** that require health workers with advanced skills (such as registered nurses, midwives or physicians) available on a permanent basis.*

FAMILY/COMMUNITY ORIENTED SERVICES	POPULATION ORIENTED/OUTREACHES/SCHEDULABLE SERVICES
Insecticide Treated Mosquito Nets for children under 5	Family planning
Insecticide Treated Mosquito Nets for pregnant women	Condom use for HIV prevention
Household water treatment	Antenatal Care
Access to improved water source	Tetanus immunization
Use of sanitary latrines	Deworming in pregnancy
Hand washing with soap	Detection and treatment of asymptomatic bacteriuria
Clean delivery and cord care	Detection and management of syphilis in pregnancy
Initiation of breastfeeding within 1st hr. and temp management	Prevention and treatment of iron deficiency anemia in pregnancy
Condoms for HIV prevention	Intermittent preventive treatment (IPTp) for malaria in pregnancy
Universal extra community-based care of LBW infants	Preventing mother to child transmission (PMTCT)
Exclusive Breastfeeding for children 0-5 mo.	Provider Initiated Testing and Counseling (PITC)
Continued Breastfeeding for children 6-11 months	Condom use for HIV prevention
Adequate and safe complementary feeding	Cotrimoxazole prophylaxis for HIV+ mothers
Supplementary feeding for malnourished children	Cotrimoxazole prophylaxis for HIV+ adults
Oral Rehydration Therapy	Cotrimoxazole prophylaxis for children of HIV+ mothers
Zinc for diarrhea management	Measles immunization
Vitamin A - Treatment for measles	BCG immunization
Artemisinin-based Combination Therapy for children	OPV immunization
Artemisinin-based Combination Therapy for pregnant women	DPT immunization
Artemisinin-based Combination Therapy for adults	Pentavalent (DPT-HiB-Hepatitis b) immunization
Antibiotics for U5 pneumonia	Hib immunization
Community based management of neonatal sepsis	Hepatitis B immunization
Follow up Management of Severe Acute Malnutrition	Yellow fever immunization
Routine postnatal care (healthy practices and illness detection)	Meningitis immunization
	Vitamin A - supplementation for U5

INDIVIDUAL/CLINICAL ORIENTED SERVICES		
Family Planning	Artemisinin-based Combination Therapy for children	TB case detection and treatment with DOTS
Normal delivery by skilled attendant	Artemisinin-based Combination Therapy for pregnant women	Re-treatment of TB patients
Basic emergency obstetric care (B-EOC)	Artemisinin-based Combination Therapy for adults	Management of multidrug resistant TB (MDR)
Resuscitation of asphyctic newborns at birth	Management of complicated malaria (2nd line drug)	Management of Severe Acute Malnutrition
Antenatal steroids for preterm labor	Detection and management of STI	Comprehensive emergency obstetric care (C-EOC)
Antibiotics for Preterm/Prelabour Rupture of Membrane (P/PROM)	Management of opportunistic infections in AIDS	

Detection and management of (pre)ecclampsia (Mg Sulphate)	Male circumcision	Management of severely sick children (Clinical IMCI)
Management of neonatal infections	First line ART for children with HIV/AIDS	Management of neonatal infections
Antibiotics for U5 pneumonia	First-line ART for pregnant women with HIV/AIDS	Clinical management of neonatal jaundice
Antibiotics for dysentery and enteric fevers	First-line ART for adults with AIDS	Universal emergency neonatal care (asphyxia aftercare, management of serious infections, management of the VLBW infant)
Vitamin A - Treatment for measles	Second line ART for children with HIV/AIDS	Other emergency acute care
Zinc for diarrhea management	Second-line ART for pregnant women with HIV/AIDS	Management of complicated AIDS
ORT for diarrhea management	Second-line ART for adults with AIDS	

Chapter 4

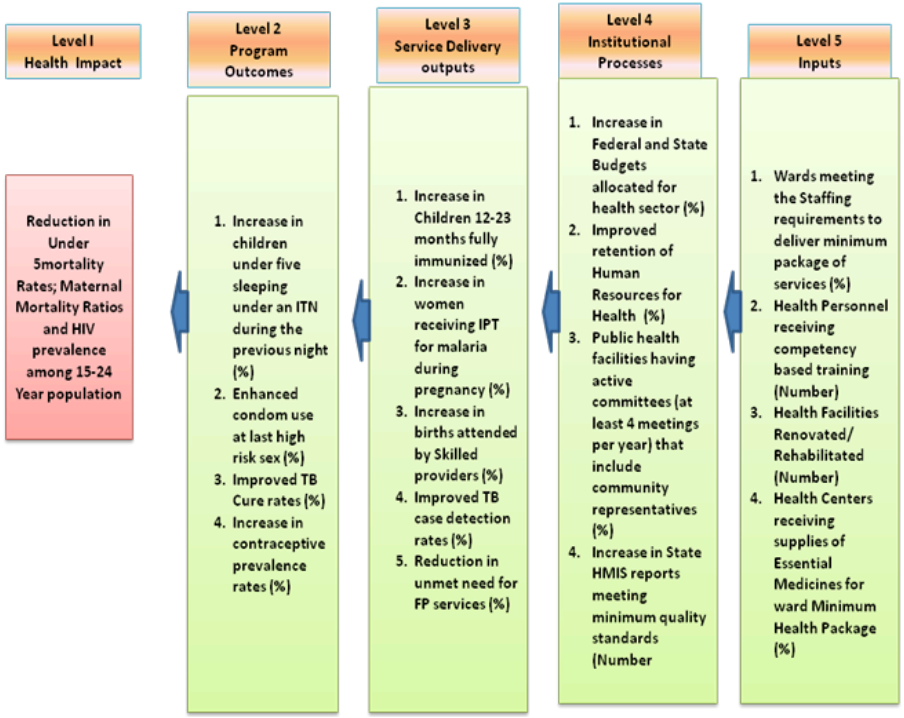
Results Matrix and Monitoring and Evaluation

The NHSDP recognizes that the improvement of health indicators in Nigeria is critical to achieve national targets and global MDGs and that reducing these inequities will accelerate the progress towards goals and MDGs.

4.1 Results Matrix:

The NHSDP Results Matrix provides an excellent summary of key performance indicators to assess the progress of the National Plan. It has a total of 52 indicators covering an essential combination of indicators on impact, outputs, process and inputs. Some of these indicators require population based data while others require facility based information collected by surveys, quantifiable supervision checklists, Health Management Information System (HMIS) and data from published reports and records. All indicators included in the National Results Matrix are clearly defined and baselines are available for most. Performance targets for each of these indicators have been established through a consultative process involving key stakeholders. The attached table presents logical flow of the indicators from inputs to health impacts.

Table 4: 1. The NSHDP Results Chain with selected indicators



4.2 Monitoring and Evaluation Systems:

The main purpose of the proposed Monitoring and Evaluation (M&E) System is to provide accurate, reliable and timely information on progress made by the NSHDP and provide regular reporting on the performance indicators listed in the results matrix. The proposed M&E system will have to meet this important reporting requirement and should ensure that the core principles of a standard M&E system (listed below) are addressed.

1. Provide data with adequate disaggregation meeting the reporting requirements of NHSDP and development partners;
2. Identify sub groups that are consistently missing out services to promote equitable access;
3. Use 3rd party assessments for evaluations to allow independence
4. Have clearly defined roles and responsibilities for M&E data collection, analysis and use to ensure accountability; and
5. Provide performance data for innovative financing instruments such as Results Based Financing, Conditional Cash Transfers and Contracting which require more precision in measuring results
6. Identify appropriate tools and methods covering both supply and demand side issues for providing accurate data and
7. Disseminate M&E results widely using approaches such as report cards to enable better informed program decisions

Apart from the above core principles , Statutory reporting to the NCH will be adhered to and there will be joint annual reviews by the government and development partners and other stakeholders to monitor the implementation progress for the NSHDP. Best practice from other settings indicates that the annual reviews will have a number of components.

Firstly, there will be quarterly field level joint monitoring by stakeholders to get a good feel of field reality. This will be done using a standard monitoring checklist which will be targeted at each of the six geo-political zones to ensure comparison. This checklist will be both qualitative and quantitative in scope. Second component will be a mid-year review which will use information from both the M&E system and the joint field monitoring exercises. The purpose of the mid-year review is to ensure that mid-course corrections are undertaken to the annual workplans and that the programme will not have to wait for a full year to agree and make such corrections. Finally is the annual programme review which will take place by year end (preferably end November or early December) and will have the purpose of annual stock-taking where important programme decisions will be made as well as serve as the basis for presentation and agreement on the next annual plans in draft. The Annual Health of the Nations report will also be previewed at this meeting and inputs made as necessary before final printing.

4.3 Approaches for Data Collection:

The main focus of the proposed M&E system will therefore be on collecting accurate, reliable and timely data on the NHSDP results at the prescribed intervals, using appropriate tools and providing data both from population and health facilities. A combination of approaches are proposed to implement the M&E systems to update the NSHDP results matrix accurately at the required periodicity. The proposed M&E systems will ensure adequate independence in information provided and will focus on building national capacities for data collection and analysis. A comprehensive table providing details of data collection instruments, frequency and responsibility is provided in table 4:2. The attached table summarizes different M&E methods proposed, types of information provided by each of them and frequency of data reporting during the NSHDP implementation period.

Table 4:3 Proposed M&E tools and methods for collecting data on NHSDP Results Matrix:

M&E Method	Information Provided	Year-wise M&E outputs					
		2010	2011	2012	2013	2014	2015
National Demographic and Health Survey (NDHS)	Population based data 26 Indicators covering Mortality, Fertility and Utilization of services		? Mini DHS		NDHS 5		? Mini DHS
Multiple Indicator Cluster Survey (MICS)	Population based data on on maternal and child health indicators covering mortality and utlization of services	MICS 3		MICS4		MICS5	
National AIDS and Reproductive Healht Survey (NARHS)	Population based data on HIV AIDS and reproductive health behaviours and use of services		NRHS 4		NRHS5		NRHS6
Facility Surveys	Facility based data on use of services, availability of inputs and quality of services	Pilots under HSDP	Round 1	Round 2	Round 3	Round 4	Round 5
Health Watch Group Reports	Data on community perceptions about health systems based on visits and community contacts in all 6 zones of the country	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports
Quatifiable Supervison Checklist	Facility based data on inputs, provider competency and quality of services	Pilots under HSDP	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports
National Health Management Information System (NHMIS)	Dta reported by health faciliteis on availability of inputs, use of services covering both public and private sectors including information on Surveillance of Communicable diseases	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports	Quarterly Reports
Human Resources in Health Database	Data on Human Resources incluidng availability, skill mix and projected demands	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports
Gezettes, Audits and Reports from Federal Ministry of Health and State Departments of Health	Data on Government notifications, budget allocation and execution, appropriate use and implemenation progress of respective plans	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports	Annual Reports

4.4 Strategy:

The Federal Ministry of Health, based on extensive consultations with States proposes to introduce more frequent household surveys in between the planned rounds of Demographic Health Surveys (DHS) and Multi Indicator Cluster Surveys (MICs) rounds. These are currently planned once every five and three years respectively. The focus will be on providing more disaggregated data at the state level. The feasibility of mini DHS and MICs rounds in between DHS as being done in some countries will be explored and if this is not possible, special surveys will be planned. At present, the next DHS round will be due in 2013 and two rounds of MICs will be due in 2010 and 2013 respectively. If these surveys are complemented by two rounds of mini DHS in 2011 and 2015 and three rounds of MICs (instead of 2 planned rounds) in 2010, 2012 and 2014, Nigeria will have one robust household survey following internationally accepted protocols every year during the next 5 years.

The Federal Ministry of Health will be supporting development of standardized tools and protocols for undertaking facility surveys and will also assist the states in developing and using quantifiable supervision checklists. Towards this, workshops and trainers training programs are planned during April-May 2010. The States will actively participate in this process and will identify appropriate institutions including public health schools, nursing/midwifery schools etc for capacity building and to undertake facility surveys on a sustained basis.

The FMOH has constituted a technical committee to facilitate this process and this committee will closely interact with all key stakeholders, including States and development partners, to ensure that the proposed strategy meets their reporting requirements fully.

Chapter 5
Resource Requirements

The resources required to fulfill the NSHDP is partly dependent on the current efficiency of the health service delivery and partly on the magnitude of ambitions to scale up the services during the next 6 years. There is no doubt that a potential for increasing efficiency in the current system exist. Moreover, without a comprehensive assessment of this important issue it is difficult to estimate resource requirements. Estimates of resource requirements must therefore remain crude based on available data. Efforts will be made to improve the basis for future analysis of the efficiency of the health service in the country.

[12]5.1 Required Human Resources

While Nigeria has one of the largest stocks of human resources for health in Africa, it is probably still inadequate to meet the country's needs. The ability of Nigerian health service to meet its health goals depends largely on the knowledge, skills, motivation and distribution of the health workforce. There are urban areas with a good coverage of the health workforce, and at the same time, there is almost an absence of such in other areas. This suggests that the resource requirements is not only just a matter of the total workforce in Nigeria, but also a challenge of getting a better distribution of the existing personnel.

Methodologically, there are no definite standards for assessing the sufficiency of the health work force to address the health care needs of a given population at a country level. It has been estimated however, that countries with fewer than 23 physicians, nurses and midwives per 10 000 population generally fail to achieve adequate coverage rates for selected primary health care interventions as prioritized by the Millennium Development Goals Framework[3]. Nigeria has 19.8 physicians, nurses and midwives per 10,000 populations [4]. Behind these numbers hide an inequitable distribution of the staff. In comparison, however the similar figure for Ghana is lower, only about 11 per 10,000 populations□: Ghana is achieving far better on most of the health targets that are set in the NSDHP□. This indicates that the Nigerian health system also has the potential for efficiency improvements.

In trying to estimate the number of personnel necessary to deliver the essential package of care, it will be necessary to take into consideration additional variables other than population size, which are known to play important roles in determining the impact of the health workforce performance on health outcomes in a given context. Such variables could be the availability of other personnel groups, availability of equipment, characteristics on population in terms of age composition, epidemiological variables, transport distances etc.

The future implementation of a national HRH policy must be lead by a continuous forecasting, monitoring and evaluation process. A national

[1]World Health Report 2006
[2]Source HRH Strategic Plan 2008-2012

[3]WHO Statistical Information System 2004
[4]WHO Statistical Information System 2004 - 2006

observatory on Human Resources for Health is an important tool to provide better knowledge on the need for HRH policies.

The difficulties in establishing estimates on future necessary growth in health workforce must not hinder an investment in more training and education of health personnel in Nigeria. It will represent an important investment for the future. Despite unemployment among some health workers in certain areas, the targeted level of activity in the NSHDP will require a significant increase in capacity of all types of health workers. The net supply of health personnel must increase to scale up service delivery according to the NSHDP. Additionally there is a need to implement a comprehensive strategy that will harness some of the human resources by;

- Using telemedicine;
- Financing/aid arrangements with other countries in which a significant population of Nigerian healthcare professionals reside and efforts to enable easier transition of these people to Nigeria; and
- Actively managing brain drain

The training curriculum for health personnel should be used as a means to achieve better coverage in rural areas. Other innovative approaches include the existing Midwife Service Scheme. The project seeks to mobilize 2,500 health personnel for deployment to the 652 designated health facilities in rural communities, to undertake a one year community service. This mobilisation exercise will include unemployed and retired but able midwives, and newly qualified graduates from the Nigerian Schools of Midwifery. This initiative seeks to provide an emergency stop gap to the shortage of skilled birth attendants at the primary health care level.

The Federal government is committed to implement the comprehensive National HRH policies to meet the aggregate demands for health personnel in the country. It is expected that these will be adopted by all states and LGAs latest by end of 2015

[5]5.2 Physical/Materials

In 2005 FMOH estimated a total of 23,640 health facilities in Nigeria of which 85.5% are primary, 14% secondary and 0.2% tertiary health care facilities. 38% of these facilities are owned by the private sector. Physical facilities are often decaying, equipment are obsolete. In order to sustain healthcare service delivery, increase access, ensure geographical spread and equity measures will be taken by the states. The State Plans envisages serious investments in physical structures and infrastructure through new buildings and renovations of existing health facilities. New hospitals and PHCs in under-served areas are planned. In addition facilities will be equipped in line with minimum requirements and upgraded during the 6-year strategic period. A comprehensive assessment of the status of equipment and supplies of medical consumables in the States is not currently available. Mapping of existing resources on each health facility has started in two states and will be strengthened to improve the basis for future planning.

As well as investments in health facilities there is a need for procurement of logistics, essential drugs, commodities and medical equipment for the successful implementation of the state and federal strategic plans.

5.3 Estimated costs of the Strategic Orientations

The total estimated costs of the NSHDP for the six year period 2010 / 2015 is NGN 3,997,966,085,850 (USD 26,653,107,239). This gives an

[5]Source: Costing workshop January Abuja. All costs are in USD. Conversion to NGN was based on the 2009 exchange rate of NGN150 per USD1.00.

annual cost per capita of NGN 4,745 (USD 31.63), when a population of 142,857,142.857 was applied. The estimated costs of the different strategic orientations reflects the challenges faced by the states in providing quality and available health service. See table below

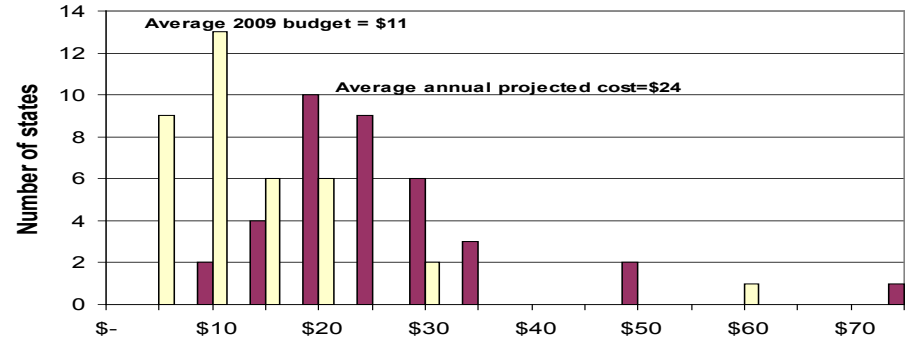
Priority Area	NGN	US$	Percent
Leadership And Governance For Health	27,587,202,750	183,914,685	0.69%
Health Service Delivery	1,946,257,153,350	12,975,047,689	48.68%
Human Resources For Health	1,664,676,299,550	11,097,841,997	41.64%
Financing For Health	218,976,510,300	1,459,843,402	5.48%
National Health Information System	41,605,199,400	277,367,996	1.04%
Community Participation And Ownership	23,913,081,450	159,420,543	0.60%
Partnerships For Health	25,502,477,700	170,016,518	0.64%
Research For Health	49,448,161,050	329,654,407	1.24%
Sum	**3,997,966,085,850**	**26,653,107,239**	**100.00%**

Source: Costing workshop January Abuja. All costs are in USD. Conversion to NGN was based on the 2009 exchange rate of NGN150 per USD1.00.

The national costs per capita of NGN 4,745 (USD 31.63) (included Federal plan) is close to the level of recommended expenses to attain a basic package of care at NGN5,100 (USD 34)[6], as estimated by the WHO Commission on Macroeconomics and Health. The NSHDP seems therefore to be nearly consistence with this recommendation.

At the State level, the average current per-capita budget for 2009 was about N1,725 ($11.50) with each State weighted equally. The average projected annual per capita expenditure for the State level is around N3,600 ($24) per capita (roughly doubling of costs). There is, however, a very large range in the current budgets as well as in the projected costs. See figure below.

Figure 5:1



Cost distribution according to The National Chart of Accounts was dominated by costs associated with salary and wages (39%) and capital investments (20%). See table below for more details.

[6]WHO - Commission on Macro-economic and Health

Table 5:1

National Chart of Account	NGN	USD	Percent
1100010 - Salary & Wages - General	1,549,084,541,550	10,327,230,277	38.75%
1200020 - Benefits And Allowances - General	139,526,668,200	930,177,788	3.49%
1300030 - Social Contribution	43,323,194,100	288,821,294	1.08%
2050110 - Travels & Transport - General	23,424,623,850	156,164,159	0.59%
2060120 - Travels & Transport (Training) - General	11,011,092,900	73,407,286	0.28%
2100200 - Utilities - General	42,728,882,700	284,859,218	1.07%
2150300 - Materials & Supplies - General	762,078,145,650	5,080,520,971	19.06%
2200400 - Maintenance Services - General	153,115,206,300	1,020,768,042	3.83%
2250500 - Training - General	85,698,145,350	571,320,969	2.14%
2300600 - Other Services - General	1,753,981,800	11,693,212	0.04%
2350700 - Consulting And Professional Services - General	12,599,752,800	83,998,352	0.32%
2400800 - Financial - General	172,440,320,700	1,149,602,138	4.31%
2450900 - Fuel & Lubricants - General	3,575,951,250	23,839,675	0.09%
2501000 - Miscellaneous	157,472,919,300	1,049,819,462	3.94%
3001100 - Loans & Advances - General	225,698,400	1,504,656	0.01%
4001200 - Grants & Contribution - General	24,231,426,150	161,542,841	0.61%
20000000 - Capital Investment	815,675,534,550	5,437,836,897	20.40%
Sum	**3,997,966,085,850**	**26,653,107,239**	**100.00%**

Chapter 6

Financing the NSHDP

This chapter considers the current health expenditure trends in Nigeria and estimates the financial resource needs for achieving the goals and targets of NSHDP. Taking into consideration the major potential sources for financing the health sector, an estimate of the financing gap and the strategic options for meeting the resource gap are presented.

The interplay of the funding sources and financing agents in the Nigerian health system is critical in ensuring adequate and timely resourcing of the National Strategic Health Development Plan. Equally for the delivery of high impact and cost effective health services within an enabling environment, will invariably promote universal access to health services. The strategic planning process for the development of the NSHDP has identified specific areas for the investments required for achieving the MDGs and health targets in Nigeria's Vision 20: 2020 blueprint for economic transition.

The financial plan of the NSHDP was therefore developed and based on a careful review of estimated costs, available and potential sources of resources, financing strategies relevant to the Nigerian context and funds allocation focused on achieving measurable results.

6.1 Assessment of the available and projected funds

The findings from the recently released NHA 2003 – 2005, highlights the critical role of government contributions to promote equitable access to essential health services, particularly for the poor and vulnerable such as women and children. With limited external aid, the onus lies on government at all levels to provide the bulk of resources required for the implementation of the 6 year NSHDP. Due to paucity of administrative routine data on budgetary allocations, releases and expenditures, the available funding from government was estimated using the retrospective review of the NHA data (1998 – 2005).

The NSHDP (2010 – 2015) projects significant financial resource needs from the public sector at the Federal, State and LGA levels for each of the eight (8) priority areas. This underscores the importance of predictable and sufficient investments by these tiers of government to achieve the targeted measurable results. In total, an investment of NGN3.997 trillion ($26.653billion) is required by governments over the six year period of the NSHDP with an annual cost requirement of NGN666.3 billion ($4.442billion). The specific earmarks by priority area and national chart of accounts are as detailed in section 5.3.

Government's share of the per capita health expenditure data from the NHA 1998 – 2005 is considered as the most reliable TGHE in estimating available funds from government to the sector as well as more accurate reflections of development partners' contributions for the same years. Based on the NHA data, projections for public expenditure on health including that of development partners have been estimated for 2010 in the first instance. This is expected to apply to subsequent years taking into consideration inflationary indices and the fact that the cost projections for the NSHDP are in constant 2009 USD rate.

The Government Share and DP share of the Total Health Expenditure in Nigeria 1998 – 2005 illustrates an overall increase in government health expenditure and notes a decline in contributions by Development partners as shown in Fig 6.1 and Table 6:1 below

The projection is based on the trend established from the available NHA data (1998 – 2005) and assumes a minimal yearly increase in both share of government expenditure out of HE (%) and government expenditure per capita from present levels.

Fig 6.1 Illustration of the estimated public expenditure on health (USD per capita) NHA 1998 - 2005 with projections to 2010

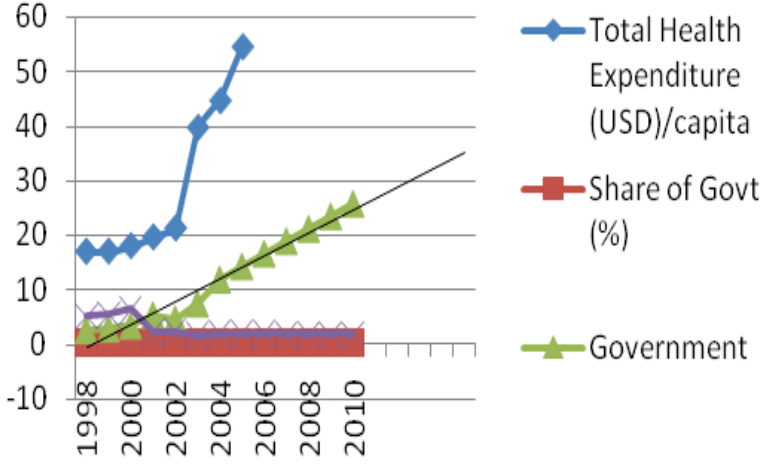


Table 6.1. Estimated public expenditure on health (USD per capita) NHA 1998-2005 including projections to 2010

Years	1998	1999	2000	2001	2002	2003	2004	2005
Total Health Expenditure (USD)/capita	16.96	17.01	18.00	19.60	21.26	39.76	44.67	54.61
Share of Govt (%)	14.96	16.61	18.77	27.22	21.60	18.69	26.40	26.02
Government ($)/capita	2.54	2.83	3.38	5.34	4.59	7.43	11.79	14.21
DPs	5.2	5.51	6.45	2.21	2.44	1.67	2.05	2.02
			2006	2007	2008	2009	**2010**	
			Projections					
Share of Govt (%)			26.50	27.00	27.50	28.00	28.50	
Government ($)/capita			16.53	18.81	21.09	23.37	**25.65**	
DPs			1.99	1.96	1.93	1.9	1.87	

6.2 Financing gap

The estimated per capita cost for delivering the evidence based plans prepared by the Federal and States Governments for the year 2010 is USD 31.6. This is fairly close to the costs estimated by the Commission for Macroeconomics in Health for delivering an essential health care package (USD 34) and it can be assumed that this is the minimum annual requirement to ensure the provision of essential health services for all Nigerians.

A review of the National Health Accounts data indicates a linear growth of government expenditure from 1998 – 2005. Assuming that the current trends in public expenditure by all three levels of Government will continue to grow in this linear trend until the year 2010 and that support from the development

partners is sustained, the resource envelope available for delivering the essential health care package would be about NGN3,848 (***USD 25.65 per capita)***. This would leave a ***financing gap of NGN897 (USD 5.98 per capita)*** needed for implementing the NHSDP for the specified year. In absolute terms this will translate to a short fall of nearly NGN 121.8USD million per annum, applying to a population of about 142,857,142.857.

These financial projections take into consideration a focus on the allocation of such funds for the implementation of the Strategic priorities within the NSHDP. The primary focus has been on high impact and cost effective delivzery of essential health services and operation of the federal health facilities at their current levels. The estimated costs also takes into consideration the marginal increase in resources required for addressing the identified bottlenecks in service delivery to optimize the public expenditure on the delivery of essential health services. Another assumption is that the funds would be deployed with strong results focus for additional investments in the health sector, with support from both domestic and the external partners. It is therefore important to note that the funding projections and estimated funding gaps do not cater for huge capital investments in health infrastructure.

Finally, it is important to note that demographic transition is taking place in Nigeria and disease pattern is also changing gradually. Increasing trends of non-communicable diseases, injuries and accidents will require additional investments as well as effective social health insurance schemes to safeguard against financial barriers to health services, while risk pooling mechanisms will ensure value for huge out of pocket expenditures being incurred by Nigerian households.

6.3 Financing the Plan: Strategic Investment Plan

As highlighted in previous sub-sections of this Chapter, the strategy for financing the NSHDP is not solely dependent on increases in Federal, State and LGA government spending. It also requires actions by all actors in the health sector - DPs, CSOs, private sector and philanthropists, in order to effectively utilise all available resources in the sector. The strategic investment plan underscores the need for effective implementation of the NSHDP towards achieving measurable results by providing a clear guidance on financing. The expenditure targets will only be achieved if resource commitments are met. On an annual basis, expenditure plans and budgets need to match available resources to meet the priorities identified by the yearly operational plans in order to achieve the NHSDP targets. It is important to ensure government flexibility in funding and untying aid by development partners to the health sector on a yearly basis to allow for necessary budget reviews that may require tradeoffs, trimmings, re-prioritization of earmarked funds, etc.

In resourcing the NSHDP therefore, three core principles are considered as platforms for leveraging funds from the various sources within and outside the Nigerian health system;

1. Optimizing the effectiveness of existing investments in the health sector spending by Federal, State and Local governments

2. Ensuring all additional investments in the health sector - from governments and development partners - have a strong result focus and support the achievement of the NHSDP results.

3. Ensuring better value for expenditures being incurred by households by promoting effective social health insurance and risk pooling mechanisms

1.) Optimizing the effectiveness of existing investments in the health sector spending by Federal, State and Local governments

Efficiency of spending in the sector will be determined if healthcare resources are being utilized to get the best value for money. Efficiency in the Nigerian health system will therefore be concerned with the relationship between resource;

- inputs such as costs, in the form of labour, capital, or equipment;
- intermediate outputs such as numbers treated, waiting time, etc and
- final health outcomes such as lives saved, life years gained, quality adjusted life years (QALYs).

In adopting the criterion of economic efficiency, it is implied that the Nigerian society will make choices that will maximize the health outcomes gained from the resources allocated to healthcare and this would be substantiated by evidence-based data. Inefficiency in the system will continue to exist when resources are not allocated in a way that would increase the health outcomes produced. This typifies the current situation.

Efforts must therefore be made to

- Achieve technical efficiency by ensuring that the available resources are deployed to maximum advantage;
- Ensure productive efficiency with different combinations of resources in the system in a manner that achieves maximum health benefit at the given minimal costs.

Equally, the system needs to be reviewed to ensure that Allocative Efficiency is achieved by funding a right mixture of healthcare programmes in order to maximize the health of the Nigerian society. State specific mix of interventions using existing health infrastructure towards addressing identified bottlenecks have been analyzed to show marked reductions in the effect of the bottlenecks, while indicating possible impact levels resulting from such efficiencies.

The THE in Nigeria was estimated at $44.67 per capita for the period 2003 – 2005. When compared with other developing countries in Africa, that have achieved improved health system performance for their populations[1], Nigeria's per capita expenditure ranks higher as illustrated in Table 6.3 below system.

Table 6:3: Per capita expenditure and health systems performance

Countries	Per capita health expd (US $)	% of GDP	WHO Health system ranking 2000
Ghana (2002)	13.6	4.24	135
Nigeria (2004)	44.67	7.96	187
Egypt (2001/2002)	71.26	6	63
Rwanda (2006)	33.93	11	172
South Africa (1998)	709.22	7.5	175
Malawi (1998)	33.3	7.2	185
Mozambique (1998)	31.51	4	184

Source WHO 2000 Health system performance country ranking

[1]2003 – 2005 Nigeria NHA Estimation, Final Report, 2009.

Since Nigeria is not an aid dependent country, the core operating government budgets at the Federal, State and LGA for all MDAs need to be utilized optimally. By so doing, specific government financial commitments to annual operational budgets and available funds allocated from the federal account to the health sector will be fully optimized. The level of funding determined by policy makers in the FMOH, FMF, Budget office of the federation and accountant general's office, as well as members of the legislative arms of government – the National assembly need to be appropriated and released timely, though in accordance to the national due process procedures and guidelines. Allocation of funds to prioritized areas within the NSHDP to ensure the delivery of high impact and cost effective interventions is required with a shift to financing for results, as a pre-requisite for success.

Increased funding of Primary Health Care (PHC) is arguably the most important financing goal for the current Government. Its commitment to the PHC approach and support of the ward health system must be backed up with sufficient financial resources. To explore recent funding and expenditure patterns in this area it is necessary to investigate allocations to different levels of care within the public health care system. The NHA 2003 – 2005 revealed a skewed allocation to curative services (74.2%) rather than public health prevention (12.8%) and to capital investments rather than to service delivery related spending. Such re-allocations need to be effected for currently available funds.

The MDG Debt Relief Gains Virtual Fund is another important and additional source for financing the health sector in Nigeria, since 2005, when the Paris Club group of government creditors wrote off about US$18 billion of Nigeria's debt. Allocation of the MDG Debt Relief Gains (DRG) for the delivery of cost effective and high impact health interventions would ensure the achievement of measurable results.

The Virtual Poverty Fund (VPF) managed by the Office of the Senior Special Assistant to the President on the MDGs (OSSAP,MDGs) disburses the DRG to various Government, Ministries, Agencies and Departments for projects that are directly pro-poor and can improve the performance of the country towards achieving the MDGs. The table below presents the disbursements for 2006 and 2007.

Recently, the DRG funds have been allocated for Community Based Health Insurance Schemes in 12 states (selected facilities and catchment populations in 3 LGAs per state) targeting maternal, newborn and child health services, health system strengthening initiatives and the Midwives Services Scheme. The continued allocation of the DRG funds in support of the National Results framework is critical.

Table 6:4 Top-up Revenue Allocated to MDAs from the Debt Relief Gains (b/₦)

	2007			2006		
Ministry	**Allocation**	**Appropriated**	**Appropriated (%)**	**Allocation**	**Appropriated**	**Appropriated (%)**
Education	18.00	15.35	85.29	20.79	18.22	87.65
Health	15.00	15.35	102.32	20.79	21.29	102.4
Agriculture	15.00	15.00	100.00	9.90	9.40	94.95
Water Resources	10.86	13.85	127.51	19.80	19.02	96.04
Power and Steel	10.00	10.11	101.09	14.85	16.96	114.22
Housing	3.00	3.00	100.00	0.50	0.50	100
FCT	2.00	1.80	90.00	-	-	
Youth	1.00	1.00	100.00		0.99	
Women Affairs	1.00	1.02	101.50	0.99	1.00	101.01
NACA	1.00	1.00	100.00	-	-	
WORKS				9.90	9.86	99.55
Environment				1.49	1.49	100
Conditional Grants	22.00	20.00	90.91			
Safety Nets	10.00	10.00	100.00			
Monitoring and Evaluation	2.00	2.00	100.00	1.00	1.00	100
Total	110.86	109.47	98.75	100.00	99.71	99.71

A key resource platform for the NSHDP implementation is the National Health Bill already passed by both the House of Representatives and the Senate, while awaiting Presidential Assent. The National Health Bill proposes a major paradigm shift in health financing in Nigeria through the establishment of a Fund to be known as the National Primary Health Care Development Fund. The Fund would be financed from the consolidated fund of the Federation, at an amount not less than 2% of its value; with grants by international donor partners; and funds from other sources serving as additional funding.

The Fund would be allocated as follows

(a) Funds for the provision of basic minimum package of health services to all citizens, in primary health care facilities through the National Health Insurance Scheme (NHIS) 50% ;

(b) Funds for essential drugs for primary healthcare services; 25% of the

(c) Funds for the provision and maintenance of facilities, equipment and transport for primary healthcare; 15% and

(d) Funds for the development of Human Resources for Primary Health Care services 10%

The National Primary Health Care Development Agency shall disburse the funds for items (b), (c) and (d) above totaling 50% through State Primary Health Care Boards for distribution to Local Government Health Authorities. Specific criteria have been detailed for State and LGAs to quality for the funds as grants, inclusive of payment of counterpart funds (LGA – 5% and State 10%)

The National Primary Health Care Development Agency is mandated by the Health Bill to develop appropriate guidelines for the administration, disbursement and monitoring of the fund accruing to the NPHCD fund.

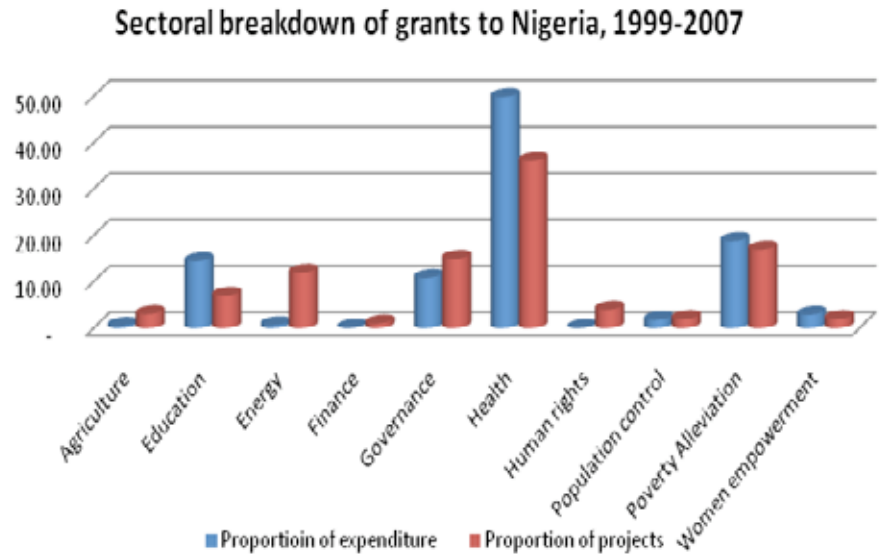
Ensuring that all additional investments in the health sector - from governments and development partners - will have a strong results focus and support the achievement of NHSDP results framework.

Nigeria's National Partnership on Health emerging from the First Presidential Summit on Health by the President and State Governors, is a potential catalyst to leverage additional funding to the sector. The declaration reflects the commitment to increase budget allocations to health at federal, state and LGAs from present levels by at least 25% each year towards meeting the Abuja 2001 Declaration of 15% national budget allocation to health. In addition, the National Partnership commits to at least 90% budget release and 100% utilization by the end of each year in the health sector. This increase in government allocations will ensure the utilization of available fiscal space within the public system at Federal, State and LGAs. In applying the funds, it is important that a results focus in support of the NSDHP is achieved.

Another source of finance for the health sector in Nigeria is the Official Development Assistance (ODA) from development partners and donors. Between 1999 and 2007, Nigerian received more than N6 billion in both credits and grants from development partners, of this, $3.2 billion were credit while $2.8 billion were grants. Although the sectoral and zonal distribution of the grants was uneven, the health sector had been the largest recipient. Figure 4 shows the share of donor support to various social sectors.

The proposed Country Compact with Development partners in health will provide the enabling platform to sustain present levels of ODA to health and also leverage additional predictable funding for the NSHSP towards achieving measureable health results. In Nigeria, a donor matrix outlining the Development partners' contribution to the health sector has been developed and serves as a veritable tool for negotiations of priority areas of the NSHDP to be supported by DPs.

Figure 6:2: Percentage of donor ODA to sectors in the Nigerian economy



In ensuring that funding opportunities are optimally utilized through the platform of the country compact, considerations need to be given to issues that will ensure the availability of Financial Absorptive capacities for the potential increase in aid. Good governance, sound macroeconomic management, effective public administration, improvement in financial system and effective fiscal management in the sector all create absorptive capacities. These are required by each level of government in order to absorb the potential increase in aid flow in the Nigerian health sector and in response to the NSHDP.

It is noteworthy that to achieve the desired levels of absorptive capacity,

- Technical assistance from the development partners must be instrumental.
- Fiduciary arrangements would need to be strengthened in the event that government and development partners in response to the NSHDP and the country compact explore opportunities for pooled funding arrangements.
- All additional investments in the health sector will have a strong results focus and support the achievement of NHSDP results frameworks through **Innovative Financing Mechanisms.**

The initial approach will include the innovative financing mechanism being pursued by government in mobilizing and channelling additional funds to health through VAT deductions. In this regard, there is an ongoing collaboration between the Federal Ministry of Health (FMOH), Federal Inland Revenue Service (FIRS), Federal Ministry of Finance (FMF), etc, to explore possible options. Efforts are also at advanced levels to strengthening Public Private sector Partnerships (PPP). These additional funding would be tied to health results.

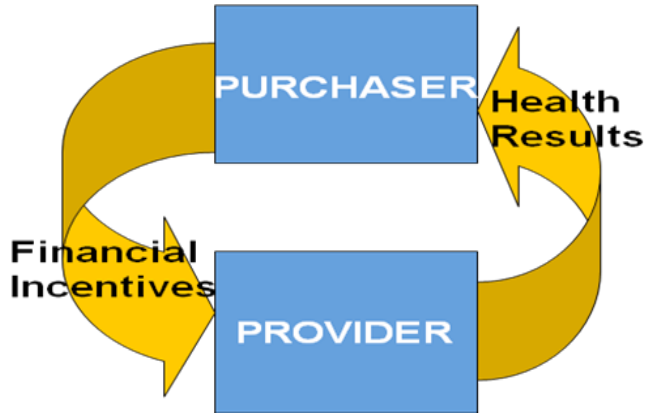
The recent developments have further broadened the scope of innovative financing mechanisms that explicitly link funding to results through mechanisms such as Results Based Financing (RBF), Conditional Cash Transfers (CCTs) and Performance based contracting for health.

The planning process for the NSHDP has highlighted a number of priorities and new ways of resourcing the plan. Linking additional investments in health to results, is a core principle recently adopted by the Federal and State Ministries of health. The Federal Government has indicated its willingness to pilot the projects of RBF, CCTs and performance based contracting for health in selected locations that will be determined by technical criteria.

The performance or results based financing pilots will require the transfer of money or material goods dependent on implementing

a measurable health related action or achieving a predetermined performance target. PBF/RBF is considered a strong financial mechanism which can change the Nigerian health system by providing performance incentives of health facility level with autonomy to address bottlenecks.

The essential elements for the initiation of PBF include:



- Performance contract for HF defining the rules of PBF;
- Focused public health and preventative services conditional on quality of services;
- Significant and regular performance based incentives for health workers and
- ensured autonomous management finances, resource allocation etc for measurable results;

Transparent governance systems and structures to manage, verify performance and oversee transparent use of funds, in addition to technical support, will be required to establish a good RBF/PBF system.

Conditional cash transfers (CCT) will provide incentives to beneficiaries of health services as a reward to increasing access to and utilization of basic health services, while at the same time creating incentives for behavioural change. In principle, government will transfer cash to poor families in response to the pre-specified actions and will in the short term support the household OOPE. In the mid-term, an accumulation of the CCTs may possibly break the inter-generational trends of poverty. It is, however, important to note that the effectiveness of the CCTs will only be effective if the supply side ensures accessible and affordable health services to beneficiaries and if there are no negative consequences from one health indicator on another.

Evaluation data and findings from the pilot schemes would guide and inform implementation of these schemes at a larger scale.

1.) Promoting effective risk pooling mechanisms:

Social Health Insurance and Risk pooling mechanism will ensure that users of health services, especially households, get better value for the substantive money spent on health with exemption schemes established and strengthened to reduce Out-Of-Pocket expenditure for vulnerable groups (children under-5, pregnant women, elderly, poor, etc).

This is underscored by the fact that OOPE contribution to the Total Health Expenditure (THE) is estimated at about 69%, indicating a health seeking behaviour and willingness to pay for health services. The need to ensure alternative means of financing the NSHDP towards ensuring universal access to quality and affordable health services is therefore critical to prevent catastrophic burdens and further impoverishment of already poor families.

Though the contribution of health insurance to health financing in Nigeria is still low, it has a high potential of making impact. Over the period 2003 – 2005, there was a significant increase in health insurance expenditure, even though its contribution to THE, was relatively constant at 2% over the three years under appraisal. The estimated expenditure on health insurance has increased from about N15.66 billion in 2003 to N21.34 billion in 2005. In addition, state level analysis shows that health insurance is limited to a few states, and where they exist, except in Lagos State, it accounts for just 1 to 2% of State Total Health Expenditure (STHE). The fact that health insurance is growing even if minimally and the fact that households are paying for their health as evidenced by the high share of Household Health Expenditure (HHHE) when compared to both State Government Health Expenditure (SGHE), suggests the need for effective risk pooling. The social health insurance (SHI) introduced recently in the formal sector has a high potential for expansion to the informal sector. Accordingly, SHI needs to be made inclusive by extending it to the informal sector. The NHIS in early 2009 developed the blueprint for implementing the Community-based Social Health Insurance Programme (CBSHIP) in the informal sector, which is currently being piloted in 12 states of the country with plans to scale up to the entire country by end of 2011. A current review of the challenges of CBSHIP will be critical in the scale up process to ensure effective and efficient services.

In summary, these three core principles provide tremendous means of leveraging resources to finance the NSHDP. They are also consistent with the principles and provisions of the National Health Financing Policy[1]. However, considering the limited financial resources, financing the NSHDP may require a phased approach in line with the M&E results matrix for the periods (i) 2010 – 2011; (ii) 2012 – 2013 and (iii) 2014 – 2015. The availability of funding would be premised on predictable, sustainable and sufficient financial resources mobilized from both domestic and external sources. Prioritized areas for action should receive priority funding using the phased approach.

[1]Federal Ministry of Health, Nigeria National Health Financing Policy, 2006

6.4 Financial Monitoring and Economic Evaluations

There is a wide spatial disparity in health care expenditure and its delivery across Nigeria, highlighting the concerns of equity. The spatial differences involve contributions and roles of government and the private sector both in funding health care and in health care delivery in the country. This issue highlighted in Chapter 5 requires action in addressing the equity gaps by the application and allocation of additional funding and investments to health. In general, households dominate funding health care across the country except in some Northern States, where the burden was much higher than the average rate. This showed that poor households in these states would be most vulnerable to catastrophic health expenditure. Governments at all levels, therefore, need to direct efforts at minimizing these disparities in financing the provision of health services by working towards equitable access to health care services. Budget monitoring and expenditure tracking during the implementation phase of NSHDP and institutionalization of NHAs, PERs, and economic evaluations including Public Expenditure Tracking Studies will provide routine and survey data on key variables required to support governance actions, transparency and accountability in the sector, while informing further revision of the financial plan to address equity, amongst other issues.

A Health financing task force comprising of government and representatives of development partners, the private sector and CSOs bodies with requisite technical expertise and experience is proposed to be established to function as a think tank and guide

the efforts to ensure effective resourcing of the NSHDP and regularly advice government, and DPs accordingly. This is akin to such bodies that advice the G8, the international donor community, the AU and some national governments in Africa. The main task of the team would be to ensure predictable and adequate levels of resources for the implementation of the NSHDP. The team would be required to work in close collaboration with M&E teams to ensure value for money in the utilization of the resources towards achieving measurable results.

Chapter 7

Implementation Modalities

7.1 Preamble

The NSHDP is a flexible, living document designed to address the national health and system priorities. It provides strategic direction for collective action by the Nigerian health system partners to;

- achieve the vision and goal of the health sector
- promote and protect health for all,
- eliminate health disparities, and transform the Nigerian health system.

The NSHDP is linked to the Vision 20:2020 and represents the national priorities, strategies and implementation framework for the whole national economy. It is an expanded version of the Vision 20:2020 chapter on health and presents a more detailed analysis of the existing situation, sector priorities, proposed strategies and expected outputs. The NSHDP is to serve as the tool for implementing the health component of the Vision 20: 2020 document plan which contains the National Health Objectives, the National Health Policy Targets, the vision's Medium Term Plan for Health, as well as detailed description of programmes and projects. The Medium Term Sector Strategy (MTSS) will also serve as important tools for implementing the NSHDP through annual operational plans for all planning entities at all levels of care, Federal, States, LGAs and development partners (in the IHP+ compact process).

7.2 Structures, Institutions and Processes

The implementation of the NSHDP is the responsibility of the authorities at the three different levels of the health care delivery system – Federal, State and LGA, in collaboration with all the stakeholders in health including the private sector, development partner agencies, NGOs in health, Civil Society Organisations (CSOs), Faith Based Organisations (FBOs) and Communities.

The leadership for the Implementation of the NSHDP at each level will be provided by the responsible authority – Federal Ministry of Health (FMoH) at Federal Level, State Ministry of Health (SMoH) at the State Level, and Local Government Health Authority (LGHA) at the Local Government Level.

An SHDP implementation steering committee will be established at the Federal and State levels to monitor the implementation of the plan accordingly. The steering committee will be chaired the Permanent Secretary of the FMoH, the Honourable Commissioner for Health at the State Level and the Chairman of the Local Health Management Team at the LGA level. It shall have representatives from the relevant departments/Units at the FMoH, SMoH and LGA Health Management Team, representatives of the Planning Commission Ministries at all levels, and relevant development partner agencies. The committee will be responsible for catalysing the implementation of the plans at each of the levels; mobilising government support for implementation through advocacy planning and implementation; resource mobilisation,

awareness creation and engagement of all stakeholders that are crucial to the implementation of the plans

i.) *Operational Plans*

Based on peculiar priorities, the Federal, State and LGAs will extract strategic activities from their SHDPs, to develop their MTSS and annual operational plans. These plans will show detailed activities that are linked to key deliverables towards the achievement of the targets of the plans. Technical assistance will be provided to the Federal, State and LGAs to develop plans with realistic costing and stakeholder participation in facilitating the implementation. It is the responsibility of the Departments of Planning Research and Statistics at all levels to ensure that these plans are developed annually and to monitor their implementation using a suitable tool that ties deliverables to the results/targets of their respective SHDPs. To this effect, the FMOH will prepare and disseminate specific guidelines on how to operationalize the NSHDP into MTSS and annual operational plans.

ii.) *Resources*

The NSHDP will have a direct influence on resource requirements, mobilization and allocation to the health sector. The implementation of the SHDP at all levels requires committed human and financial resources. Dedicated resources are required to

- facilitate the meetings of the steering committee; and
- strengthen the DPRS at all levels of planning and monitoring; and reporting on progress and implementation of the M&E plan.

Core technical staff will be identified in the DPRS at each level, they will be empowered with necessary skills in planning, monitoring and evaluating the tools necessary to facilitate their work. The SHDP implementation steering committee is responsible for identifying resource needs and mobilisation from governments and development partner agencies. Resource mobilization and allocation will be directed towards addressing the health sector priority interventions to achieve the vision and goal of the NSHDP.

ii.) *Managing implementation*

The SHDP implementation steering committee and the DPRS at each level will be responsible for managing the implementation of the SHDPs. Managing implementation of the SHDPs will require provision of TA for development of operational plans; orientation of all stakeholders on the plan and required actions and responsibilities for achieving the targets of the plan; progress review and feedback.

7.3 Strategic Partners

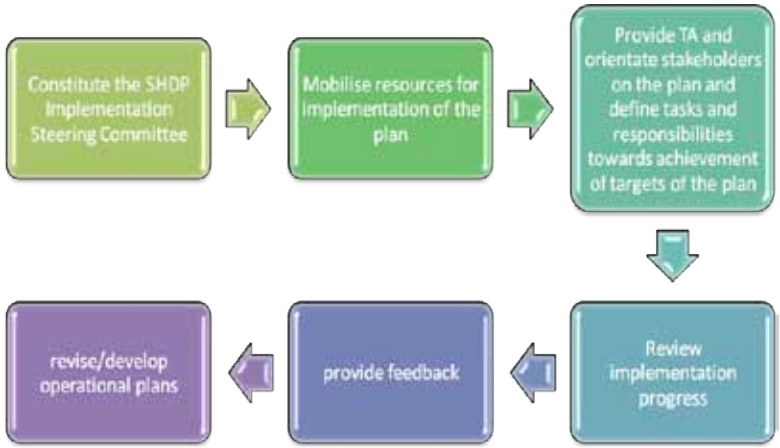
The FMOH will periodically review the overall progress of the implementation of the NSHDP. It will provide feedback to all the states highlighting their progress towards achieving set targets in the Presidential Health Summit Declaration. Since all governments have signed onto this declaration, which has committed them to delivering on key results and targets of the NSHDP, this activity will facilitate accountability and provide information that will enable healthy competition among the States. The development partner agencies, CSOs and media will be closely involved in this process.

The Country Compact on the NSHDP requires development partner agencies to align with and support the implementation of the NSHDP at all levels. In line with this compact therefore, development partner agencies are important and key stakeholders in the implementation of the NSHDP, and the SHDPs at the Federal, State and LGA.

All development partner agencies in health will engage with the responsible authority at the Federal, and State levels to support the implementation of the SHDPs, especially in providing technical

support and building the capacity of the implementation teams at all levels of planning, monitoring and evaluating the progress of the implementation strategies among others. They will provide financial support for the implementation of the SHDPs within the limits of their resources and extant financial policies.

Key Steps



Annexes

Annex 1: National Results Matrix and M&E Systems

National Operational Plan for the Monitoring and Evaluation Framework for the National Strategic Health Development Plan (NHSDP)

1. Introduction

This National Operational Plan for Monitoring and Evaluation Framework for the National Strategic Health Development Plan (NSHDP) was developed by a group of experts from various agencies including the Federal Ministry of Health, NPHCDA, UNICEF, USAID, The Partnerships for Transforming Health Systems 2 (PATHS2), UNFPA, The World Bank, UNAIDS and WHO.

The purpose of the National M&E Framework is aimed at getting, data periodically to measure progress towards the goals and objectives of the NSHDP at the national level. The M&E Framework also allows states to collect and analyse their own data and be better able to adjudge where improvements are needed in their programmatic interventions. In addition, it promotes comparison of performance on key indicators among states and among different geo-political zones in the country. At the national level such, performance on selective indicators are expected to be published periodically, disaggregated states by states and by extension, states are expected to do likewise at the LGA levels.

This National M&E Framework encourages participation of different actors (public sector, private-for-profit, private-not-for-profit, NGOs, faith-based organizations, etc.) in harmonizing their data and be mutually accountable for results at their respective levels. To complement the National M&E Framework, a generic sub-national M&E framework has also been developed that states and LGAs can adapt to their own contexts, although indicators selected for sub-national are different from those of the national level. At sub-national level, the focus is more on inputs, processes and outputs, whereas at the national level, the indicators are more on outcomes and impacts.

2. Definitions

It is important to clearly differentiate between monitoring *and* evaluation as they serve different purposes in an M&E system.

Monitoring is the *routine tracking* of the key elements of programme performance through record keeping, regular reporting, surveillance systems and periodic surveys. Monitoring assists programmes to determine which areas require greater efforts or change in strategies and identify areas that contribute to improved performance. In this proposed M&E framework, monitoring contributes greatly to evaluation. Indicators selected for monitoring will be different depending on the reporting level within the health system and the range of interventions integrated.

Evaluation is the *periodic assessment* of the change in targeted results that can be attributed to an intervention. It attempts to link a particular outcome or (health) impact directly to a particular intervention after a period of time. It helps determine the value or worth of a particular programme. The results can also help to strengthen the implementation of the programme. Evaluations can be used to link any two parts of the M&E framework (inputs, processes, outputs, outcomes, or impact). For

example, one could evaluate whether financial inputs are effectively generating the desired trainings or service deliveries.

Indicator is a gauge of progress which should be measurable, factual, valid, verifiable and sensitive. Indicators could be at the levels of input, process, output, outcome and impact in a programme. The National M&E Results Framework consists of 52 indicators carefully selected because of national and international commitments to their achievements and they measure performance, outcomes or impacts in the eight priority areas agreed for the NSHDP. Please see Appendix 1.

Targets on the other hand, are levels of achievement for indicators at a given time frame. For this M&E Results Framework, final targets have been set for end of 2015 i.e. the end of the planning period. But intermediate targets have been set for 2011 i.e. 2 years into the life of the NSHDP and 2013, 4 years into the life of the programme. The intermediate targets could be regarded as milestones during the planning horizon.

3. Approaches to Data Collection

Many approaches to data collection have been examined for the M&E Operational Plan. These approaches build on existing routine systems, surveys and special studies that are already ongoing. However special studies and/or approaches are proposed if the routine system cannot provide the required information at all, or produce them in untimely fashion. This is expected to strengthen the health system and avoid the creation of parallel and unsustainable systems.

To make this operational plan light on all concerned, data collection frequency and sources have been streamlined. The Frequency varies from only once in the life of the NSHDP for two indicators to annually for 36 indicators; biennially for 9 indicators, and every five years for 5 indicators. The major instruments for data collection are: The National Demographic and Health Survey which happen every five years (for 25 indicators); the Multiple Indicators Cluster Surveys which are conducted every 3 years (for 24 indicators); FMoH/SMoH reports for 15 indicators; NARHS Surveys every two years (for 6 indicators); HMIS Reports will be used for 1 indicator, NPHCDA Surveys (for 3 indicators); biannual immunization coverage surveys (for 3 indicators); and finally, a new proposed instrument -- The Annual Household and Facilities Surveys to speed up the timely collection and dissemination of key indicators (for 28 indicators) as other instruments are not flexible enough to collect data annually. For obvious reasons, many indicators have more than one source of data. This will permit comparison of data from various sources for the same indicator so as to accommodate deficiencies in, and limitations in design and methodology

In-like manner, the responsibility for data collection have been assigned to those who are currently in charge of collecting them and very importantly when there are new sources of information, responsibilities have been assigned to the institution with comparative advantage in collecting them.

Table 1: Selected Indicators, Data Collection Instruments, Frequency and Responsibility

Indicator	Data Collection and Reporting		
	Frequency	Instruments	Responsibility
Overarching Indicators			
1. Life expectancy at birth	5 yearly (baseline 2010 & end line 2015)	NDHS/MICS/Annual Household and Facilities Survey Phases I & III (HHFS-I & III)	National Pop. Commission(NPC)/ National Bureau of Statistics (NBS) and DPRS-FMoH
2. Under-five mortality rate	5 yearly (baseline 2010 & end line 2015)	NDHS/MICS/ HHFS Phases I & III)	NPC/NBS and DPRS-FMoH
3. Infant mortality rate	5 yearly (baseline 2010 & end line 2015)	NDHS/MICS/HHFS Phases I & III)	NPC/ NBS and DPRS-FMoH
4. Proportion of 1 year old immunized against measles	Yearly	Immunization Coverage Surveys/NDHS/MICS/ HHFS Phases I-III	NPC/NBS and DPRS-FMoH
5. Prevalence of children under five years of age who are underweight	Yearly	NDHS/MICS/Annual HHFS Phases I – III	NPC/NBS and DPRS-FMoH
6 Percentage of children under 5 sleeping under insecticide-treated bed nets	Annually	NDHS/MICS/HHFS Phases I – III	NPC/NBS and DPRS-FMoH
7. Maternal mortality ratio	5 yearly (baseline 2010 & end line 2015)	NDHS/HHFS Phases I & III	NPC/NBS and DPRS-FMoH
8. Adolescents Birth Rates	5 yearly (baseline 2010 & end line 2015)	NARHS/NDHS/MICS/HHFS Phases I & III	NARHS-FMoH/ NPC/NBS/ DPRS-FMoH
9. HIV prevalence among population aged 15- 24 years	Biennially	NARHS/NDHS/MICS/HHFS Phases I & III	NPC/NBS and DPRS-FMoH
Priority Area 1: Leadership and Governance			
10. National Health Act gazetted.	Once	Federal Government Gazette	FMoH/Head of Services (HoS)
11. Percentage of State adopting the National Health Bill (to their LGAs)	Annually	SMoH Annual Reports	SMoHs
12. % of states executing more than 70% of the annual non-personnel budget	Annually	Federal and State Auditors General and Accountants Generals' Reports	FMF/Auditors General's offices
13. % of federal and states/FCT with published annual Health Watch Reports	Annually	Health Watch Reports	FMoH and SMoHs

Indicator	Data Collection and Reporting		
	Frequency	Instruments	Responsibility
Priority Area 2: Health Service Delivery			
14. % wards with a functioning public health facility providing minimum health care package according to quality of care standards.	Biennially (2011, 2013, & 2015)	HHFS Phases I-III	DPRS-FMoH
15. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	Biennially	NARHS/NDHS/MICS	National AIDS and STI Control Programme (NASCP)-FMoH/ NPC/NBS
16. % of HIV infected pregnant women who receive ARV prophylaxis to reduce the risk of MTCT.	Biennially	NARHS/NDHS/MICS	NASCP-FMoH/ NPC/NBS
17. Proportion of population with advanced HIV infection with access to antiretroviral drugs	Biennially	NARHS/NDHS/MICS	NASCP-FMoH/ NPC/NBS
18. Prevalence of tuberculosis	Biennially	NARHS/NDHS	NASCP-FMoH
19 Proportion of tuberculosis cases detected and cured under directly observed treatment short course	Biennially	NARHS/NDHS	NASCP-FMoH
20. Malaria incidence among under-five children	Yearly	NDHS/MICS/HHFS Phases I-III	NPC/NBS
21. % of women with pregnancy within the last 2 years who received intermittent preventive treatment for malaria	Yearly	NDHS/MICS/HHFS Phases I-III	NPopC/NBS
22. Proportion of 12-23 months-old children fully immunized	Annually	Imm.Cov.Surveys/NDHS/MICS	NPHCDA/NPC/NBS
23. % of children 6-59 months receiving Vitamin A supplements twice a year	Annually	Imm.Cov.Surveys/NDHS/MICS	NPHCDA/NPC/NBS
24. % of children under 6 months exclusively breastfed	Annually	NDHS/MICS/HHFS Phases I-III/HMIS	NPC/NBS/ DPRS-FMoH
25. % of under-five children sleeping under ITN in the previous night.	Annually	NDHS/MICS/HHFS phases I-III	NPC/NBS/ DPRS-FMoH
26. % of children under 5 with suspected pneumonia receiving appropriate treatment from a health provider	Annually	NDHS/MICS/HHFS Phases I-III	NPC/NBS/ DPRS-FMoH
27. % of newborns and mothers visited within 48 hours of delivery by a skilled health care provider	Annually	NDHS/MICS/HHFS Phases I-III	NPC/NBS DPRS-FMoH

Indicator	Data Collection and Reporting		
	Frequency	Instruments	Responsibility
28. Prevalence of malaria in children under-five years of age*	Annually	NDHS/MICS/HHFS Phases I-III	NPC/NBS DPRS-FMoH
29. Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	Annually	NDHS/MICS/HHFS Phases I-III	NPC/NBS DPRS-FMoH
30. Number of new wild poliovirus cases	Annually	WHO Global Update	FMoH/WHO/NPHCDA
31. Unmet need for Family Planning	Biennially	NDHS/MICS	NPC/NBS
32. % of pregnant women with 4 ANC visits performed according to standards	Annually	NDHS/MICS/HHFS Phases I-III	NPC/NBS DPRS-FMoH
33. Proportion of births attended by skilled health personnel	Annually	NDHS/MICS/HHFS Phases I-III	NPopC/NBS DPRS-FMoH
34. Proportion of all births in Basic and Comprehesive EMoC Facilities	Annually	HHFS Phases I-III	DPRS-FMoH
35 Case fertility rate among women with obstretic complications in EmOC facilities	Biennially	HHFS Phases I & III	DPRS-FMoH
36. Contraceptive prevalence rate (Modern)	Annually	NDHS/MICS/HHFS Phases I-III	NPC/NBS DPRS-FMoH
37. Health facilities experiencing stock-outs of key health commodities within the last one month	Annually	Monitoring Reports by SMOHs/HHFS Phases I-III	SMOHs DPRS-FMoH
Priority Area 3: Human Resources for Health			
38. % of wards that have appropriate HRH complement as per service delivery norm (urban/rural).	Annually	NPHCDA Survey (planned from 2010)/ HHFS Phases I-III	NPHCDA DPRS-FMoH
39. Proportion of Health Professionals per population	Annually	NPHCDA Survey (planned from 2010)/ HHFS Phases I & III	NPHCDA DPRS-FMoH
Priority Area 4: Financing for Health			
40. % of federal, state and LGA budget allocated to the health sector.	Annually	Federal and State Annual Reviews	SMoH/FMoH
41. Proportion of Nigerians covered by any risk-pooling mechanisms	Annually	Federal and State Annual Reviews	FMoH/NHIS/SMoH
42. Out-of pocket expenditure as a % of total health expenditure	Annually	Annual Household Income and Expenditure Surveys/NHA	NBS/ DPRS-FMoH

Indicator	Data Collection and Reporting		
	Frequency	Instruments	Responsibility
Priority Area 5: National Health Information System			
43. % of States whose routine HMIS returns meet minimum requirement for data quality standard	Annually	State Reports	FMoH-HMIS
44. % of States that timely submit disease surveillance reports	Annually	Federal Reports	FMoH
45. % of Federal and State plans and strategies that are based on routine HMIS data to improve coverage and quality of high impact interventions	Annually	Plan Content Analysis by SMoH & FMoH	DPRS-FMoH/ DPRS-SMoH
Priority Area 6: Community Participation and Ownership			
46. % States with policy and implementation framework for community participation in health with multi-sectoral focus in place	Once	Policy and Implementation Framework/HHFS Phases I-III	NPHCDA/ SMoH/SPHCDA/ DPRS-FMoH
47. Proportion of public health facilities having active committees (at least 4 meetings per year) that include community representatives	Annually	HHFS Phases I-III	DPRS-FMoH
Priority Area 7: Partnerships for Health			
48. Proportion of states implementing at least 4 new PPP initiatives per year.	Annually	SMoH Reports/FMoH Reports	FMoH
49. % of states with standards and mechanisms for graded accreditation of private providers in place	Annually	State Reports/FMoH Reports	FMoH/SMoH
50. % of Federal and State multi-sectoral and development partner meetings held according to extant coordination mechanism	Annually	Federal and State MoH Reports	FMoH/SMoH
Priority Area 8: Research for Health			
51. % of health budget spent on health research and evaluation at federal level	Annually	FMoH Reports	FMoH
52. Proportion of research fund spent on evaluation and studies in critical areas identified in the NSHDP framework	Annually	FMoH Reports	FMoH

4. Operational Plan

In this section, each of the data collection instruments is described along with frequency and responsibility for data collection.

4.1 National Demographic and Health Survey (NDHS)

The NDHS is conducted every five years in Nigeria under the umbrella of the National Population Commission (NPopC) and with financial and technical support from USAID and MACRO. The last NDHS (2008) was also supported by UNFPA. The first NDHS in Nigeria was conducted in 1990 but the next exercise did not take place until 1999. The 2003 exercise brought into focus differentials in performances by each geo-political zone and the 2008 which was the fourth in the series of NDHS built on the success of the preceding NDHS, especially in providing disaggregated data by states. The 2011 and 2013 are milestone years during which at least progress in 25 of the 52 NSHDP indicators are expected.

It is important that the FMoH work very closely with the survey design team from the start of the design through the data collection phase to data analysis and report writing. This will permit the FMoH to include and/or modify the survey instruments to collect information that are germane to the NSHDP. Collaboration between FMoH and NPopC will be led and coordinated by the Department of Health Planning, Research and Statistics of the Federal Ministry of Health.

4.2 Multiple Indicator Cluster Survey (MICS)

The MICS is conducted under the umbrella of the National Bureau of Statistics (NBS) with financial and technical support from UNICEF. The first MICS in Nigeria was conducted in 1995 with a follow-up in 1999. But the next one did not happen until 2007 for inexplicable reason. MICs is now a 3-yearly exercise and the next one will happen in 2010. Although one year short of the intermediate milestone year of 2011, this exercise will help the FMoH assess the level of progress in the first year of the NSHDP and further reinforce the baseline data available. MICS focus is mainly on children and women and in this regard, it is also multi-sectoral and covers sectors that affect health e.g. education, especially education of women which is a major determinant of child health and mortality; water and sanitation which is also another major determinant of child health and mortality. It also covers health and nutrition of children and women.

As with the NDHS, the FMoH will work with MICS team from the start of the exercise in the first quarter of 2010, and modifications will be made to the survey instruments to accommodate much of the indicators where MICS have been specified as the preferred instrument for data collection.

4.3. FMOH Reports

These reports are expected to be used for data collection in 15 indicators. In one instance, it is an official gazette for the National Health Bill, so this will not require much effort (technical or financial) to collect. In the case of another indicator, it is the amount of fund released to the health sector during the year i.e. information available from the Federal Ministry of Finance and the Auditor General's office. In the third case, this is the report of the Health Watch Group that is to be set up by the Honourable Minister of Health. It is important that this group be set up early in the year and facilitated as early as possible in the life of the NSHDP. Their first annual report could serve as a baseline of the state of health in the nation. For this group to do a good job, it is expected that they will undertake field visits in the 6 geo-political part of the country; talk to, or interview people who are informed in health matters at both the Federal and local levels.

This group is expected to be facilitated by the Department of National Health Planning, Research and Statistics under the overall umbrella

and direction of the Hon. Minister of Health. It is also expected that field visits and other work of this group will cost significant amount of money which need to be estimated and budgeted for early on during the year 2010. The first step in this process is, however to set up the group and DPRS should be consulting with colleagues as soon as possible to begin to tease out names of potential members of the Health Watch Group.

In one indicator, i.e. the National Health Account (NHA), major expenditure is anticipated, but much of this is expected to come from development partners as in the past. The last NHA covered 2003-2005 and a new one is needed for 2006-2008/2009 and the process needs to start as soon as practicable as this process takes a gestation period of about two years.

Two other indicators (% of states that timely submit disease surveillance reports and % of Federal and State plans and strategies that are derived from the HMIS data to improve coverage and quality of high impact interventions) are expected to be available in the existing HMIS system and the first is already reported on while the second could be derived from the Federal and State SHDPs. The major efforts required for these two indicators are technical in-house within the FMoH.

In four of the indicators i.e. two related to partnerships for health, FMOH will have to rely on information provided annually by SMoHs while for research for health priority area, the information itself should be available from the research institutions affiliated with the FMoH and whose budgets are under the Ministry.

4.4 State Ministries of Health (SMoH)

In one indicator i.e. percentage of states adapting the National Health Bill (to their LGAs), this data will be available from the states annual SHDP reports. The same applies to the indicator on percent of states/FCT with published annual Health Watch Reports. As in the case of FMoH, this data will derive from the report of the States' Health Watch Groups and it is expected that the first step in the process i.e. the setting up of the group will happen early in 2010 and that enough financial resources will be allocated for the group to visit the component LGA and talk with decision-makers, health practitioners, professional associations and other stakeholders in health. Data on the indicator relating to stock-out of essential health commodities are expected to derive from supervisory visits by states to the LGAs and health facilities. In this regard, it is expected that each SMoH will allocate sufficient finances and logistics support for quarterly monitoring and supervisory visits. To be properly done, this activity needs significant financial, personnel and logistics resources.

For the indicator on percentage of states and LGAs budget allocated to health sector, this report is obtainable from State Annual Review Reports which in turn they will get from their Ministries of Finance and Auditors Generals' offices. The same applies to indicator on proportion of Nigerians covered by any risk pooling mechanisms. The input required to obtain these two sets of data will be insignificant in terms of financing, but would require significant staff time and commitment.

As for per cent of states whose routine HMIS returns meet minimum requirement for data quality, this will require political commitment from states to allocate sufficient financial and human resources to this component of the SHDP at the state level. Significant resources are also required for per cent of states with standards and mechanisms for graded accreditation of private providers in place. This indicator impinges on ethics and quality especially in the private sector where an estimated 70% of Nigerians receive their health care. This indicator has received little attention in the past and much action will be required at the initial stage to develop criteria for inspection, inspect, accredit qualified institution and close down those not meeting the required

standards including flushing out fake practitioners.

State records are also required for per cent of state partners meeting held. But this does not require significant financial input but rather time commitment.

4.5 National AIDS and Reproductive Health Survey (NARHS)

As part of efforts to generate reliable data for effective programming, the Federal Ministry of Health (FMOH) in collaboration with the National Agency for the Control of AIDS (NACA), the Society for Family Health (SFH), other development partners and key stakeholders conducted Nigeria's first National HIV and AIDS and Reproductive Health Survey (NARHS) in 2003 and the second in 2005. The 2007 survey is the third in the series. NARHS was conceptualised to be a biennial nationwide survey to generate a series of datasets and reliable figures on key sets of indicators that will facilitate trend analysis in the HIV/AIDS and Reproductive Health field. This implies that the survey takes place every two years and the last one was held in 2009 and results are now awaited and the next one will be due in 2011.

These surveys require significant financial and technical resources but it seems that such resources are available within the National AIDS Control Agency (NACA) and the National AIDS and STI Control Programme (NASCP) Division of the Public Health Department, FMoH.

4.6 The National Health Management Information System (NHMIS)

The NHMIS derives from the National Council on Health (NCH) Resolution which called on all tiers of government, private sector and other stakeholders to actively participate in its implementation. The objectives of the NHMIS are to: provide appropriate infrastructure; establish procedures for collecting and analyzing health data for providing needed information to assess the state of health of the population; identify major health problems; set priorities at local, state and national levels; and monitor progress towards stated goals and targets of health services.

States started using the NHMIS formats in February 2007 and bi-annual reports are being produced starting with the period July to December 2007. Ideally, the NHMIS should be the major instrument of the M&E framework at all levels. But many states and LGAs have not yet imbibed the spirit and letter of the NCH resolution and therefore, do not send their reports to the next level as and at when due, if they send it at all. Hence the need to rely on other tools described in this part of the operational plan. Efforts will continue to strengthen the NHMIS and it is hoped that in the not-so-distant future, these efforts will pay off in the quantity and quality of data generated, analyzed and disseminated through the NHMIS to the extent that the health sector will use this instrument as the main source of information and others will serve as validation of this instrument.

Besides being a source of data, the NHMIS is one of the priority areas of focus for the NSHDP; requiring investments in time, technical assistance and financial resources.

4.7 Annual Household and Facility Surveys

Nigeria's Vision 20: 2020 highlights its commitment to meet the MDGs. Without progress in a social sector as important as health in the MDGs, Nigeria's achievement of its own Vision 20: 2020 will not be possible. The Vision 20:2020 clearly identifies strategies for improving the health and nutrition status of Nigerians and sets specific targets for achieving them. For monitoring the progress of these key targets, it is critical to have a reliable Monitoring and Evaluation (M&E) system that provides desegregated data at State and LGA levels on a more regular basis, preferably annual and also validates the National Health Management Information System. As noted earlier, the most important population based surveys, the Multiple Indicator Cluster Survey (MICS) supported

by UNICEF and the Demographic and Health Survey supported by US Government and other partners are being carried out once every 3-5 years and provide very valuable information on impact indicators. Despite such well established surveys, key information gaps still remain, especially for providing desegregated coverage data and complementary data on impact indicators which are difficult to measure such as maternal mortality ratio.

Access to such information will enable the program managers at state and LGA levels to identify critical implementation bottlenecks on a more regular basis and evolve locally relevant strategies to improve coverage and quality of high impact interventions. Improved reliability of coverage information also will immensely help to implementing new initiatives such as "results based financing" which is increasingly being used by many countries to enhance accountability and incentives for better performance.

Strategy: For meeting the above information needs a "*periodic household surveys*" using rapid assessment techniques and complementing them with "limited facility surveys" which will provide a comprehensive picture of both "*demand and supply*" side bottlenecks will be implemented. By carrying out such surveys at State and LGA levels on a regular basis will immensely support development of appropriate strategies to address the bottlenecks. UNICEF is supporting regular coverage evaluation surveys for EPI and the proposed surveys could build on this.

Nigeria is well known for its institutional capacity – especially the Medical Research Institute, schools of public health, medical and nursing schools including schools of health technology- to undertake such surveys and it is important to use this capacity and complement where additional technical assistance is required. This ensures the sustainability by building in-country capacities as well as reducing the costs of implementing such surveys on a regular basis.

Approach: A phased Approach is proposed to implement the surveys

Phase I (2010): Development of sampling protocols, survey and analysis tools for Annual Rapid Household and Facility Surveys representative at the state level building on the EPI coverage evaluation surveys. These surveys will be complemented by additional information on coverage for maternal and reproductive services and malaria. A facility survey will be undertaken in a facility located nearest to sampled cluster. In addition, all general and teaching hospitals in the state will be also covered. At each sampled cluster "snow balling" technique will be used to obtain information on maternal deaths and also the maternal deaths reported at health facilities will also be recorded. During this phase, the surveys will be piloted in 6 states covering one state in each Zone.

Phase II (2011-2013): Finalization of survey protocols and tools based on feedback from the pilots and implementation of the Annual Rapid Household and Facility Surveys by all states

Phase III (2014-2015): Piloting the surveys using the standardized approach at the LGA level and subsequent scaling-up. As Nigeria has 774 LGAs, the surveys will be carried out in all LGAs once in 2/3 years depending on institutional capacities and financing.

The Annual Household and facilities survey will be used to gather information on indicators related to life expectancy at birth, infant and under-five mortality, maternal mortality ratio (every 3 years); proportion of 1 year old immunized against measles, percentage of children under-five sleeping under ITN, (every year) and as capacity increases, this instruments could be expanded to accommodate other indicators as necessary.

It is expected that this annual surveys will carry significant costs in

terms of technical capacity, finance and time of a designated unit within the FMoH/DPRS. It will also need significant political commitment at the three levels of governments. But the benefits that could be derived from this survey if properly planned and implemented will far outweigh the costs. Especially, it is to be noted that the last in the series of these surveys will cover the 774 LGAs and will, therefore, serve the purpose of evaluation of the NSHDP.

NSHDP National Result Framework						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**BASELINE**	**TARGET**		
			2008/9	**2011**	**2013**	**2015**
	1. Life expectancy at birth	NDHS /MICS	47 years	55 years	63 years	70 years
OVER-ARCHING GOAL: **To significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system**	2. Under-5 mortality rate	NDHS/MICS	157/1000 LBs (NDHS, 2008)	130/1000 LBs	103/1000 LBs	75/1000 LBs
	3. Infant mortality rate	NDHS/MICS	75 (NDHS, 2008)	60/1000 LBs	45/1000 LBs	30/1000 LBs
	4. Proportion of 1 year old immunized against measles	NDHS/MICS/Health Facility Surveys	41.4 (NDHS 2008)	60%	80%	95%
	5 Prevalence of children under – 5 years of age who are underweight	NDHS/MICS/Health Facility Surveys	27.1 (NDHS, 2008)	24%	20%	17.90%
	6 Percentage of children under - 5 sleeping under insecticide-treated bed nets	NDHS/MICS	5.5 (NDHS, 2008)	24%	42%	60%
	7. Maternal mortality ratio	1) Develop demographic surveillance sites (DHSS) 2) Expert Committee on mortality estimation	545/100,000 LBs (NDHS 2008)	409/100,000 LBs	273/100,000 LBs	136/100,000 LBs
	8. Adolescents Birth Rates	NDHS/Maternal Death Audits	126/1000	114/1000	102/1000	90/1000
	9. HIV prevalence among population aged 15-24 years	HMIS, Disease surveillance	4.2% (ANC Sentinel Survey)	3.2%	2.1%	1%

NSHDP National Result Framework						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**BASELINE**	**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						
1. Improved strategic health plans implemented at Federal and State levels **2. Transparent and accountable health systems management**	10. National Health Act gazetted.	Government gazette	N/A	2010	-	-
	11. Percentage of State adopting the National Health Bill (in their LGAs)	SMOH annual reports	0	25	50	75%
	12. Percentage of States executing more than 70% of the annual non-personnel budget	1. Federal and State Accountants General Reports				
		2. Federal and States Auditors General Reports	0%	30%	55%	80%
		3. Federal and State Public Expenditure Reviews				
	13. Percentage of Federal and States/ FCT with published annual Health Watch Reports	Health Watch Reports	N/A	33%	66%	100%
STRATEGIC AREA 2: HEALTH SERVICES DELIVERY						
NSHDP GOAL: To revitalize integrated service delivery towards a quality, equitable and sustainable healthcare						
3. Universal availability and access to an essential package of primary health care services focusing in particular on vulnerable socio-economic groups and geographical areas **4. Improved quality of primary health care services** **5. Increased use of primary health care services**	14. Percentage of wards with a functioning public health facility providing minimum health care package according to quality of care standards.	NPHCDA Survey Report	No baseline	25%	55%	80%
	15. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	NDHS/MICS/NARHS	22.2% (female) 32.6% male (NDHS 2008)	50%	76%	100%

NSHDP National Result Framework						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**BASELINE**	**TARGET**		
			2008/9	**2011**	**2013**	**2015**
	16. Percentage of HIV infected pregnant women who receive ARV prophylaxis to reduce the risk of MTCT.	NDHS/MICS/NARHS	TBD	30%	60%	90%
	17. Proportion of population with advanced HIV infection and access to antiretroviral drugs	NARHS	No baseline	20%	40%	60%
	18. Prevalence of tuberculosis	Sentinel/Health Facility Surveys	No Baseline	NA.	1%	0.50%
	19. Proportion of tuberculosis cases cured under directly observed treatment short course	Quarterly and annual NTBLCP reports	71% cure rates and 82% treatment success rate (2008)	85%	85%	85%
	20. TB Case Detection Rate under directly observed treatment short course	Annual NTBLCP Report; National Statistical Data Report	31% (2008)	50%	70%	70%
	21. Malaria incidence among under-5 children	NDHS /MICS/ Sentinel Surveys	16% (NDHS 2008)	10%	7%	5%
	22. Percentage of women with pregnancy within the last 2 years who received intermittent preventive treatment for malaria	NDHS, HMIS, MICS	18% (NDHS, 2008)	38%	60%	80%

NSHDP National Result Framework						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**BASELINE**	**TARGET**		
			2008/9	**2011**	**2013**	**2015**
	23. Proportion of 12-23 months-old children fully immunized	NDHS/MICS/Immunization coverage surveys	22.7 (NDHS, 2008)	47	71%	95%
	24. Percentage of children 6-59 months receiving Vitamin A supplements twice a year	NDHS/MICS/Immunization coverage surveys	83% (Immunization coverage surveys May 2009)	90%	95%	100%
	25. Percentage of children under 6 months exclusively breastfed	NDHS	13% (NDHS, 2008)	25%	38%	50%
	26. Percentage of under- 5 children sleeping under ITN in the previous night	NDHS	5.5 (NDHS, 2008)	30%	55%	80%
	27. Percentage of children under - 5 with suspected pneumonia receiving appropriate treatment from a health provider	NDHS/ Sentinel Surveys/ Health Facility Surveys	22.5% - ARI (NDHS, 2008	43%	63%	80%
	28. Percentage of newborns and mothers visited within 72 HOURS of delivery by a skilled health care provider	MICS/NDHS/Sentinel Surveys	No baseline	15%	35%	50%
	29. Prevalence of malaria in children under-5 years of age*	MICS/NDHS/Sentinel Surveys/ Health Facility Surveys	15.9% (NDHS 2008)	12%	8%	5%
	30. Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	NDHS 2008/MICS/ Sentinel Surveys/ Health Facility Surveys	33.2% (NDHS 2008)	50%	65%	80%

NSHDP National Result Framework						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**BASELINE**	**TARGET**		
			2008/9	**2011**	**2013**	**2015**
	31. Number of new wild poliovirus cases	WHO Global Update	382 (WHO Global Update Oct 28, 2009)	150	50	0
	32. Unmet need for Family Planning	MICS/NDHS	21% (NDHS 2008)	18%	12%	10%
	33. Contraceptive prevalence rate (Modern)	NDHS/MICS	9.7 (NDHS, 2008)	20%	26%	30%
	34. Percentage of pregnant women MAKING ATLEAST 4 ANC visits according to standards	NDHS/MICS	44.8% (NDHS 2008)	60%	70%	80%
	35. Proportion of births attended by skilled health personnel	NDHS/ Sentinel Surveys/ Health Facility Surveys	38.9 (NDHS, 2008)	50%	70%	85%
	36. Proportion of health care facilities providing basic emergency obstetric care services	EOC Survey/ Sentinel Surveys/ Health Facility Surveys	TBD	10%	20%	25%
	37. Case Fatality rate among women with obstetric complications in EmOC facilities	EOC Survey (Facility Service Statistics)	TBD	25%	10%	1%
	38. Health facilities experiencing stock-outs of key tracer health commodities within the last one month	NHMIS/ Sentinel Surveys/ Health Facility Surveys	TBD	80%	40%	<10%

NSHDP National Result Framework						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**BASELINE**	**TARGET**		
			2008/9	**2011**	**2013**	**2015**
	39. Reduction in Case Fatality rate resulting from epidemic outbreaks/ emergencies	National IDSR System	No Baseline	60%	80%	100%
PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH						
NSHDP GOAL: To plan and implement strategies to address the human resources for health needs in order to ensure its availability as well as ensure equity and quality of health care						
6. The Federal government implements comprehensive HRH policies and plans for health development	40. Percentage of wards that have appropriate HRH complement as per service delivery norm (urban/ rural).	NPHCDA Survey	No baseline	20%	40%	>60%
7. All States and LGAs are actively using adaptations of the National HRH policy and plan for health development by end of 2015	41. Proportion of Health Professionals per population	NHMIS/HRHIS	TBD	1:2000	1:1000	>1:500
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						
8. Health financing strategies implemented at Federal, State and Local levels consistent with the National Health Financing Policy	42. Percentage of federal, state and LGA budget allocated to the health sector.	Federal and State review PER/NHA	TBD	5%	10%	15%

NSHDP National Result Framework						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**BASELINE**	**TARGET**		
			2008/9	**2011**	**2013**	**2015**
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	43. Proportion of Nigerians falling into the bottom 2 quintiles covered by any risk-pooling mechanisms	Federal and State review PER/NHA	TBD	5%	10%	30%
	44. Out-of pocket expenditure as a Percentage of total health expenditure	NHA	67.2% (2006 – NHA 2003-2005)	65%	60%	<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, including Monitoring & Evaluation, for informed decision-making at all levels and improved health care						
10. National health management information system and sub-systems provides public and private sector data to inform health plan development and implementation at Federal, State and LGA levels	45. Percentage of States whose routine HMIS returns meet minimum requirement for data quality standard	State reports/Integrated Disease Surveillance System	TBD	40%	60%	80%
	46. Percentage of States that timely submit disease surveillance reports	Federal reports/Integrated Disease Surveillance System	TBD	40%	60%	80%
	47. Percentage of Federal and State plans and strategies that are based on routine HMIS data to improve coverage and quality of high impact interventions	Rapid Annual Household and Facility Surveys (TBD)	No baseline	40%	60%	80%
PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP						
NSHDP GOAL 6: To attain effective citizen participation in the development, management and monitoring of health policy and services						
11. Strengthened community participation in health development	48. Percentage States with evidence-based policy and implementation framework for community participation in health	Policy and Implementation Framework	None in place	40%	60%	80%

NSHDP National Result Framework						
OUTCOME	**INDICATORS**	**SOURCE OF DATA**	**BASELINE**	**TARGET**		
			2008/9	**2011**	**2013**	**2015**
12. Increased capacity for integrated multi-sectoral health promotion	49. Proportion of public health facilities having active committees (at least 4 meetings per year) that include community representatives	Health Facilities Survey (TBD)	TBD	40%	60%	80%
	50. Percentage States with civil society organizations involved in the development, monitoring and review of MTSS		TBD	40%	60%	80%
PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH						
NSHDP GOAL 7: To enhance harmonized implementation of essential health services in line with national health policy goals.						
13. Functional multi partner and multi-sectoral participatory mechanisms at Federal and State levels contribute to achievement of the goals and objectives of the NSHDP.	51. Proportion of states implementing at least 4 new PPP initiatives per year.	Federal and state PPP reports	No baseline	15%	30%	50%
	52. Percentage of states with standards and mechanisms for graded accreditation of private providers in place	State reports	No baseline	30%	60%	80%
	53. Percentage of Federal and State multi-sectoral and development partner meetings held according to extant coordination mechanism	Federal and state MOH reports	TBD	40%	70%	90%
PRIORITY AREA 8: RESEARCH FOR HEALTH						
NSHDP GOAL 8: To utilize research to generate knowledge to inform policy, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform.						
14. Research and evaluation create knowledge base to inform health policy and programming.	54. Percentage of health budget spent on health research and evaluation at federal level	FMOH report	TBD	0.50%	1%	2%
	55. Proportion of research and evaluation studies undertaken on identified critical areas in the NSHDP framework.		TBD	20%	40%	60%

Annex 2: Cost Sheets (Federal & State)

State	Total	Abia	Adamawa	Akwa	Anambra	Bauchi	Bayelsa	Benue	Borno	Cross River
Source for costing	N	MBB	MBB	MBB	MBB	MBB	MBB	MBB	State	MBB
Total cost	NGN 2,862,501,496,685	NGN 53,667,794,559	NGN 35,880,846,683	NGN 94,597,453,260	NGN 80,759,567,909	NGN 86,226,863,401	NGN 114,501,638,180	NGN 71,660,290,553	NGN 76,750,735,617	NGN 88,159,307,877
Population	140,431,790	2,845,380	3,178,950	3,902,051	4,177,828	4,653,066	1,704,515	4,253,641	4,171,104	2,892,988
Total cost per capita	NGN 20,384	NGN 18,861	NGN 11,287	NGN 24,243	NGN 19,331	NGN 18,531	NGN 67,175	NGN 16,847	NGN 18,401	NGN 30,473
By priority area:										
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 25,739,610,774	NGN 536,677,946	NGN 313,400,893	NGN 945,974,533	NGN 688,343,468	NGN 707,726,519	NGN 857,775,788	NGN 716,602,906	NGN 1,032,408,000	NGN 881,593,079
HEALTH SERVICE DELIVERY	NGN 1,508,402,077,678	NGN 32,807,894,252	NGN 17,698,854,993	NGN 57,281,091,564	NGN 39,116,970,090	NGN 44,422,330,003	NGN 65,425,307,665	NGN 40,787,715,590	NGN 34,323,119,400	NGN 43,924,622,484
HUMAN RESOURCES FOR HEALTH	NGN 975,645,196,139	NGN 14,465,667,837	NGN 12,175,706,494	NGN 27,938,608,591	NGN 29,188,358,347	NGN 31,629,373,909	NGN 35,532,083,208	NGN 24,495,062,181	NGN 38,011,261,317	NGN 23,143,116,702
FINANCING FOR HEALTH	NGN 217,492,646,291	NGN 2,905,825,825	NGN 4,148,767,206	NGN 3,228,918,642	NGN 8,514,468,952	NGN 6,353,497,567	NGN 9,629,155,927	NGN 1,719,593,896	NGN 2,329,514,000	NGN 15,361,213,679
NATIONAL HEALTH INFORMATION SYSTEM	NGN 40,050,279,470	NGN 805,016,918	NGN 448,918,122	NGN 1,418,961,799	NGN 969,472,924	NGN 969,754,957	NGN 1,090,805,745	NGN 1,074,904,358	NGN 245,284,500	NGN 1,322,389,618
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 22,962,763,020	NGN 536,677,946	NGN 260,375,764	NGN 945,974,533	NGN 530,538,118	NGN 477,848,626	NGN 367,510,668	NGN 716,602,906	NGN 338,141,800	NGN 881,593,079
PARTNERSHIPS FOR HEALTH	NGN 24,847,161,699	NGN 536,677,946	NGN 289,242,179	NGN 945,974,533	NGN 616,445,965	NGN 602,992,133	NGN 634,406,695	NGN 716,602,906	NGN 81,006,600	NGN 881,593,079
RESEARCH FOR HEALTH	NGN 47,361,761,614	NGN 1,073,355,891	NGN 545,581,032	NGN 1,891,949,065	NGN 1,134,970,042	NGN 1,063,339,688	NGN 964,592,485	NGN 1,433,205,811	NGN 390,000,000	NGN 1,763,186,158
Total	NGN 2,862,501,496,685									
By National Chart of Accounts										
1100010 - SALARY & WAGES - GENERAL	NGN 861,680,010,074	NGN 8,502,574,579	NGN 10,698,984,356	NGN 33,396,777,314	NGN 25,038,473,504	NGN 29,851,582,891	NGN 43,571,963,883	NGN 27,266,254,190	NGN 32,989,058,948	NGN 9,686,517,457
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 139,526,668,252	NGN 3,107,616,887	NGN 2,090,889,083	NGN 5,991,394,267	NGN 3,319,521,620	NGN 2,354,646,109	NGN 4,523,723,965	NGN 3,261,165,907	NGN 492,389,000	NGN 5,033,700,075
1300030 - SOCIAL CONTRIBUTION	NGN 43,302,194,130	NGN 82,444,254	NGN 254,215,869	NGN 1,805,349,417	NGN 756,558,739	NGN 1,102,092,733	NGN 2,350,454,920	NGN 945,264,028	NGN 4,123,632,369	NGN 144,019,844
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 23,335,143,864	NGN 580,611,763	NGN 125,589,945	NGN 429,939,509	NGN 185,330,930	NGN 607,265,347	NGN 305,656,726	NGN 1,206,003,762	NGN 77,839,000	NGN 606,974,198
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 7,888,845,471	NGN 103,759,608	NGN 15,999,128	NGN 57,005,098	NGN 27,467,032	NGN 205,445,901	NGN 80,962,361	NGN 98,701,110	NGN 65,770,500	NGN 721,756,171

State	Total	Abia	Adamawa	Akwa	Anambra	Bauchi	Bayelsa	Benue	Borno	Cross River
2100200 - UTILITIES - GENERAL	NGN 42,715,602,756	NGN 507,989,602	NGN 1,297,809,944	NGN 1,934,800,123	NGN 1,444,421,348	NGN 1,471,556,329	NGN 2,461,739,895	NGN 1,767,774,668	NGN 691,995,000	NGN 764,395,734
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 686,712,131,615	NGN 16,341,543,347	NGN 9,684,191,860	NGN 22,432,470,657	NGN 17,189,036,008	NGN 19,038,703,642	NGN 20,555,348,336	NGN 16,991,522,407	NGN 16,257,634,700	NGN 19,067,441,129
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 152,851,206,324	NGN 3,108,799,882	NGN 2,278,553,389	NGN 6,875,663,168	NGN 5,482,712,868	NGN 4,776,130,257	NGN 8,087,607,490	NGN 6,506,800,594	NGN 5,540,210,000	NGN 3,520,964,417
2250500 - TRAINING - GENERAL	NGN 85,698,145,344	NGN 4,184,241,573	NGN 1,447,909,440	NGN 2,674,351,094	NGN 2,383,725,963	NGN 4,004,090,757	NGN 3,241,434,546	NGN 2,543,277,746	NGN 74,736,000	NGN 8,409,149,429
2300600 - OTHER SERVICES - GENERAL	NGN 1,517,981,844	NGN 10,546,817	NGN 5,466,817	NGN 38,823,360	NGN 16,269,511	NGN 23,700,090	NGN 50,545,649	NGN 20,327,547	NGN 282,000,000	NGN 471,785,014
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 7,526,492,809	NGN 589,673,024	NGN 31,194,828	NGN 221,534,421	NGN 92,837,321	NGN 135,237,796	NGN 288,424,316	NGN 115,993,346	NGN 516,000,000	NGN 1,055,338,694
2400800 - FINANCIAL - GENERAL	NGN 172,440,320,682	NGN 39,440,997	NGN 4,021,190,788	NGN 2,322,916,936	NGN 8,134,795,354	NGN 5,800,420,203	NGN 8,449,596,919	NGN 1,245,219,897	NGN 59,700,000	NGN 10,566,622,010
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 3,575,951,239	NGN 15,815,750	NGN 3,336,090	NGN 23,691,709	NGN 9,928,366	NGN 14,462,829	NGN 30,845,162	NGN 25,936,767	NGN 155,953,500	NGN 14,964,274
2501000 - MISCELLANEOUS	NGN 156,873,540,266	NGN 5,973,457,706	NGN 1,800,542,980	NGN 6,324,152,231	NGN 4,000,969,253	NGN 3,357,616,587	NGN 4,475,207,828	NGN 2,671,030,046	NGN 2,824,416,600	NGN 8,767,834,477
3001100 - LOANS & ADVANCES - GENERAL	NGN 225,698,442	NGN 0	NGN 138,208	NGN 981,504	NGN 411,314	NGN 599,168	NGN 1,277,858	NGN 513,906	NGN 0	NGN 0
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 23,691,426,081	NGN 708,347,267	NGN 51,399,610	NGN 365,021,493	NGN 152,967,729	NGN 284,163,806	NGN 475,235,739	NGN 191,121,831	NGN 100,000,000	NGN 1,186,945,227
20000000 - CAPITAL INVESTMENT	NGN 452,940,137,493	NGN 9,810,931,503	NGN 2,073,434,346	NGN 9,702,580,957	NGN 12,524,141,048	NGN 13,199,148,955	NGN 15,551,612,587	NGN 6,803,382,799	NGN 12,499,400,000	NGN 18,140,899,729
	NGN 2,862,501,496,685									

State	Delta	Ebonyi	Edo	Ekiti	Enugu	FCT	Gombe	Imo	Jigawa
Source for costing	MBB	MBB	MBB	State	MBB	State	MBB	State	MBB
Total cost	NGN 131,913,068,873	NGN 43,348,309,979	NGN 76,871,257,844	NGN 41,789,988,263	NGN 74,908,161,737	NGN 62,291,322,482	NGN 39,599,887,121	NGN 26,316,412,001	NGN 67,792,298,746
Population	4,112,445	2,176,947	3,233,366	2,398,957	3,267,837	1,406,239	2,365,040	3,927,563	4,361,002
Total cost per capita	NGN 32,077	NGN 19,912	NGN 23,774	NGN 17,420	NGN 22,923	NGN 44,296	NGN 16,744	NGN 6,700	NGN 15,545
By priority area:									
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 1,319,130,689	NGN 433,483,100	NGN 768,712,578	NGN 34,892,522	NGN 641,701,471	NGN 334,490,799	NGN 354,873,000	NGN 573,523,000	NGN 677,922,987
HEALTH SERVICE DELIVERY	NGN 73,850,512,743	NGN 19,396,511,757	NGN 43,970,585,654	NGN 16,751,319,080	NGN 35,114,989,579	NGN 21,427,957,136	NGN 21,048,689,761	NGN 9,377,295,000	NGN 41,625,490,646
HUMAN RESOURCES FOR HEALTH	NGN 44,790,436,568	NGN 11,560,966,099	NGN 27,006,007,865	NGN 11,906,108,477	NGN 26,383,281,356	NGN 36,689,729,441	NGN 12,425,252,907	NGN 11,676,094,001	NGN 20,610,120,010
FINANCING FOR HEALTH	NGN 4,697,770,085	NGN 9,573,191,973	NGN 898,032,565	NGN 12,824,462,762	NGN 9,709,881,240	NGN 1,415,894,234	NGN 3,948,808,704	NGN 1,312,175,000	NGN 1,150,188,671
NATIONAL HEALTH INFORMATION SYSTEM	NGN 1,978,696,033	NGN 650,224,650	NGN 1,153,068,868	NGN 74,305,793	NGN 906,989,671	NGN 1,024,117,708	NGN 517,029,802	NGN 206,933,000	NGN 1,016,884,481
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 1,319,130,689	NGN 433,483,100	NGN 768,712,578	NGN 35,785,475	NGN 502,619,167	NGN 94,261,016	NGN 316,625,366	NGN 198,735,000	NGN 677,922,987
PARTNERSHIPS FOR HEALTH	NGN 1,319,130,689	NGN 433,483,100	NGN 768,712,578	NGN 32,502,952	NGN 578,334,352	NGN 124,272,123	NGN 337,447,042	NGN 1,627,700,000	NGN 677,922,987
RESEARCH FOR HEALTH	NGN 2,638,261,377	NGN 866,966,200	NGN 1,537,425,157	NGN 130,611,201	NGN 1,070,364,901	NGN 1,180,600,024	NGN 651,160,538	NGN 1,343,957,000	NGN 1,355,845,975
Total									
By National Chart of Accounts									
1100010 - SALARY & WAGES - GENERAL	NGN 58,774,199,851	NGN 11,180,953,176	NGN 18,074,008,009	NGN 8,258,322	NGN 20,485,803,847	NGN 25,954,397,589	NGN 7,718,879,373	NGN 8,457,700,000	NGN 16,457,827,846
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 3,639,776,811	NGN 1,624,367,814	NGN 6,248,934,282	NGN 1,274,263,500	NGN 3,470,311,712	NGN 233,435,973	NGN 2,615,585,714	NGN 941,395,000	NGN 2,370,468,132
1300030 - SOCIAL CONTRIBUTION	NGN 2,672,637,678	NGN 313,065,592	NGN 1,429,290,234	NGN 1,032,290	NGN 666,795,722	NGN 237,457,519	NGN 183,368,824	NGN 113,405,000	NGN 418,610,617
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 431,740,512	NGN 257,172,145	NGN 8,282,121,743	NGN 136,487,400	NGN 249,943,534	NGN 58,538,000	NGN 247,599,254	NGN 60,900,000	NGN 1,031,510,015
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 116,352,487	NGN 23,793,105	NGN 30,755,303	NGN 23,730,500	NGN 44,097,368	NGN 141,465,600	NGN 11,979,922	NGN 150,895,000	NGN 223,012,724
2100200 - UTILITIES - GENERAL	NGN 2,444,195,576	NGN 1,024,382,295	NGN 266,608,650	NGN 24,319,000	NGN 1,487,631,363	NGN 29,286,000	NGN 600,352,801	NGN 262,550,000	NGN 1,115,143,676
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 26,181,000,674	NGN 11,045,961,619	NGN 18,396,448,380	NGN 6,422,357,050	NGN 14,306,956,403	NGN 14,323,787,574	NGN 11,557,430,749	NGN 2,444,315,000	NGN 20,337,971,932
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 8,205,191,151	NGN 1,984,696,601	NGN 5,518,471,598	NGN 18,156,000	NGN 4,599,949,426	NGN 2,442,000	NGN 1,828,971,055	NGN 752,255,000	NGN 4,565,810,684
2250500 - TRAINING - GENERAL	NGN 3,831,218,305	NGN 1,289,179,331	NGN 2,554,228,460	NGN 1,358,884,000	NGN 1,665,908,083	NGN 699,465,510	NGN 1,053,664,896	NGN 918,798,000	NGN 3,039,942,515
2300600 - OTHER SERVICES - GENERAL	NGN 57,474,068	NGN 6,732,358	NGN 1,072,720	NGN 38,178,000	NGN 14,339,191	NGN 2,580,000	NGN 3,943,278	NGN 146,000,000	NGN 9,002,064

State	Delta	Ebonyi	Edo	Ekiti	Enugu	FCT	Gombe	Imo	Jigawa
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 327,959,361	NGN 38,416,278	NGN 1,550,700	NGN 22,450,900	NGN 81,822,501	NGN 226,100,000	NGN 22,501,188	NGN 1,020,025,000	NGN 51,367,707
2400800 - FINANCIAL - GENERAL	NGN 3,356,525,962	NGN 9,416,082,243	NGN 725,606,582	NGN 0	NGN 9,375,254,571	NGN 0	NGN 3,856,786,371	NGN 0	NGN 940,111,924
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 37,251,244	NGN 4,108,379	NGN 2,318,388	NGN 21,784,000	NGN 8,750,400	NGN 13,488,000	NGN 2,406,360	NGN 59,335,000	NGN 2,047,924,571
2501000 - MISCELLANEOUS	NGN 8,591,628,855	NGN 2,569,866,525	NGN 8,242,177,907	NGN 151,213,300	NGN 3,773,790,027	NGN 368,685,117	NGN 2,121,740,084	NGN 2,464,739,001	NGN 483,985,038
3001100 - LOANS & ADVANCES - GENERAL	NGN 1,453,018	NGN 170,203	NGN 0	NGN 200,000,000	NGN 362,513	NGN 12,000,000	NGN 99,691	NGN 0	NGN 227,584
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 540,377,495	NGN 63,298,367	NGN 0	NGN 2,275,375,000	NGN 134,818,649	NGN 162,000,000	NGN 37,075,129	NGN 1,790,800,000	NGN 139,372,368
20000000 - CAPITAL INVESTMENT	NGN 12,704,085,823	NGN 2,506,063,948	NGN 7,097,664,888	NGN 29,813,499,000	NGN 14,541,626,426	NGN 19,826,193,600	NGN 7,737,502,434	NGN 6,733,300,000	NGN 14,560,009,349

State	Kaduna	Kano	Katsina	Kebbi	Kogi	Kwara	Lagos	Nasarawa	Niger
Source for costing	MBB	MBB	MBB	MBB	MBB	MBB	MBB	MBB	MBB
Total cost	NGN 85,484,358,290	NGN 216,764,597,522	NGN 43,400,127,313	NGN 48,240,740,702	NGN 80,745,128,446	NGN 59,813,474,889	NGN 155,768,767,051	NGN 43,100,043,895	NGN 138,442,067,507
Population	6,113,503	9,401,288	5,801,584	3,256,541	3,314,043	2,365,353	9,113,605	1,869,377	3,954,772
Total cost per capita	NGN 13,983	NGN 23,057	NGN 7,481	NGN 14,813	NGN 24,365	NGN 25,287	NGN 17,092	NGN 23,056	NGN 35,006
By priority area:									
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 731,296,787	NGN 2,167,645,975	NGN 434,001,273	NGN 430,897,820	NGN 807,451,284	NGN 479,698,259	NGN 1,557,687,671	NGN 431,000,439	NGN 1,384,420,675
HEALTH SERVICE DELIVERY	NGN 44,386,959,359	NGN 120,678,357,699	NGN 28,132,587,027	NGN 23,640,846,418	NGN 49,542,160,977	NGN 34,243,791,712	NGN 74,401,124,439	NGN 35,683,005,505	NGN 68,343,842,751
HUMAN RESOURCES FOR HEALTH	NGN 29,081,881,629	NGN 56,546,322,977	NGN 12,038,933,356	NGN 18,529,228,485	NGN 23,303,095,402	NGN 17,921,314,895	NGN 52,340,733,148	NGN 4,583,261,483	NGN 50,590,795,268
FINANCING FOR HEALTH	NGN 7,807,328,563	NGN 25,450,218,007	NGN 407,598,655	NGN 3,438,405,106	NGN 2,651,438,718	NGN 5,156,220,695	NGN 18,901,939,606	NGN 32,274,053	NGN 10,508,695,100
NATIONAL HEALTH INFORMATION SYSTEM	NGN 1,032,631,545	NGN 3,251,468,963	NGN 651,001,910	NGN 626,462,510	NGN 1,211,176,927	NGN 645,720,626	NGN 2,336,531,506	NGN 646,500,658	NGN 2,076,631,013
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 570,309,020	NGN 2,167,645,975	NGN 434,001,273	NGN 381,124,296	NGN 807,451,284	NGN 294,897,546	NGN 1,557,687,671	NGN 431,000,439	NGN 1,384,420,675
PARTNERSHIPS FOR HEALTH	NGN 657,949,347	NGN 2,167,645,975	NGN 434,001,273	NGN 408,220,565	NGN 807,451,284	NGN 395,501,432	NGN 1,557,687,671	NGN 431,000,439	NGN 1,384,420,675
RESEARCH FOR HEALTH	NGN 1,216,002,041	NGN 4,335,291,950	NGN 868,002,546	NGN 785,555,502	NGN 1,614,902,569	NGN 676,329,724	NGN 3,115,375,341	NGN 862,000,878	NGN 2,768,841,350
Total									
By National Chart of Accounts									
1100010 - SALARY & WAGES - GENERAL	NGN 27,637,959,465	NGN 32,483,675,271	NGN 6,139,803,553	NGN 11,958,954,985	NGN 30,039,890,725	NGN 20,087,050,743	NGN 49,827,841,432	NGN 23,245,414,548	NGN 33,778,290,688

State	Kaduna	Kano	Katsina	Kebbi	Kogi	Kwara	Lagos	Nasarawa	Niger
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 4,590,801,421	NGN 16,768,034,420	NGN 551,773,496	NGN 1,739,369,909	NGN 3,047,416,852	NGN 3,177,227,602	NGN 11,949,708,029	NGN 1,244,945,121	NGN 16,628,291,681
1300030 - SOCIAL CONTRIBUTION	NGN 771,816,048	NGN 72,941,639	NGN 145,067,677	NGN 238,626,858	NGN 1,483,641,334	NGN 885,981,333	NGN 1,682,973,393	NGN 2,522,565,379	NGN 1,481,324,001
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 263,851,983	NGN 833,773,067	NGN 423,072,415	NGN 126,921,372	NGN 736,594,597	NGN 309,175,803	NGN 334,720,196	NGN 300,245,719	NGN 410,105,556
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 37,982,221	NGN 121,544,567	NGN 23,240,032	NGN 17,672,594	NGN 88,797,092	NGN 116,708,235	NGN 58,725,636	NGN 403,972,877	NGN 4,130,948,234
2100200 - UTILITIES - GENERAL	NGN 1,808,376,856	NGN 2,018,138,399	NGN 913,788,363	NGN 735,336,505	NGN 1,769,066,321	NGN 1,580,707,375	NGN 2,641,307,256	NGN 195,039,822	NGN 2,106,129,997
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 19,189,409,694	NGN 80,524,225,149	NGN 14,708,951,328	NGN 10,296,212,004	NGN 17,440,056,979	NGN 13,122,120,064	NGN 38,731,419,284	NGN 9,629,395,113	NGN 32,482,479,816
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 5,798,471,022	NGN 7,349,870,752	NGN 4,011,704,116	NGN 2,942,232,301	NGN 6,462,272,834	NGN 3,986,770,521	NGN 8,478,943,137	NGN 1,037,758,326	NGN 6,724,673,123
2250500 - TRAINING - GENERAL	NGN 2,974,898,815	NGN 4,107,260,356	NGN 2,880,772,877	NGN 2,152,397,058	NGN 2,600,573,156	NGN 1,665,764,028	NGN 3,808,170,150	NGN 840,618,030	NGN 2,925,984,248
2300600 - OTHER SERVICES - GENERAL	NGN 16,597,614	NGN 0	NGN 3,119,626	NGN 5,131,581	NGN 31,905,149	NGN 19,052,695	NGN 36,191,710	NGN 7,458,069	NGN 31,855,315
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 94,709,545	NGN 323,365,644	NGN 17,801,254	NGN 29,281,901	NGN 182,057,623	NGN 108,718,767	NGN 206,517,660	NGN 26,481,501	NGN 181,773,264
2400800 - FINANCIAL - GENERAL	NGN 7,419,998,194	NGN 25,345,534,333	NGN 334,797,478	NGN 3,318,651,922	NGN 1,906,883,915	NGN 4,711,597,294	NGN 18,057,351,433	NGN 0	NGN 9,765,303,234
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 10,128,589	NGN 8,445,874	NGN 1,903,732	NGN 3,131,515	NGN 29,240,336	NGN 11,626,786	NGN 22,085,761	NGN 16,707,429	NGN 19,439,504
2501000 - MISCELLANEOUS	NGN 4,174,332,827	NGN 12,455,380,079	NGN 2,417,001,728	NGN 2,567,574,150	NGN 4,302,745,712	NGN 2,319,945,097	NGN 10,338,743,391	NGN 2,231,686,511	NGN 9,071,048,162
3001100 - LOANS & ADVANCES - GENERAL	NGN 419,609	NGN 0	NGN 78,868	NGN 129,733	NGN 806,603	NGN 481,676	NGN 914,973	NGN 65,155	NGN 805,343
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 156,052,587	NGN 139,280,141	NGN 29,331,064	NGN 48,247,686	NGN 299,975,711	NGN 179,135,532	NGN 340,278,427	NGN 0	NGN 299,507,172
20000000 - CAPITAL INVESTMENT	NGN 10,538,551,802	NGN 34,213,127,831	NGN 10,797,919,706	NGN 12,060,868,629	NGN 10,323,203,508	NGN 7,531,411,336	NGN 9,252,875,184	NGN 1,397,690,295	NGN 18,404,108,170

State	Ogun	Ondo	Osun	Oyo	Plateau	Rivers	Sokoto	Taraba	Yobe
Source for costing	MBB	MBB	MBB	MBB	MBB	State	State	State	MBB
Total cost	NGN 76,493,329,488	NGN 59,541,046,099	NGN 64,238,862,790	NGN 65,454,041,672	NGN 60,812,385,619	NGN 163,124,352,788	NGN 68,601,615,696	NGN 43,748,909,603	NGN 67,441,199,747
Population	3,751,140	3,460,877	3,416,959	5,580,894	3,206,531	5,198,716	3,702,676	2,294,800	2,321,339
Total cost per capita	NGN 20,392	NGN 17,204	NGN 18,800	NGN 11,728	NGN 18,965	NGN 31,378	NGN 18,528	NGN 19,064	NGN 29,053
By priority area:									
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 651,961,059	NGN 595,410,461	NGN 642,388,628	NGN 654,540,417	NGN 608,123,856	NGN 616,237,500	NGN 318,183,000	NGN 254,724,231	NGN 674,411,997
HEALTH SERVICE DELIVERY	NGN 38,860,872,296	NGN 28,572,199,014	NGN 36,620,095,212	NGN 35,185,802,160	NGN 31,656,233,702	NGN 83,715,283,600	NGN 25,639,557,496	NGN 24,255,560,782	NGN 39,584,985,997
HUMAN RESOURCES FOR HEALTH	NGN 25,041,282,822	NGN 19,539,678,528	NGN 17,785,350,581	NGN 25,414,006,976	NGN 19,817,072,333	NGN 70,475,906,688	NGN 37,226,134,000	NGN 13,179,877,142	NGN 21,438,286,316
FINANCING FOR HEALTH	NGN 8,859,806,236	NGN 7,559,000,560	NGN 5,657,890,915	NGN 599,719,827	NGN 5,386,274,519	NGN 6,442,915,000	NGN 518,148,500	NGN 3,079,854,738	NGN 2,034,249,451
NATIONAL HEALTH INFORMATION SYSTEM	NGN 918,211,863	NGN 893,115,691	NGN 963,582,942	NGN 981,810,625	NGN 912,185,784	NGN 742,765,000	NGN 3,350,363,200	NGN 1,230,523,863	NGN 1,011,617,996
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 502,447,582	NGN 595,410,461	NGN 642,388,628	NGN 654,540,417	NGN 608,123,856	NGN 39,165,000	NGN 780,336,500	NGN 620,214,341	NGN 674,411,997
PARTNERSHIPS FOR HEALTH	NGN 583,841,406	NGN 595,410,461	NGN 642,388,628	NGN 654,540,417	NGN 608,123,856	NGN 300,500,000	NGN 393,282,000	NGN 495,950,477	NGN 674,411,997
RESEARCH FOR HEALTH	NGN 1,074,906,224	NGN 1,190,820,922	NGN 1,284,777,256	NGN 1,309,080,833	NGN 1,216,247,712	NGN 791,580,000	NGN 375,611,000	NGN 632,204,030	NGN 1,348,823,995
Total									
By National Chart of Accounts									
1100010 - SALARY & WAGES - GENERAL	NGN 23,061,687,585	NGN 26,543,565,111	NGN 16,101,154,472	NGN 29,179,595,099	NGN 18,344,887,082	NGN 44,109,421,500	NGN 30,567,255,552	NGN 12,245,903,512	NGN 23,860,574,129
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 5,524,391,020	NGN 1,677,776,651	NGN 5,113,471,947	NGN 1,844,395,926	NGN 2,630,624,361	NGN 2,133,760,000	NGN 1,895,248,000	NGN 574,587,874	NGN 1,692,898,225
1300030 - SOCIAL CONTRIBUTION	NGN 716,805,401	NGN 1,654,238,118	NGN 637,404,127	NGN 1,818,519,791	NGN 637,404,127	NGN 5,513,677,688	NGN 3,820,906,944	NGN 164,157,089	NGN 1,139,709,992
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 287,568,970	NGN 130,551,002	NGN 719,977,857	NGN 143,515,966	NGN 751,852,483	NGN 64,145,000	NGN 1,966,862,000	NGN 59,329,400	NGN 248,654,563
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 38,120,331	NGN 47,616,215	NGN 190,416,617	NGN 52,344,961	NGN 175,581,542	NGN 9,850,000	NGN 165,188,000	NGN 6,557,080	NGN 40,420,373
2100200 - UTILITIES - GENERAL	NGN 1,903,373,898	NGN 1,445,369,131	NGN 897,880,129	NGN 1,588,908,115	NGN 1,192,743,540	NGN 21,400,000	NGN 8,640,000	NGN 74,287,500	NGN 1,396,757,506
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 16,462,554,522	NGN 9,273,371,082	NGN 17,214,103,881	NGN 10,194,305,559	NGN 11,885,382,073	NGN 54,231,460,000	NGN 10,847,536,200	NGN 8,199,949,350	NGN 16,897,040,364

State	Ogun	Ondo	Osun	Oyo	Plateau	Rivers	Sokoto	Taraba	Yobe
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 4,595,869,169	NGN 4,848,860,161	NGN 3,758,288,117	NGN 5,330,398,369	NGN 4,573,390,538	NGN 715,950,000	NGN 1,208,660,000	NGN 225,885,000	NGN 4,521,543,416
2250500 - TRAINING - GENERAL	NGN 1,900,671,040	NGN 1,993,462,638	NGN 1,430,262,031	NGN 2,191,432,552	NGN 1,645,122,604	NGN 137,640,000	NGN 2,141,266,000	NGN 11,500,000	NGN 2,642,629,658
2300600 - OTHER SERVICES - GENERAL	NGN 15,414,631	NGN 35,573,769	NGN 13,707,136	NGN 39,106,584	NGN 13,707,136	NGN 6,000,000	NGN 0	NGN 13,097,000	NGN 24,509,035
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 87,959,189	NGN 202,991,554	NGN 78,215,858	NGN 223,150,558	NGN 78,215,858	NGN 0	NGN 105,350,000	NGN 563,000,000	NGN 139,853,810
2400800 - FINANCIAL - GENERAL	NGN 8,500,082,567	NGN 2,077,533,081	NGN 5,338,014,208	NGN 2,283,851,994	NGN 5,066,397,812	NGN 400,000	NGN 0	NGN 5,420,000,000	NGN 1,462,294,134
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 9,406,681	NGN 21,708,667	NGN 18,438,530	NGN 23,864,545	NGN 17,818,148	NGN 611,000,000	NGN 199,861,500	NGN 39,756,050	NGN 14,956,483
2501000 - MISCELLANEOUS	NGN 3,803,909,356	NGN 1,912,580,491	NGN 2,810,791,398	NGN 2,102,518,033	NGN 2,728,223,782	NGN 12,382,448,600	NGN 2,500,741,500	NGN 2,354,690,985	NGN 4,596,083,433
3001100 - LOANS & ADVANCES - GENERAL	NGN 389,702	NGN 899,350	NGN 346,534	NGN 988,664	NGN 346,534	NGN 0	NGN 0	NGN 0	NGN 619,620
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 144,930,048	NGN 334,468,476	NGN 178,155,038	NGN 367,684,395	NGN 171,787,041	NGN 12,000,200,000	NGN 0	NGN 50,000,000	NGN 230,436,634
20000000 - CAPITAL INVESTMENT	NGN 9,440,195,379	NGN 7,340,480,602	NGN 9,738,234,908	NGN 8,069,460,561	NGN 10,898,900,957	NGN 31,187,000,000	NGN 13,174,100,000	NGN 13,746,208,763	NGN 8,532,218,372

State	Zamfara	Federal
Source for costing	MBB	MBB+ Current Budget + Federal Plan Matrix
Total cost	NGN 54,251,242,485	NGN 1,135,464,589,117
Population	3,278,873	
Total cost per capita	NGN 16,546	
By priority area:		
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 480,296,165	NGN 1,847,592,000
HEALTH SERVICE DELIVERY	NGN 26,907,554,136	NGN 437,855,075,653
HUMAN RESOURCES FOR HEALTH	NGN 21,164,798,801	NGN 689,031,103,464
FINANCING FOR HEALTH	NGN 3,279,307,112	NGN 1,483,864,000
NATIONAL HEALTH INFORMATION SYSTEM	NGN 694,217,901	NGN 1,554,920,000
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 414,647,240	NGN 950,318,500
PARTNERSHIPS FOR HEALTH	NGN 450,385,938	NGN 655,316,000
RESEARCH FOR HEALTH	NGN 860,035,193	NGN 2,086,399,500
Total		
By National Chart of Accounts		
1100010 - SALARY & WAGES - GENERAL	NGN 14,352,869,484	NGN 687,404,531,464
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 4,148,359,865	NGN 0
1300030 - SOCIAL CONTRIBUTION	NGN 314,737,542	NGN 21,000,000
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 343,002,132	NGN 89,480,000
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 20,209,944	NGN 3,122,247,500
2100200 - UTILITIES - GENERAL	NGN 821,400,037	NGN 13,280,000
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 12,808,037,686	NGN 75,366,014,080
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 2,626,279,845	NGN 264,000,000
2250500 - TRAINING - GENERAL	NGN 2,273,514,454	NGN 0
2300600 - OTHER SERVICES - GENERAL	NGN 6,768,312	NGN 236,000,000

State	Zamfara	Federal
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 38,621,443	NGN 5,073,260,000
2400800 - FINANCIAL - GENERAL	NGN 3,121,358,325	NGN 0
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 4,130,320	NGN 0
2501000 - MISCELLANEOUS	NGN 2,840,041,472	NGN 599,379,000
3001100 - LOANS & ADVANCES - GENERAL	NGN 171,112	NGN 0
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 63,636,416	NGN 540,000,000
20000000 - CAPITAL INVESTMENT	NGN 10,468,104,097	NGN 362,735,397,073

AVERAGE ANNUAL COST State	Total	Abia	Adamawa	Akwa	Anambra	Bauchi	Bayelsa	Benue	Borno	Cross River
Source for costing	NGN	MBB	MBB	MBB	MBB	MBB	MBB	MBB	State	MBB
Total cost	NGN 477,083,582,781	NGN 8,944,632,427	NGN 5,980,141,114	NGN 15,766,242,210	NGN 13,459,927,985	NGN 14,371,143,900	NGN 19,083,606,363	NGN 11,943,381,759	NGN 12,791,789,269	NGN 14,693,217,980
Population	2,845,380	2,845,380	3,178,950	3,902,051	4,177,828	4,653,066	1,704,515	4,253,641	4,171,104	2,892,988
Total cost per capita per year	NGN 3,397	NGN 3,144	NGN 1,881	NGN 4,041	NGN 3,222	NGN 3,089	NGN 11,196	NGN 2,808	NGN 3,067	NGN 5,079
FEDERAL DOES NOT INCLUDE SCALE-UP OF TERTIARY CARE FACILITIES and FEDERAL MAPPING TO CHART OF ACCOUNTS AND PRIORITY AREA ARE THEREFORE ROUGH ESTIMATES										
By priority area:										
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 4,289,935,129	NGN 89,446,324	NGN 52,233,482	NGN 157,662,422	NGN 114,723,911	NGN 117,954,420	NGN 142,962,631	NGN 119,433,818	NGN 172,068,000	NGN 146,932,180
HEALTH SERVICE DELIVERY	NGN 251,400,346,280	NGN 5,467,982,375	NGN 2,949,809,166	NGN 9,546,848,594	NGN 6,519,495,015	NGN 7,403,721,667	NGN 10,904,217,944	NGN 6,797,952,598	NGN 5,720,519,900	NGN 7,320,770,414
HUMAN RESOURCES FOR HEALTH	NGN 162,607,532,690	NGN 2,410,944,639	NGN 2,029,284,416	NGN 4,656,434,765	NGN 4,864,726,391	NGN 5,271,562,318	NGN 5,922,013,868	NGN 4,082,510,363	NGN 6,335,210,219	NGN 3,857,186,117
FINANCING FOR HEALTH	NGN 36,248,774,382	NGN 484,304,304	NGN 691,461,201	NGN 538,153,107	NGN 1,419,078,159	NGN 1,058,916,261	NGN 1,604,859,321	NGN 286,598,983	NGN 388,252,333	NGN 2,560,202,280
NATIONAL HEALTH INFORMATION SYSTEM	NGN 6,675,046,578	NGN 134,169,486	NGN 74,819,687	NGN 236,493,633	NGN 161,578,821	NGN 161,625,826	NGN 181,800,958	NGN 179,150,726	NGN 40,880,750	NGN 220,398,270
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 3,827,127,170	NGN 89,446,324	NGN 43,395,961	NGN 157,662,422	NGN 88,423,020	NGN 79,641,438	NGN 61,251,778	NGN 119,433,818	NGN 56,356,967	NGN 146,932,180
PARTNERSHIPS FOR HEALTH	NGN 4,141,193,617	NGN 89,446,324	NGN 48,207,030	NGN 157,662,422	NGN 102,740,994	NGN 100,498,689	NGN 105,734,449	NGN 119,433,818	NGN 13,501,100	NGN 146,932,180
RESEARCH FOR HEALTH	NGN 7,893,626,936	NGN 178,892,649	NGN 90,930,172	NGN 315,324,844	NGN 189,161,674	NGN 177,223,281	NGN 160,765,414	NGN 238,867,635	NGN 65,000,000	NGN 293,864,360
	NGN 477,083,582,781									
By National Chart of Accounts										
1100010 - SALARY & WAGES - GENERAL	NGN 143,613,335,012	NGN 1,417,095,763	NGN 1,783,164,059	NGN 5,566,129,552	NGN 4,173,078,917	NGN 4,975,263,815	NGN 7,261,993,980	NGN 4,544,375,698	NGN 5,498,176,491	NGN 1,614,419,576
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 23,254,444,709	NGN 517,936,148	NGN 348,481,514	NGN 998,565,711	NGN 553,253,603	NGN 392,441,018	NGN 753,953,994	NGN 543,527,651	NGN 82,064,833	NGN 838,950,013

AVERAGE ANNUAL COST State	Total	Abia	Adamawa	Akwa	Anambra	Bauchi	Bayelsa	Benue	Borno	Cross River
1300030 - SOCIAL CONTRIBUTION	NGN 7,217,032,355	NGN 13,740,709	NGN 42,369,312	NGN 300,891,570	NGN 126,093,123	NGN 183,682,122	NGN 391,742,487	NGN 157,544,005	NGN 687,272,061	NGN 24,003,307
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 3,889,190,644	NGN 96,768,627	NGN 20,931,657	NGN 71,656,585	NGN 30,888,488	NGN 101,210,891	NGN 50,942,788	NGN 201,000,627	NGN 12,973,167	NGN 101,162,366
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 1,314,807,578	NGN 17,293,268	NGN 2,666,521	NGN 9,500,850	NGN 4,577,839	NGN 34,240,983	NGN 13,493,727	NGN 16,450,185	NGN 10,961,750	NGN 120,292,695
2100200 - UTILITIES - GENERAL	NGN 7,119,267,126	NGN 84,664,934	NGN 216,301,657	NGN 322,466,687	NGN 240,736,891	NGN 245,259,388	NGN 410,289,983	NGN 294,629,111	NGN 115,332,500	NGN 127,399,289
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 114,452,021,936	NGN 2,723,590,558	NGN 1,614,031,977	NGN 3,738,745,109	NGN 2,864,839,335	NGN 3,173,117,274	NGN 3,425,891,389	NGN 2,831,920,401	NGN 2,709,605,783	NGN 3,177,906,855
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 25,475,201,054	NGN 518,133,314	NGN 379,758,898	NGN 1,145,943,861	NGN 913,785,478	NGN 796,021,709	NGN 1,347,934,582	NGN 1,084,466,766	NGN 923,368,333	NGN 586,827,403
2250500 - TRAINING - GENERAL	NGN 14,283,024,224	NGN 697,373,596	NGN 241,318,240	NGN 445,725,182	NGN 397,287,661	NGN 667,348,459	NGN 540,239,091	NGN 423,879,624	NGN 12,456,000	NGN 1,401,524,905
2300600 - OTHER SERVICES - GENERAL	NGN 252,996,974	NGN 1,757,803	NGN 911,136	NGN 6,470,560	NGN 2,711,585	NGN 3,950,015	NGN 8,424,275	NGN 3,387,925	NGN 47,000,000	NGN 78,630,836
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 1,254,415,468	NGN 98,278,837	NGN 5,199,138	NGN 36,922,404	NGN 15,472,887	NGN 22,539,633	NGN 48,070,719	NGN 19,332,224	NGN 86,000,000	NGN 175,889,782
2400800 - FINANCIAL - GENERAL	NGN 28,740,053,447	NGN 6,573,499	NGN 670,198,465	NGN 387,152,823	NGN 1,355,799,226	NGN 966,736,701	NGN 1,408,266,153	NGN 207,536,649	NGN 9,950,000	NGN 1,761,103,668
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 595,991,873	NGN 2,635,958	NGN 556,015	NGN 3,948,618	NGN 1,654,728	NGN 2,410,472	NGN 5,140,860	NGN 4,322,795	NGN 25,992,250	NGN 2,494,046
2501000 - MISCELLANEOUS	NGN 26,145,590,044	NGN 995,576,284	NGN 300,090,497	NGN 1,054,025,372	NGN 666,828,209	NGN 559,602,765	NGN 745,867,971	NGN 445,171,674	NGN 470,736,100	NGN 1,461,305,746
3001100 - LOANS & ADVANCES - GENERAL	NGN 37,616,407	NGN 0	NGN 23,035	NGN 163,584	NGN 68,552	NGN 99,861	NGN 212,976	NGN 85,651	NGN 0	NGN 0

AVERAGE ANNUAL COST										
State	Total	Abia	Adamawa	Akwa	Anambra	Bauchi	Bayelsa	Benue	Borno	Cross River
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 3,948,571,013	NGN 118,057,878	NGN 8,566,602	NGN 60,836,916	NGN 25,494,622	NGN 47,360,634	NGN 79,205,956	NGN 31,853,639	NGN 16,666,667	NGN 197,824,205
20000000 - CAPITAL INVESTMENT	NGN 75,490,022,915	NGN 1,635,155,251	NGN 345,572,391	NGN 1,617,096,826	NGN 2,087,356,841	NGN 2,199,858,159	NGN 2,591,935,431	NGN 1,133,897,133	NGN 2,083,233,333	NGN 3,023,483,288

State	Delta	Ebonyi	Edo	Ekiti	Enugu	FCT	Gombe	Imo	Jigawa	Kaduna
Source for costing	MBB	MBB	MBB	State	MBB	State	MBB	State	MBB	MBB
Total cost	NGN 21,985,511,479	NGN 7,224,718,330	NGN 12,811,876,307	NGN 6,964,998,044	NGN 12,484,693,623	NGN 10,381,887,080	NGN 6,599,981,187	NGN 4,386,068,667	NGN 11,298,716,458	NGN 14,247,393,048
Population	4,112,445	2,176,947	3,233,366	2,398,957	3,267,837	1,406,239	2,365,040	3,927,563	4,361,002	6,113,503
Total cost per capita per year	NGN 5,346	NGN 3,319	NGN 3,962	NGN 2,903	NGN 3,820	NGN 7,383	NGN 2,791	NGN 1,117	NGN 2,591	NGN 2,330
By priority area:	NGN 219,855,115	NGN 72,247,183	NGN 128,118,763	NGN 5,815,420	NGN 106,950,245	NGN 55,748,466	NGN 59,145,500	NGN 95,587,167	NGN 112,987,165	NGN 121,882,798
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 12,308,418,790	NGN 3,232,751,960	NGN 7,328,430,942	NGN 2,791,886,513	NGN 5,852,498,263	NGN 3,571,326,189	NGN 3,508,114,960	NGN 1,562,882,500	NGN 6,937,581,774	NGN 7,397,826,560
HEALTH SERVICE DELIVERY	NGN 7,465,072,761	NGN 1,926,827,683	NGN 4,501,001,311	NGN 1,984,351,413	NGN 4,397,213,559	NGN 6,114,954,907	NGN 2,070,875,485	NGN 1,946,015,667	NGN 3,435,020,002	NGN 4,846,980,271
HUMAN RESOURCES FOR HEALTH	NGN 782,961,681	NGN 1,595,531,996	NGN 149,672,094	NGN 2,137,410,460	NGN 1,618,313,540	NGN 235,982,372	NGN 658,134,784	NGN 218,695,833	NGN 191,698,112	NGN 1,301,221,427
FINANCING FOR HEALTH	NGN 329,782,672	NGN 108,370,775	NGN 192,178,145	NGN 12,384,299	NGN 151,164,945	NGN 170,686,285	NGN 86,171,634	NGN 34,488,833	NGN 169,480,747	NGN 172,105,258
NATIONAL HEALTH INFORMATION SYSTEM	NGN 219,855,115	NGN 72,247,183	NGN 128,118,763	NGN 5,964,246	NGN 83,769,861	NGN 15,710,169	NGN 52,770,894	NGN 33,122,500	NGN 112,987,165	NGN 95,051,503
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 219,855,115	NGN 72,247,183	NGN 128,118,763	NGN 5,417,159	NGN 96,389,059	NGN 20,712,021	NGN 56,241,174	NGN 271,283,333	NGN 112,987,165	NGN 109,658,224
PARTNERSHIPS FOR HEALTH	NGN 439,710,230	NGN 144,494,367	NGN 256,237,526	NGN 21,768,534	NGN 178,394,150	NGN 196,766,671	NGN 108,526,756	NGN 223,992,833	NGN 225,974,329	NGN 202,667,007
RESEARCH FOR HEALTH										
By National Chart of Accounts	NGN 9,795,699,975	NGN 1,863,492,196	NGN 3,012,334,668	NGN 1,376,387	NGN 3,414,300,641	NGN 4,325,732,932	NGN 1,286,479,896	NGN 1,409,616,667	NGN 2,742,971,308	NGN 4,606,326,577
1100010 - SALARY & WAGES - GENERAL	NGN 606,629,469	NGN 270,727,969	NGN 1,041,489,047	NGN 212,377,250	NGN 578,385,285	NGN 38,905,995	NGN 435,930,952	NGN 156,899,167	NGN 395,078,022	NGN 765,133,570

State	Delta	Ebonyi	Edo	Ekiti	Enugu	FCT	Gombe	Imo	Jigawa	Kaduna
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 445,439,613	NGN 52,177,599	NGN 238,215,039	NGN 172,048	NGN 111,132,620	NGN 39,576,253	NGN 30,561,471	NGN 18,900,833	NGN 69,768,436	NGN 128,636,008
1300030 - SOCIAL CONTRIBUTION	NGN 71,956,752	NGN 42,862,024	NGN 1,380,353,624	NGN 22,747,900	NGN 41,657,256	NGN 9,756,333	NGN 41,266,542	NGN 10,150,000	NGN 171,918,336	NGN 43,975,330
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 19,392,081	NGN 3,965,517	NGN 5,125,884	NGN 3,955,083	NGN 7,349,561	NGN 23,577,600	NGN 1,996,654	NGN 25,149,167	NGN 37,168,787	NGN 6,330,370
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 407,365,929	NGN 170,730,383	NGN 44,434,775	NGN 4,053,167	NGN 247,938,561	NGN 4,881,000	NGN 100,058,800	NGN 43,758,333	NGN 185,857,279	NGN 301,396,143
2100200 - UTILITIES - GENERAL	NGN 4,363,500,112	NGN 1,840,993,603	NGN 3,066,074,730	NGN 1,070,392,842	NGN 2,384,492,734	NGN 2,387,297,929	NGN 1,926,238,458	NGN 407,385,833	NGN 3,389,661,989	NGN 3,198,234,949
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 1,367,531,858	NGN 330,782,767	NGN 919,745,266	NGN 3,026,000	NGN 766,658,238	NGN 407,000	NGN 304,828,509	NGN 125,375,833	NGN 760,968,447	NGN 966,411,837
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 638,536,384	NGN 214,863,222	NGN 425,704,743	NGN 226,480,667	NGN 277,651,347	NGN 116,577,585	NGN 175,610,816	NGN 153,133,000	NGN 506,657,086	NGN 495,816,469
2250500 - TRAINING - GENERAL	NGN 9,579,011	NGN 1,122,060	NGN 178,787	NGN 6,363,000	NGN 2,389,865	NGN 430,000	NGN 657,213	NGN 24,333,333	NGN 1,500,344	NGN 2,766,269
2300600 - OTHER SERVICES - GENERAL	NGN 54,659,894	NGN 6,402,713	NGN 258,450	NGN 3,741,817	NGN 13,637,083	NGN 37,683,333	NGN 3,750,198	NGN 170,004,167	NGN 8,561,285	NGN 15,784,924
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 559,420,994	NGN 1,569,347,040	NGN 120,934,430	NGN 0	NGN 1,562,542,429	NGN 0	NGN 642,797,728	NGN 0	NGN 156,685,321	NGN 1,236,666,366
2400800 - FINANCIAL - GENERAL	NGN 6,208,541	NGN 684,730	NGN 386,398	NGN 3,630,667	NGN 1,458,400	NGN 2,248,000	NGN 401,060	NGN 9,889,167	NGN 341,320,762	NGN 1,688,098
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 1,431,938,142	NGN 428,311,088	NGN 1,373,696,318	NGN 25,202,217	NGN 628,965,005	NGN 61,447,519	NGN 353,623,347	NGN 410,789,834	NGN 80,664,173	NGN 695,722,138
2501000 - MISCELLANEOUS	NGN 242,170	NGN 28,367	NGN 0	NGN 33,333,333	NGN 60,419	NGN 2,000,000	NGN 16,615	NGN 0	NGN 37,931	NGN 69,935

State	Delta	Ebonyi	Edo	Ekiti	Enugu	FCT	Gombe	Imo	Jigawa	Kaduna
3001100 - LOANS & ADVANCES - GENERAL	NGN 90,062,916	NGN 10,549,728	NGN 0	NGN 379,229,167	NGN 22,469,775	NGN 27,000,000	NGN 6,179,188	NGN 298,466,667	NGN 23,228,728	NGN 26,008,764
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 2,117,347,637	NGN 417,677,325	NGN 1,182,944,148	NGN 4,968,916,500	NGN 2,423,604,404	NGN 3,304,365,600	NGN 1,289,583,739	NGN 1,122,216,667	NGN 2,426,668,225	NGN 1,756,425,300

State	Kano	Katsina	Kebbi	Kogi	Kwara	Lagos	Nasarawa	Niger	Ogun	Ondo
Source for costing	MBB	MBB	MBB	MBB	MBB	MBB	MBB	MBB	MBB	MBB
Total cost	NGN 36,127,432,920	NGN 7,233,354,552	NGN 8,040,123,450	NGN 13,457,521,408	NGN 9,968,912,482	NGN 25,961,461,175	NGN 7,183,340,649	NGN 23,073,677,918	NGN 12,748,888,248	NGN 9,923,507,683
Population	9,401,288	5,801,584	3,256,541	3,314,043	2,365,353	9,113,605	1,869,377	3,954,772	3,751,140	3,460,877
Total cost per capita per year	NGN 3,843	NGN 1,247	NGN 2,469	NGN 4,061	NGN 4,215	NGN 2,849	NGN 3,843	NGN 5,834	NGN 3,399	NGN 2,867
By priority area:	NGN 361,274,329	NGN 72,333,546	NGN 71,816,303	NGN 134,575,214	NGN 79,949,710	NGN 259,614,612	NGN 71,833,406	NGN 230,736,779	NGN 108,660,176	NGN 99,235,077
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 20,113,059,617	NGN 4,688,764,505	NGN 3,940,141,070	NGN 8,257,026,830	NGN 5,707,298,619	NGN 12,400,187,406	NGN 5,947,167,584	NGN 11,390,640,459	NGN 6,476,812,049	NGN 4,762,033,169
HEALTH SERVICE DELIVERY	NGN 9,424,387,163	NGN 2,006,488,893	NGN 3,088,204,747	NGN 3,883,849,234	NGN 2,986,885,816	NGN 8,723,455,525	NGN 763,876,914	NGN 8,431,799,211	NGN 4,173,547,137	NGN 3,256,613,088
HUMAN RESOURCES FOR HEALTH	NGN 4,241,703,001	NGN 67,933,109	NGN 573,067,518	NGN 441,906,453	NGN 859,370,116	NGN 3,150,323,268	NGN 5,379,009	NGN 1,751,449,183	NGN 1,476,634,373	NGN 1,259,833,427
FINANCING FOR HEALTH	NGN 541,911,494	NGN 108,500,318	NGN 104,410,418	NGN 201,862,821	NGN 107,620,104	NGN 389,421,918	NGN 107,750,110	NGN 346,105,169	NGN 153,035,310	NGN 148,852,615
NATIONAL HEALTH INFORMATION SYSTEM	NGN 361,274,329	NGN 72,333,546	NGN 63,520,716	NGN 134,575,214	NGN 49,149,591	NGN 259,614,612	NGN 71,833,406	NGN 230,736,779	NGN 83,741,264	NGN 99,235,077
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 361,274,329	NGN 72,333,546	NGN 68,036,761	NGN 134,575,214	NGN 65,916,905	NGN 259,614,612	NGN 71,833,406	NGN 230,736,779	NGN 97,306,901	NGN 99,235,077
PARTNERSHIPS FOR HEALTH	NGN 722,548,658	NGN 144,667,091	NGN 130,925,917	NGN 269,150,428	NGN 112,721,621	NGN 519,229,224	NGN 143,666,813	NGN 461,473,558	NGN 179,151,037	NGN 198,470,154
RESEARCH FOR HEALTH										
By National Chart of Accounts	NGN 5,413,945,879	NGN 1,023,300,592	NGN 1,993,159,164	NGN 5,006,648,454	NGN 3,347,841,791	NGN 8,304,640,239	NGN 3,874,235,758	NGN 5,629,715,115	NGN 3,843,614,598	NGN 4,423,927,519
1100010 - SALARY & WAGES - GENERAL	NGN 2,794,672,403	NGN 91,962,249	NGN 289,894,985	NGN 507,902,809	NGN 529,537,934	NGN 1,991,618,005	NGN 207,490,854	NGN 2,771,381,947	NGN 920,731,837	NGN 279,629,442
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 12,156,940	NGN 24,177,946	NGN 39,771,143	NGN 247,273,556	NGN 147,663,556	NGN 280,495,565	NGN 420,427,563	NGN 246,887,333	NGN 119,467,567	NGN 275,706,353

State	Kano	Katsina	Kebbi	Kogi	Kwara	Lagos	Nasarawa	Niger	Ogun	Ondo
1300030 - SOCIAL CONTRIBUTION	NGN 138,962,178	NGN 70,512,069	NGN 21,153,562	NGN 122,765,766	NGN 51,529,300	NGN 55,786,699	NGN 50,040,953	NGN 68,350,926	NGN 47,928,162	NGN 21,758,500
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 20,257,428	NGN 3,873,339	NGN 2,945,432	NGN 14,799,515	NGN 19,451,373	NGN 9,787,606	NGN 67,328,813	NGN 688,491,372	NGN 6,353,389	NGN 7,936,036
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 336,356,400	NGN 152,298,060	NGN 122,556,084	NGN 294,844,387	NGN 263,451,229	NGN 440,217,876	NGN 32,506,637	NGN 351,021,666	NGN 317,228,983	NGN 240,894,855
2100200 - UTILITIES - GENERAL	NGN 13,420,704,192	NGN 2,451,491,888	NGN 1,716,035,334	NGN 2,906,676,163	NGN 2,187,020,011	NGN 6,455,236,547	NGN 1,604,899,186	NGN 5,413,746,636	NGN 2,743,759,087	NGN 1,545,561,847
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 1,224,978,459	NGN 668,617,353	NGN 490,372,050	NGN 1,077,045,472	NGN 664,461,753	NGN 1,413,157,189	NGN 172,959,721	NGN 1,120,778,854	NGN 765,978,195	NGN 808,143,360
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 684,543,393	NGN 480,128,813	NGN 358,732,843	NGN 433,428,859	NGN 277,627,338	NGN 634,695,025	NGN 140,103,005	NGN 487,664,041	NGN 316,778,507	NGN 332,243,773
2250500 - TRAINING - GENERAL	NGN 0	NGN 519,938	NGN 855,263	NGN 5,317,525	NGN 3,175,449	NGN 6,031,952	NGN 1,243,011	NGN 5,309,219	NGN 2,569,105	NGN 5,928,961
2300600 - OTHER SERVICES - GENERAL	NGN 53,894,274	NGN 2,966,876	NGN 4,880,317	NGN 30,342,937	NGN 18,119,794	NGN 34,419,610	NGN 4,413,583	NGN 30,295,544	NGN 14,659,865	NGN 33,831,926
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 4,224,255,722	NGN 55,799,580	NGN 553,108,654	NGN 317,813,986	NGN 785,266,216	NGN 3,009,558,572	NGN 0	NGN 1,627,550,539	NGN 1,416,680,428	NGN 346,255,513
2400800 - FINANCIAL - GENERAL	NGN 1,407,646	NGN 317,289	NGN 521,919	NGN 4,873,389	NGN 1,937,798	NGN 3,680,960	NGN 2,784,571	NGN 3,239,917	NGN 1,567,780	NGN 3,618,111
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 2,075,896,680	NGN 402,833,621	NGN 427,929,025	NGN 717,124,285	NGN 386,657,516	NGN 1,723,123,898	NGN 371,947,752	NGN 1,511,841,360	NGN 633,984,893	NGN 318,763,415
2501000 - MISCELLANEOUS	NGN 0	NGN 13,145	NGN 21,622	NGN 134,434	NGN 80,279	NGN 152,495	NGN 10,859	NGN 134,224	NGN 64,950	NGN 149,892
3001100 - LOANS & ADVANCES - GENERAL	NGN 23,213,357	NGN 4,888,511	NGN 8,041,281	NGN 49,995,952	NGN 29,855,922	NGN 56,713,071	NGN 0	NGN 49,917,862	NGN 24,155,008	NGN 55,744,746
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 5,702,187,972	NGN 1,799,653,284	NGN 2,010,144,771	NGN 1,720,533,918	NGN 1,255,235,223	NGN 1,542,145,864	NGN 232,948,382	NGN 3,067,351,362	NGN 1,573,365,897	NGN 1,223,413,434

State	Osun	Oyo	Plateau	Rivers	Sokoto	Taraba	Yobe	Zamfara	Federal
Source for costing	MBB	MBB	MBB	State	State	State	MBB	MBB	MBB+ Current Budget + Federal Plan Matrix
Total cost	NGN 10,706,477,132	NGN 10,909,006,945	NGN 10,135,397,603	NGN 27,187,392,131	NGN 11,433,602,616	NGN 7,291,484,934	NGN 11,240,199,958	NGN 9,041,873,748	NGN 189,244,098,186
Population	3,416,959	5,580,894	3,206,531	5,198,716	3,702,676	2,294,800	2,321,339	3,278,873	3,278,873
Total cost per capita per year	NGN 3,133	NGN 1,955	NGN 3,161	NGN 5,230	NGN 3,088	NGN 3,177	NGN 4,842	NGN 2,758	NGN 0
By priority area:	NGN 107,064,771	NGN 109,090,069	NGN 101,353,976	NGN 102,706,250	NGN 53,030,500	NGN 42,454,038	NGN 112,402,000	NGN 80,049,361	NGN 307,932,000
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 6,103,349,202	NGN 5,864,300,360	NGN 5,276,038,950	NGN 13,952,547,267	NGN 4,273,259,583	NGN 4,042,593,464	NGN 6,597,497,666	NGN 4,484,592,356	NGN 72,975,845,942
HEALTH SERVICE DELIVERY	NGN 2,964,225,097	NGN 4,235,667,829	NGN 3,302,845,389	NGN 11,745,984,448	NGN 6,204,355,667	NGN 2,196,646,190	NGN 3,573,047,719	NGN 3,527,466,467	NGN 114,838,517,244
HUMAN RESOURCES FOR HEALTH	NGN 942,981,819	NGN 99,953,304	NGN 897,712,420	NGN 1,073,819,167	NGN 86,358,083	NGN 513,309,123	NGN 339,041,575	NGN 546,551,185	NGN 247,310,667
FINANCING FOR HEALTH	NGN 160,597,157	NGN 163,635,104	NGN 152,030,964	NGN 123,794,167	NGN 558,393,867	NGN 205,087,311	NGN 168,602,999	NGN 115,702,983	NGN 259,153,333
NATIONAL HEALTH INFORMATION SYSTEM	NGN 107,064,771	NGN 109,090,069	NGN 101,353,976	NGN 6,527,500	NGN 130,056,083	NGN 103,369,057	NGN 112,402,000	NGN 69,107,873	NGN 158,386,417
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 107,064,771	NGN 109,090,069	NGN 101,353,976	NGN 50,083,333	NGN 65,547,000	NGN 82,658,413	NGN 112,402,000	NGN 75,064,323	NGN 109,219,333
PARTNERSHIPS FOR HEALTH	NGN 214,129,543	NGN 218,180,139	NGN 202,707,952	NGN 131,930,000	NGN 62,601,833	NGN 105,367,338	NGN 224,803,999	NGN 143,339,199	NGN 347,733,250
RESEARCH FOR HEALTH									
By National Chart of Accounts	NGN 2,683,525,745	NGN 4,863,265,850	NGN 3,057,481,180	NGN 7,351,570,250	NGN 5,094,542,592	NGN 2,040,983,919	NGN 3,976,762,355	NGN 2,392,144,914	NGN 114,567,421,911
1100010 - SALARY & WAGES - GENERAL	NGN 852,245,324	NGN 307,399,321	NGN 438,437,393	NGN 355,626,667	NGN 315,874,667	NGN 95,764,646	NGN 282,149,704	NGN 691,393,311	NGN 0
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 106,234,021	NGN 303,086,632	NGN 106,234,021	NGN 918,946,281	NGN 636,817,824	NGN 27,359,515	NGN 189,951,665	NGN 52,456,257	NGN 3,500,000
1300030 - SOCIAL CONTRIBUTION	NGN 119,996,310	NGN 23,919,328	NGN 125,308,747	NGN 10,690,833	NGN 327,810,333	NGN 9,888,233	NGN 41,442,427	NGN 57,167,022	NGN 14,913,333
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 31,736,103	NGN 8,724,160	NGN 29,263,590	NGN 1,641,667	NGN 27,531,333	NGN 1,092,847	NGN 6,736,729	NGN 3,368,324	NGN 520,374,583

State	Osun	Oyo	Plateau	Rivers	Sokoto	Taraba	Yobe	Zamfara	Federal
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 149,646,688	NGN 264,818,019	NGN 198,790,590	NGN 3,566,667	NGN 1,440,000	NGN 12,381,250	NGN 232,792,918	NGN 136,900,006	NGN 2,213,333
2100200 - UTILITIES - GENERAL	NGN 2,869,017,314	NGN 1,699,050,926	NGN 1,980,897,012	NGN 9,038,576,667	NGN 1,807,922,700	NGN 1,366,658,225	NGN 2,816,173,394	NGN 2,134,672,948	NGN 12,561,002,347
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 626,381,353	NGN 888,399,728	NGN 762,231,756	NGN 119,325,000	NGN 201,443,333	NGN 37,647,500	NGN 753,590,569	NGN 437,713,307	NGN 44,000,000
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 238,377,005	NGN 365,238,759	NGN 274,187,101	NGN 22,940,000	NGN 356,877,667	NGN 1,916,667	NGN 440,438,276	NGN 378,919,076	NGN 0
2250500 - TRAINING - GENERAL	NGN 2,284,523	NGN 6,517,764	NGN 2,284,523	NGN 1,000,000	NGN 0	NGN 2,182,833	NGN 4,084,839	NGN 1,128,052	NGN 39,333,333
2300600 - OTHER SERVICES - GENERAL	NGN 13,035,976	NGN 37,191,760	NGN 13,035,976	NGN 0	NGN 17,558,333	NGN 93,833,333	NGN 23,308,968	NGN 6,436,907	NGN 845,543,333
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 889,669,035	NGN 380,641,999	NGN 844,399,635	NGN 66,667	NGN 0	NGN 903,333,333	NGN 243,715,689	NGN 520,226,388	NGN 0
2400800 - FINANCIAL - GENERAL	NGN 3,073,088	NGN 3,977,424	NGN 2,969,691	NGN 101,833,333	NGN 33,310,250	NGN 6,626,008	NGN 2,492,747	NGN 688,387	NGN 0
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 468,465,233	NGN 350,419,672	NGN 454,703,964	NGN 2,063,741,433	NGN 416,790,250	NGN 392,448,497	NGN 766,013,905	NGN 473,340,245	NGN 99,896,500
2501000 - MISCELLANEOUS	NGN 57,756	NGN 164,777	NGN 57,756	NGN 0	NGN 0	NGN 0	NGN 103,270	NGN 28,519	NGN 0
3001100 - LOANS & ADVANCES - GENERAL	NGN 29,692,506	NGN 61,280,733	NGN 28,631,174	NGN 2,000,033,333	NGN 0	NGN 8,333,333	NGN 38,406,106	NGN 10,606,069	NGN 90,000,000
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 1,623,039,151	NGN 1,344,910,093	NGN 1,816,483,493	NGN 5,197,833,333	NGN 2,195,683,333	NGN 2,291,034,794	NGN 1,422,036,395	NGN 1,744,684,016	NGN 60,455,899,512

AVERAGE ANNUAL COST										
State	**Total**	**Abia**	**Adamawa**	**Akwa**	**Anambra**	**Bauchi**	**Bayelsa**	**Benue**	**Borno**	**Cross River**
Source for costing	NGN	MBB	MBB	MBB	MBB	MBB	MBB	MBB	State	MBB
Total cost	NGN 477,083,582,781	NGN 8,944,632,427	NGN 5,980,141,114	NGN 15,766,242,210	NGN 13,459,927,985	NGN 14,371,143,900	NGN 19,083,606,363	NGN 11,943,381,759	NGN 12,791,789,269	NGN 14,693,217,980
Population	2,845,380	2,845,380	3,178,950	3,902,051	4,177,828	4,653,066	1,704,515	4,253,641	4,171,104	2,892,988
Total cost per capita per year	NGN 3,397	NGN 3,144	NGN 1,881	NGN 4,041	NGN 3,222	NGN 3,089	NGN 11,196	NGN 2,808	NGN 3,067	NGN 5,079
FEDERAL DOES NOT INCLUDE SCALE-UP OF TERTIARY CARE FACILITIES and FEDERAL MAPPING TO CHART OF ACCOUNTS AND PRIORITY AREA ARE THEREFORE ROUGH ESTIMATES										
By priority area:										
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 4,289,935,129	NGN 89,446,324	NGN 52,233,482	NGN 157,662,422	NGN 114,723,911	NGN 117,954,420	NGN 142,962,631	NGN 119,433,818	NGN 172,068,000	NGN 146,932,180
HEALTH SERVICE DELIVERY	NGN 251,400,346,280	NGN 5,467,982,375	NGN 2,949,809,166	NGN 9,546,848,594	NGN 6,519,495,015	NGN 7,403,721,667	NGN 10,904,217,944	NGN 6,797,952,598	NGN 5,720,519,900	NGN 7,320,770,414
HUMAN RESOURCES FOR HEALTH	NGN 162,607,532,690	NGN 2,410,944,639	NGN 2,029,284,416	NGN 4,656,434,765	NGN 4,864,726,391	NGN 5,271,562,318	NGN 5,922,013,868	NGN 4,082,510,363	NGN 6,335,210,219	NGN 3,857,186,117
FINANCING FOR HEALTH	NGN 36,248,774,382	NGN 484,304,304	NGN 691,461,201	NGN 538,153,107	NGN 1,419,078,159	NGN 1,058,916,261	NGN 1,604,859,321	NGN 286,598,983	NGN 388,252,333	NGN 2,560,202,280
NATIONAL HEALTH INFORMATION SYSTEM	NGN 6,675,046,578	NGN 134,169,486	NGN 74,819,687	NGN 236,493,633	NGN 161,578,821	NGN 161,625,826	NGN 181,800,958	NGN 179,150,726	NGN 40,880,750	NGN 220,398,270
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 3,827,127,170	NGN 89,446,324	NGN 43,395,961	NGN 157,662,422	NGN 88,423,020	NGN 79,641,438	NGN 61,251,778	NGN 119,433,818	NGN 56,356,967	NGN 146,932,180
PARTNERSHIPS FOR HEALTH	NGN 4,141,193,617	NGN 89,446,324	NGN 48,207,030	NGN 157,662,422	NGN 102,740,994	NGN 100,498,689	NGN 105,734,449	NGN 119,433,818	NGN 13,501,100	NGN 146,932,180
RESEARCH FOR HEALTH	NGN 7,893,626,936	NGN 178,892,649	NGN 90,930,172	NGN 315,324,844	NGN 189,161,674	NGN 177,223,281	NGN 160,765,414	NGN 238,867,635	NGN 65,000,000	NGN 293,864,360
	NGN 477,083,582,781									
By National Chart of Accounts										
1100010 - SALARY & WAGES - GENERAL	NGN 143,613,335,012	NGN 1,417,095,763	NGN 1,783,164,059	NGN 5,566,129,552	NGN 4,173,078,917	NGN 4,975,263,815	NGN 7,261,993,980	NGN 4,544,375,698	NGN 5,498,176,491	NGN 1,614,419,576
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 23,254,444,709	NGN 517,936,148	NGN 348,481,514	NGN 998,565,711	NGN 553,253,603	NGN 392,441,018	NGN 753,953,994	NGN 543,527,651	NGN 82,064,833	NGN 838,950,013
1300030 - SOCIAL CONTRIBUTION	NGN 7,217,032,355	NGN 13,740,709	NGN 42,369,312	NGN 300,891,570	NGN 126,093,123	NGN 183,682,122	NGN 391,742,487	NGN 157,544,005	NGN 687,272,061	NGN 24,003,307
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 3,889,190,644	NGN 96,768,627	NGN 20,931,657	NGN 71,656,585	NGN 30,888,488	NGN 101,210,891	NGN 50,942,788	NGN 201,000,627	NGN 12,973,167	NGN 101,162,366

AVERAGE ANNUAL COST										
State	Total	Abia	Adamawa	Akwa	Anambra	Bauchi	Bayelsa	Benue	Borno	Cross River
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 1,314,807,578	NGN 17,293,268	NGN 2,666,521	NGN 9,500,850	NGN 4,577,839	NGN 34,240,983	NGN 13,493,727	NGN 16,450,185	NGN 10,961,750	NGN 120,292,695
2100200 - UTILITIES - GENERAL	NGN 7,119,267,126	NGN 84,664,934	NGN 216,301,657	NGN 322,466,687	NGN 240,736,891	NGN 245,259,388	NGN 410,289,983	NGN 294,629,111	NGN 115,332,500	NGN 127,399,289
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 114,452,021,936	NGN 2,723,590,558	NGN 1,614,031,977	NGN 3,738,745,109	NGN 2,864,839,335	NGN 3,173,117,274	NGN 3,425,891,389	NGN 2,831,920,401	NGN 2,709,605,783	NGN 3,177,906,855
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 25,475,201,054	NGN 518,133,314	NGN 379,758,898	NGN 1,145,943,861	NGN 913,785,478	NGN 796,021,709	NGN 1,347,934,582	NGN 1,084,466,766	NGN 923,368,333	NGN 586,827,403
2250500 - TRAINING - GENERAL	NGN 14,283,024,224	NGN 697,373,596	NGN 241,318,240	NGN 445,725,182	NGN 397,287,661	NGN 667,348,459	NGN 540,239,091	NGN 423,879,624	NGN 12,456,000	NGN 1,401,524,905
2300600 - OTHER SERVICES - GENERAL	NGN 252,996,974	NGN 1,757,803	NGN 911,136	NGN 6,470,560	NGN 2,711,585	NGN 3,950,015	NGN 8,424,275	NGN 3,387,925	NGN 47,000,000	NGN 78,630,836
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 1,254,415,468	NGN 98,278,837	NGN 5,199,138	NGN 36,922,404	NGN 15,472,887	NGN 22,539,633	NGN 48,070,719	NGN 19,332,224	NGN 86,000,000	NGN 175,889,782
2400800 - FINANCIAL - GENERAL	NGN 28,740,053,447	NGN 6,573,499	NGN 670,198,465	NGN 387,152,823	NGN 1,355,799,226	NGN 966,736,701	NGN 1,408,266,153	NGN 207,536,649	NGN 9,950,000	NGN 1,761,103,668
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 595,991,873	NGN 2,635,958	NGN 556,015	NGN 3,948,618	NGN 1,654,728	NGN 2,410,472	NGN 5,140,860	NGN 4,322,795	NGN 25,992,250	NGN 2,494,046
2501000 - MISCELLANEOUS	NGN 26,145,590,044	NGN 995,576,284	NGN 300,090,497	NGN 1,054,025,372	NGN 666,828,209	NGN 559,602,765	NGN 745,867,971	NGN 445,171,674	NGN 470,736,100	NGN 1,461,305,746
3001100 - LOANS & ADVANCES - GENERAL	NGN 37,616,407	NGN 0	NGN 23,035	NGN 163,584	NGN 68,552	NGN 99,861	NGN 212,976	NGN 85,651	NGN 0	NGN 0
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 3,948,571,013	NGN 118,057,878	NGN 8,566,602	NGN 60,836,916	NGN 25,494,622	NGN 47,360,634	NGN 79,205,956	NGN 31,853,639	NGN 16,666,667	NGN 197,824,205
20000000 - CAPITAL INVESTMENT	NGN 75,490,022,915	NGN 1,635,155,251	NGN 345,572,391	NGN 1,617,096,826	NGN 2,087,356,841	NGN 2,199,858,159	NGN 2,591,935,431	NGN 1,133,897,133	NGN 2,083,233,333	NGN 3,023,483,288

State	Delta	Ebonyi	Edo	Ekiti	Enugu	FCT	Gombe	Imo	Jigawa	Kaduna
Source for costing	MBB	MBB	MBB	State	MBB	State	MBB	State	MBB	MBB
Total cost	NGN 21,985,511,479	NGN 7,224,718,330	NGN 12,811,876,307	NGN 6,964,998,044	NGN 12,484,693,623	NGN 10,381,887,080	NGN 6,599,981,187	NGN 4,386,068,667	NGN 11,298,716,458	NGN 14,247,393,048
Population	4,112,445	2,176,947	3,233,366	2,398,957	3,267,837	1,406,239	2,365,040	3,927,563	4,361,002	6,113,503

State	Delta	Ebonyi	Edo	Ekiti	Enugu	FCT	Gombe	Imo	Jigawa	Kaduna
Total cost per capita per year	NGN 5,346	NGN 3,319	NGN 3,962	NGN 2,903	NGN 3,820	NGN 7,383	NGN 2,791	NGN 1,117	NGN 2,591	NGN 2,330
By priority area:	NGN 219,855,115	NGN 72,247,183	NGN 128,118,763	NGN 5,815,420	NGN 106,950,245	NGN 55,748,466	NGN 59,145,500	NGN 95,587,167	NGN 112,987,165	NGN 121,882,798
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 12,308,418,790	NGN 3,232,751,960	NGN 7,328,430,942	NGN 2,791,886,513	NGN 5,852,498,263	NGN 3,571,326,189	NGN 3,508,114,960	NGN 1,562,882,500	NGN 6,937,581,774	NGN 7,397,826,560
HEALTH SERVICE DELIVERY	NGN 7,465,072,761	NGN 1,926,827,683	NGN 4,501,001,311	NGN 1,984,351,413	NGN 4,397,213,559	NGN 6,114,954,907	NGN 2,070,875,485	NGN 1,946,015,667	NGN 3,435,020,002	NGN 4,846,980,271
HUMAN RESOURCES FOR HEALTH	NGN 782,961,681	NGN 1,595,531,996	NGN 149,672,094	NGN 2,137,410,460	NGN 1,618,313,540	NGN 235,982,372	NGN 658,134,784	NGN 218,695,833	NGN 191,698,112	NGN 1,301,221,427
FINANCING FOR HEALTH	NGN 329,782,672	NGN 108,370,775	NGN 192,178,145	NGN 12,384,299	NGN 151,164,945	NGN 170,686,285	NGN 86,171,634	NGN 34,488,833	NGN 169,480,747	NGN 172,105,258
NATIONAL HEALTH INFORMATION SYSTEM	NGN 219,855,115	NGN 72,247,183	NGN 128,118,763	NGN 5,964,246	NGN 83,769,861	NGN 15,710,169	NGN 52,770,894	NGN 33,122,500	NGN 112,987,165	NGN 95,051,503
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 219,855,115	NGN 72,247,183	NGN 128,118,763	NGN 5,417,159	NGN 96,389,059	NGN 20,712,021	NGN 56,241,174	NGN 271,283,333	NGN 112,987,165	NGN 109,658,224
PARTNERSHIPS FOR HEALTH	NGN 439,710,230	NGN 144,494,367	NGN 256,237,526	NGN 21,768,534	NGN 178,394,150	NGN 196,766,671	NGN 108,526,756	NGN 223,992,833	NGN 225,974,329	NGN 202,667,007
RESEARCH FOR HEALTH										
By National Chart of Accounts	NGN 9,795,699,975	NGN 1,863,492,196	NGN 3,012,334,668	NGN 1,376,387	NGN 3,414,300,641	NGN 4,325,732,932	NGN 1,286,479,896	NGN 1,409,616,667	NGN 2,742,971,308	NGN 4,606,326,577
1100010 - SALARY & WAGES - GENERAL	NGN 606,629,469	NGN 270,727,969	NGN 1,041,489,047	NGN 212,377,250	NGN 578,385,285	NGN 38,905,995	NGN 435,930,952	NGN 156,899,167	NGN 395,078,022	NGN 765,133,570
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 445,439,613	NGN 52,177,599	NGN 238,215,039	NGN 172,048	NGN 111,132,620	NGN 39,576,253	NGN 30,561,471	NGN 18,900,833	NGN 69,768,436	NGN 128,636,008
1300030 - SOCIAL CONTRIBUTION	NGN 71,956,752	NGN 42,862,024	NGN 1,380,353,624	NGN 22,747,900	NGN 41,657,256	NGN 9,756,333	NGN 41,266,542	NGN 10,150,000	NGN 171,918,336	NGN 43,975,330
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 19,392,081	NGN 3,965,517	NGN 5,125,884	NGN 3,955,083	NGN 7,349,561	NGN 23,577,600	NGN 1,996,654	NGN 25,149,167	NGN 37,168,787	NGN 6,330,370
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 407,365,929	NGN 170,730,383	NGN 44,434,775	NGN 4,053,167	NGN 247,938,561	NGN 4,881,000	NGN 100,058,800	NGN 43,758,333	NGN 185,857,279	NGN 301,396,143
2100200 - UTILITIES - GENERAL	NGN 4,363,500,112	NGN 1,840,993,603	NGN 3,066,074,730	NGN 1,070,392,842	NGN 2,384,492,734	NGN 2,387,297,929	NGN 1,926,238,458	NGN 407,385,833	NGN 3,389,661,989	NGN 3,198,234,949
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 1,367,531,858	NGN 330,782,767	NGN 919,745,266	NGN 3,026,000	NGN 766,658,238	NGN 407,000	NGN 304,828,509	NGN 125,375,833	NGN 760,968,447	NGN 966,411,837
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 638,536,384	NGN 214,863,222	NGN 425,704,743	NGN 226,480,667	NGN 277,651,347	NGN 116,577,585	NGN 175,610,816	NGN 153,133,000	NGN 506,657,086	NGN 495,816,469

State	Delta	Ebonyi	Edo	Ekiti	Enugu	FCT	Gombe	Imo	Jigawa	Kaduna
2250500 - TRAINING - GENERAL	NGN 9,579,011	NGN 1,122,060	NGN 178,787	NGN 6,363,000	NGN 2,389,865	NGN 430,000	NGN 657,213	NGN 24,333,333	NGN 1,500,344	NGN 2,766,269
2300600 - OTHER SERVICES - GENERAL	NGN 54,659,894	NGN 6,402,713	NGN 258,450	NGN 3,741,817	NGN 13,637,083	NGN 37,683,333	NGN 3,750,198	NGN 170,004,167	NGN 8,561,285	NGN 15,784,924
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 559,420,994	NGN 1,569,347,040	NGN 120,934,430	NGN 0	NGN 1,562,542,429	NGN 0	NGN 642,797,728	NGN 0	NGN 156,685,321	NGN 1,236,666,366
2400800 - FINANCIAL - GENERAL	NGN 6,208,541	NGN 684,730	NGN 386,398	NGN 3,630,667	NGN 1,458,400	NGN 2,248,000	NGN 401,060	NGN 9,889,167	NGN 341,320,762	NGN 1,688,098
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 1,431,938,142	NGN 428,311,088	NGN 1,373,696,318	NGN 25,202,217	NGN 628,965,005	NGN 61,447,519	NGN 353,623,347	NGN 410,789,834	NGN 80,664,173	NGN 695,722,138
2501000 - MISCELLANEOUS	NGN 242,170	NGN 28,367	NGN 0	NGN 33,333,333	NGN 60,419	NGN 2,000,000	NGN 16,615	NGN 0	NGN 37,931	NGN 69,935
3001100 - LOANS & ADVANCES - GENERAL	NGN 90,062,916	NGN 10,549,728	NGN 0	NGN 379,229,167	NGN 22,469,775	NGN 27,000,000	NGN 6,179,188	NGN 298,466,667	NGN 23,228,728	NGN 26,008,764
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 2,117,347,637	NGN 417,677,325	NGN 1,182,944,148	NGN 4,968,916,500	NGN 2,423,604,404	NGN 3,304,365,600	NGN 1,289,583,739	NGN 1,122,216,667	NGN 2,426,668,225	NGN 1,756,425,300

State	Kano	Katsina	Kebbi	Kogi	Kwara	Lagos	Nasarawa	Niger	Ogun	Ondo
Source for costing	MBB	MBB	MBB	MBB	MBB	MBB	MBB	MBB	MBB	MBB
Total cost	NGN 36,127,432,920	NGN 7,233,354,552	NGN 8,040,123,450	NGN 13,457,521,408	NGN 9,968,912,482	NGN 25,961,461,175	NGN 7,183,340,649	NGN 23,073,677,918	NGN 12,748,888,248	NGN 9,923,507,683
Population	9,401,288	5,801,584	3,256,541	3,314,043	2,365,353	9,113,605	1,869,377	3,954,772	3,751,140	3,460,877
Total cost per capita per year	NGN 3,843	NGN 1,247	NGN 2,469	NGN 4,061	NGN 4,215	NGN 2,849	NGN 3,843	NGN 5,834	NGN 3,399	NGN 2,867
By priority area:	NGN 361,274,329	NGN 72,333,546	NGN 71,816,303	NGN 134,575,214	NGN 79,949,710	NGN 259,614,612	NGN 71,833,406	NGN 230,736,779	NGN 108,660,176	NGN 99,235,077
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 20,113,059,617	NGN 4,688,764,505	NGN 3,940,141,070	NGN 8,257,026,830	NGN 5,707,298,619	NGN 12,400,187,406	NGN 5,947,167,584	NGN 11,390,640,459	NGN 6,476,812,049	NGN 4,762,033,169
HEALTH SERVICE DELIVERY	NGN 9,424,387,163	NGN 2,006,488,893	NGN 3,088,204,747	NGN 3,883,849,234	NGN 2,986,885,816	NGN 8,723,455,525	NGN 763,876,914	NGN 8,431,799,211	NGN 4,173,547,137	NGN 3,256,613,088
HUMAN RESOURCES FOR HEALTH	NGN 4,241,703,001	NGN 67,933,109	NGN 573,067,518	NGN 441,906,453	NGN 859,370,116	NGN 3,150,323,268	NGN 5,379,009	NGN 1,751,449,183	NGN 1,476,634,373	NGN 1,259,833,427
FINANCING FOR HEALTH	NGN 541,911,494	NGN 108,500,318	NGN 104,410,418	NGN 201,862,821	NGN 107,620,104	NGN 389,421,918	NGN 107,750,110	NGN 346,105,169	NGN 153,035,310	NGN 148,852,615
NATIONAL HEALTH INFORMATION SYSTEM	NGN 361,274,329	NGN 72,333,546	NGN 63,520,716	NGN 134,575,214	NGN 49,149,591	NGN 259,614,612	NGN 71,833,406	NGN 230,736,779	NGN 83,741,264	NGN 99,235,077

State	Kano	Katsina	Kebbi	Kogi	Kwara	Lagos	Nasarawa	Niger	Ogun	Ondo
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 361,274,329	NGN 72,333,546	NGN 68,036,761	NGN 134,575,214	NGN 65,916,905	NGN 259,614,612	NGN 71,833,406	NGN 230,736,779	NGN 97,306,901	NGN 99,235,077
PARTNERSHIPS FOR HEALTH	NGN 722,548,658	NGN 144,667,091	NGN 130,925,917	NGN 269,150,428	NGN 112,721,621	NGN 519,229,224	NGN 143,666,813	NGN 461,473,558	NGN 179,151,037	NGN 198,470,154
RESEARCH FOR HEALTH										
By National Chart of Accounts	NGN 5,413,945,879	NGN 1,023,300,592	NGN 1,993,159,164	NGN 5,006,648,454	NGN 3,347,841,791	NGN 8,304,640,239	NGN 3,874,235,758	NGN 5,629,715,115	NGN 3,843,614,598	NGN 4,423,927,519
1100010 - SALARY & WAGES - GENERAL	NGN 2,794,672,403	NGN 91,962,249	NGN 289,894,985	NGN 507,902,809	NGN 529,537,934	NGN 1,991,618,005	NGN 207,490,854	NGN 2,771,381,947	NGN 920,731,837	NGN 279,629,442
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 12,156,940	NGN 24,177,946	NGN 39,771,143	NGN 247,273,556	NGN 147,663,556	NGN 280,495,565	NGN 420,427,563	NGN 246,887,333	NGN 119,467,567	NGN 275,706,353
1300030 - SOCIAL CONTRIBUTION	NGN 138,962,178	NGN 70,512,069	NGN 21,153,562	NGN 122,765,766	NGN 51,529,300	NGN 55,786,699	NGN 50,040,953	NGN 68,350,926	NGN 47,928,162	NGN 21,758,500
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 20,257,428	NGN 3,873,339	NGN 2,945,432	NGN 14,799,515	NGN 19,451,373	NGN 9,787,606	NGN 67,328,813	NGN 688,491,372	NGN 6,353,389	NGN 7,936,036
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 336,356,400	NGN 152,298,060	NGN 122,556,084	NGN 294,844,387	NGN 263,451,229	NGN 440,217,876	NGN 32,506,637	NGN 351,021,666	NGN 317,228,983	NGN 240,894,855
2100200 - UTILITIES - GENERAL	NGN 13,420,704,192	NGN 2,451,491,888	NGN 1,716,035,334	NGN 2,906,676,163	NGN 2,187,020,011	NGN 6,455,236,547	NGN 1,604,899,186	NGN 5,413,746,636	NGN 2,743,759,087	NGN 1,545,561,847
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 1,224,978,459	NGN 668,617,353	NGN 490,372,050	NGN 1,077,045,472	NGN 664,461,753	NGN 1,413,157,189	NGN 172,959,721	NGN 1,120,778,854	NGN 765,978,195	NGN 808,143,360
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 684,543,393	NGN 480,128,813	NGN 358,732,843	NGN 433,428,859	NGN 277,627,338	NGN 634,695,025	NGN 140,103,005	NGN 487,664,041	NGN 316,778,507	NGN 332,243,773
2250500 - TRAINING - GENERAL	NGN 0	NGN 519,938	NGN 855,263	NGN 5,317,525	NGN 3,175,449	NGN 6,031,952	NGN 1,243,011	NGN 5,309,219	NGN 2,569,105	NGN 5,928,961
2300600 - OTHER SERVICES - GENERAL	NGN 53,894,274	NGN 2,966,876	NGN 4,880,317	NGN 30,342,937	NGN 18,119,794	NGN 34,419,610	NGN 4,413,583	NGN 30,295,544	NGN 14,659,865	NGN 33,831,926
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 4,224,255,722	NGN 55,799,580	NGN 553,108,654	NGN 317,813,986	NGN 785,266,216	NGN 3,009,558,572	NGN 0	NGN 1,627,550,539	NGN 1,416,680,428	NGN 346,255,513
2400800 - FINANCIAL - GENERAL	NGN 1,407,646	NGN 317,289	NGN 521,919	NGN 4,873,389	NGN 1,937,798	NGN 3,680,960	NGN 2,784,571	NGN 3,239,917	NGN 1,567,780	NGN 3,618,111
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 2,075,896,680	NGN 402,833,621	NGN 427,929,025	NGN 717,124,285	NGN 386,657,516	NGN 1,723,123,898	NGN 371,947,752	NGN 1,511,841,360	NGN 633,984,893	NGN 318,763,415

State	Kano	Katsina	Kebbi	Kogi	Kwara	Lagos	Nasarawa	Niger	Ogun	Ondo
2501000 - MISCELLANEOUS	NGN 0	NGN 13,145	NGN 21,622	NGN 134,434	NGN 80,279	NGN 152,495	NGN 10,859	NGN 134,224	NGN 64,950	NGN 149,892
3001100 - LOANS & ADVANCES - GENERAL	NGN 23,213,357	NGN 4,888,511	NGN 8,041,281	NGN 49,995,952	NGN 29,855,922	NGN 56,713,071	NGN 0	NGN 49,917,862	NGN 24,155,008	NGN 55,744,746
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 5,702,187,972	NGN 1,799,653,284	NGN 2,010,144,771	NGN 1,720,533,918	NGN 1,255,235,223	NGN 1,542,145,864	NGN 232,948,382	NGN 3,067,351,362	NGN 1,573,365,897	NGN 1,223,413,434

State	Osun	Oyo	Plateau	Rivers	Sokoto	Taraba	Yobe	Zamfara	Federal
Source for costing	MBB	MBB	MBB	State	State	State	MBB	MBB	MBB+ Current Budget + Federal Plan Matrix
Total cost	NGN 10,706,477,132	NGN 10,909,006,945	NGN 10,135,397,603	NGN 27,187,392,131	NGN 11,433,602,616	NGN 7,291,484,934	NGN 11,240,199,958	NGN 9,041,873,748	NGN 189,244,098,186
Population	3,416,959	5,580,894	3,206,531	5,198,716	3,702,676	2,294,800	2,321,339	3,278,873	3,278,873
Total cost per capita per year	NGN 3,133	NGN 1,955	NGN 3,161	NGN 5,230	NGN 3,088	NGN 3,177	NGN 4,842	NGN 2,758	NGN 0
By priority area:	NGN 107,064,771	NGN 109,090,069	NGN 101,353,976	NGN 102,706,250	NGN 53,030,500	NGN 42,454,038	NGN 112,402,000	NGN 80,049,361	NGN 307,932,000
LEADERSHIP AND GOVERNANCE FOR HEALTH	NGN 6,103,349,202	NGN 5,864,300,360	NGN 5,276,038,950	NGN 13,952,547,267	NGN 4,273,259,583	NGN 4,042,593,464	NGN 6,597,497,666	NGN 4,484,592,356	NGN 72,975,845,942
HEALTH SERVICE DELIVERY	NGN 2,964,225,097	NGN 4,235,667,829	NGN 3,302,845,389	NGN 11,745,984,448	NGN 6,204,355,667	NGN 2,196,646,190	NGN 3,573,047,719	NGN 3,527,466,467	NGN 114,838,517,244
HUMAN RESOURCES FOR HEALTH	NGN 942,981,819	NGN 99,953,304	NGN 897,712,420	NGN 1,073,819,167	NGN 86,358,083	NGN 513,309,123	NGN 339,041,575	NGN 546,551,185	NGN 247,310,667
FINANCING FOR HEALTH	NGN 160,597,157	NGN 163,635,104	NGN 152,030,964	NGN 123,794,167	NGN 558,393,867	NGN 205,087,311	NGN 168,602,999	NGN 115,702,983	NGN 259,153,333
NATIONAL HEALTH INFORMATION SYSTEM	NGN 107,064,771	NGN 109,090,069	NGN 101,353,976	NGN 6,527,500	NGN 130,056,083	NGN 103,369,057	NGN 112,402,000	NGN 69,107,873	NGN 158,386,417
COMMUNITY PARTICIPATION AND OWNERSHIP	NGN 107,064,771	NGN 109,090,069	NGN 101,353,976	NGN 50,083,333	NGN 65,547,000	NGN 82,658,413	NGN 112,402,000	NGN 75,064,323	NGN 109,219,333
PARTNERSHIPS FOR HEALTH	NGN 214,129,543	NGN 218,180,139	NGN 202,707,952	NGN 131,930,000	NGN 62,601,833	NGN 105,367,338	NGN 224,803,999	NGN 143,339,199	NGN 347,733,250
RESEARCH FOR HEALTH									
By National Chart of Accounts	NGN 2,683,525,745	NGN 4,863,265,850	NGN 3,057,481,180	NGN 7,351,570,250	NGN 5,094,542,592	NGN 2,040,983,919	NGN 3,976,762,355	NGN 2,392,144,914	NGN 114,567,421,911
1100010 - SALARY & WAGES - GENERAL	NGN 852,245,324	NGN 307,399,321	NGN 438,437,393	NGN 355,626,667	NGN 315,874,667	NGN 95,764,646	NGN 282,149,704	NGN 691,393,311	NGN 0

State	Osun	Oyo	Plateau	Rivers	Sokoto	Taraba	Yobe	Zamfara	Federal
1200020 - BENEFITS AND ALLOWANCES - GENERAL	NGN 106,234,021	NGN 303,086,632	NGN 106,234,021	NGN 918,946,281	NGN 636,817,824	NGN 27,359,515	NGN 189,951,665	NGN 52,456,257	NGN 3,500,000
1300030 - SOCIAL CONTRIBUTION	NGN 119,996,310	NGN 23,919,328	NGN 125,308,747	NGN 10,690,833	NGN 327,810,333	NGN 9,888,233	NGN 41,442,427	NGN 57,167,022	NGN 14,913,333
2050110 - TRAVELS & TRANSPORT - GENERAL	NGN 31,736,103	NGN 8,724,160	NGN 29,263,590	NGN 1,641,667	NGN 27,531,333	NGN 1,092,847	NGN 6,736,729	NGN 3,368,324	NGN 520,374,583
2060120 - TRAVELS & TRANSPORT (TRAINING) - GENERAL	NGN 149,646,688	NGN 264,818,019	NGN 198,790,590	NGN 3,566,667	NGN 1,440,000	NGN 12,381,250	NGN 232,792,918	NGN 136,900,006	NGN 2,213,333
2100200 - UTILITIES - GENERAL	NGN 2,869,017,314	NGN 1,699,050,926	NGN 1,980,897,012	NGN 9,038,576,667	NGN 1,807,922,700	NGN 1,366,658,225	NGN 2,816,173,394	NGN 2,134,672,948	NGN 12,561,002,347
2150300 - MATERIALS & SUPPLIES - GENERAL	NGN 626,381,353	NGN 888,399,728	NGN 762,231,756	NGN 119,325,000	NGN 201,443,333	NGN 37,647,500	NGN 753,590,569	NGN 437,713,307	NGN 44,000,000
2200400 - MAINTENANCE SERVICES - GENERAL	NGN 238,377,005	NGN 365,238,759	NGN 274,187,101	NGN 22,940,000	NGN 356,877,667	NGN 1,916,667	NGN 440,438,276	NGN 378,919,076	NGN 0
2250500 - TRAINING - GENERAL	NGN 2,284,523	NGN 6,517,764	NGN 2,284,523	NGN 1,000,000	NGN 0	NGN 2,182,833	NGN 4,084,839	NGN 1,128,052	NGN 39,333,333
2300600 - OTHER SERVICES - GENERAL	NGN 13,035,976	NGN 37,191,760	NGN 13,035,976	NGN 0	NGN 17,558,333	NGN 93,833,333	NGN 23,308,968	NGN 6,436,907	NGN 845,543,333
2350700 - CONSULTING AND PROFESSIONAL SERVICES - GENERAL	NGN 889,669,035	NGN 380,641,999	NGN 844,399,635	NGN 66,667	NGN 0	NGN 903,333,333	NGN 243,715,689	NGN 520,226,388	NGN 0
2400800 - FINANCIAL - GENERAL	NGN 3,073,088	NGN 3,977,424	NGN 2,969,691	NGN 101,833,333	NGN 33,310,250	NGN 6,626,008	NGN 2,492,747	NGN 688,387	NGN 0
2450900 - FUEL & LUBRICANTS - GENERAL	NGN 468,465,233	NGN 350,419,672	NGN 454,703,964	NGN 2,063,741,433	NGN 416,790,250	NGN 392,448,497	NGN 766,013,905	NGN 473,340,245	NGN 99,896,500
2501000 - MISCELLANEOUS	NGN 57,756	NGN 164,777	NGN 57,756	NGN 0	NGN 0	NGN 0	NGN 103,270	NGN 28,519	NGN 0
3001100 - LOANS & ADVANCES - GENERAL	NGN 29,692,506	NGN 61,280,733	NGN 28,631,174	NGN 2,000,033,333	NGN 0	NGN 8,333,333	NGN 38,406,106	NGN 10,606,069	NGN 90,000,000
4001200 - GRANTS & CONTRIBUTION - GENERAL	NGN 1,623,039,151	NGN 1,344,910,093	NGN 1,816,483,493	NGN 5,197,833,333	NGN 2,195,683,333	NGN 2,291,034,794	NGN 1,422,036,395	NGN 1,744,684,016	NGN 60,455,899,512

Annex 3:

Methodology & Process of Plan Development

This methodology and process for the development of the NSHDP is extracted from the report of the Technical Working Group that was constituted by the Honourable Minister of Health to develop a suitable methodology and framework for the development and implementation of an NSHDP for Nigeria.

Methodology

The process involved the development of NSHDP Framework by a 20 member Technical Working Group commissioned by the Honorable Minister of Health on February 24, 2009. The Technical Working Group (TWG) consists of representatives of FMoH, SMoH, National Planning Commission (NPC), Civil Society Organisations (CSOs) independent consultants and academics. The TWG is expected to serve as the Health Sector Development Team, required to shepherd the preparation of the NSHDP. The inauguration of the TWG was attended by all States' Commissioners for Health, Development Partners and other stakeholders in health sector. The Health Agenda of the FMoH and the proposed agenda for the development of the NSHDP were presented to the TWG and inputs were collected.

The next step in the development of the NSHDP was a ten-day retreat during which the first draft of the NSHDP Framework was developed. The steps involved were: review of the Health Sector Reform Programme (HSRP) documents, the draft 5th National Development Plan, the National Health Policy and other relevant policies and strategic plans and programmes, background reports of 11 study groups commissioned by the FMOH and desk reviews. From these, the overarching principles and strategic thrust/focus for NSHDP were identified and the zero draft of NSHDP was developed. This was finalized using inputs from multi-stakeholder consultations for the review, editing and finalization of NSHDP document.

The development of the NSHDP Framework was informed by extant national laws, policies, and international declarations. The major steps adopted for the development of the draft NSHDP Framework were as follows:

a. Identification and harmonization of priority areas of concern from the Health Agenda of the FMOH that gives its strategic thrusts, the 2008 Ouagadougou Declaration that gives the African regional direction for health development on the continent and the common ground, an outcome from the Nigeria's stakeholders conference titled 'Securing a better health future: transforming Nigeria's health care system', using the Future Search methodology – March 2008.

b. Definition of eight priority areas namely: leadership and governance, service delivery, health financing, human resources for health, health information system, community participation and ownership, partnerships for health development and research for health

c. Identification of priority, goals, strategic objectives, interventions and potential actions for each priority area, using these as the basis for the development of the NSHDP Framework.

The major thrusts of the thematic areas, which were identified as central to a functional and effective health system, are:

1. Leadership and Governance
2. Health Service Delivery
3. Human Resource for Health,
4. Financing for Health
5. Health information System
6. Community Participation and Ownership
7. Partnership for Health
8. Research for Health

1.2 Rationale for the development of the National Strategic Health Development Framework

In response to the issues highlighted above, the Federal government launched a Health Sector Reform Programme (HSRP), which was to be implemented from 2004 to 2007. The seven (7) strategic thrusts of the HSRP were: improving the stewardship role of Government; strengthening the national health system and its management; reducing the burden of disease; improving health resources and their management; improving access to quality health services, improving consumers' awareness and community involvement; and promoting effective partnership, collaboration and coordination.

It is noteworthy that the HSRP recorded some successes, particularly in the development of policy initiatives, such as the Revised National Health Policy, Framework for Achieving the Health-Related MDGs in Nigeria, National Health Bill, Revitalization of the National Council on Health, Report on "Repositioning of the Federal Ministry of Health", Formal launching of the National Health Insurance Scheme and several sub-sectoral policies, including on Public-Private Partnerships; Human Resources for Health; Health Financing; Maternal, Neonatal and Child Health; Adolescent Health; National Drug Policy; Health Promotion; NMSP (National Malaria Strategic Plan); Health Sector Response to HIV/AIDS and Development of the Integrated Maternal, Newborn and Child Health Strategy.

However, the large majority of the problems it was designed to address still persist. Specifically, some of these include the fact that while the HSRP was designed at the federal level, efforts to ensure that states and LGAs buy-in and develop their own HSRP was limited, thus the contributions of states, LGAs and development partners is minimal. Given the centrality of PHC to health development in Nigeria, the role and contributions of local governments to the revitalization of PHC were not defined in the HSRP document. The pernicious underfunding of all levels of the health sector, the scarcity of health professionals, the poor motivation of health workers, the very wide inequities in health resource distribution and health status across the country and the prevalent decaying health infrastructure, especially at the lower levels of the health care system were additional constraints to the success of the HSRP. Others include inadequate stewardship and leadership function of government, fragmentation of health services delivery, weak health information system and inadequate utilization of the private sector.

The Federal Government, in recognition of developmental challenges has adopted a 7-Point Development Agenda, inclusive of the health sector. Within this national development agenda, it is recognized that access to quality health care and prevention services are vital for poverty reduction and economic growth. This is of particular importance as Nigeria is lagging behind in attaining the health-related MDGs by 2015.

Therefore, in order to meet the challenges of achieving country health targets and the health-related Millennium Development Goals (MDGs), particularly for its poorest and most vulnerable population, the health system must be strengthened, proven cost-effective interventions must be scaled up and gains in health must be sustained and expanded. The

FMOH appreciates that this can best be done within the context of a costed National Strategic Health Development Plan, which is aimed at providing an overarching framework for sustained health development in the country. The National Strategic Health Development Plan (NSHDP) is thus a logical follow up to the HSRP, which ended in 2007 and is developed in line with extant national health policies and legislation, and international declarations and goals to which Nigeria is a signatory, namely MDGs, Ouagadougou Declaration and the Paris Declaration.

As a prelude to the development of the NSHDP, a generic Framework has been developed to serve as a guide for the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians. It is also expected, therefore, that in using the NSHDP Framework, the respective levels would respectively develop costed federal, states and local government plans. The harmonized costed National Strategic Health Development Plan will serve as the basis for collective ownership, adequate resource allocation, intersectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability for results within the national health systems and for all health actors: federal, states, LGAs, development partners and civil society organizations and the private sector. It would also stipulate the health investments requirements for sustainable universal access and coverage within the planned period.

1.1.5 Methodology of the NSHDP Framework

1. The process used in the development of the NSHDP is shown in diagram 1. The schematic diagrams reflect the stages for the development of the NSHDP and its framework and are described below:

1. The first step in the development of the NSHDP was the commissioning of 11 background studies on key areas of the health sector so as to provide a critical assessment and analysis of key national issues in these domains, namely Review of HSRP, Governance for Health, Burden of Disease, Social determinants of health, Partnerships for Health Development, Macroeconomics and health financing, Human resource for Health, Health Information and M&E Systems, Health infrastructure and commodities, and Research for Health.

2. A 20 member Technical Working Group was commissioned by the Honorable Minister of Health to support the development of the NSHDP Framework and Plan. Invited to the meeting to inaugurate the TWG, were all the States' Commissioners for Health and Development Partners who were presented with the Health Agenda of the FMOH and the proposed agenda for the development of the NSHDP, to which they made inputs.

3. Using the background documents, other national and international documents and declarations the draft NSHDP Framework was developed. The following process was adopted in the development of the first draft of the NSHDP Framework:

    a. Identification and harmonization of priority areas of concern from the Health Agenda of the FMOH that gives its strategic thrusts, the 2008 Ouagadougou Declaration that gives the African regional direction for health development on the continent and the common ground, an outcome from the Nigeria's stakeholders conference titled 'Securing a better health future: transforming Nigeria's health care system', using the Future Search methodology, that held March 2008.

    b. Eight priority areas were identified through this process, namely: leadership and governance, service delivery, health financing, human resources for health, health information

system, community participation and ownership, partnerships for health development and research for health

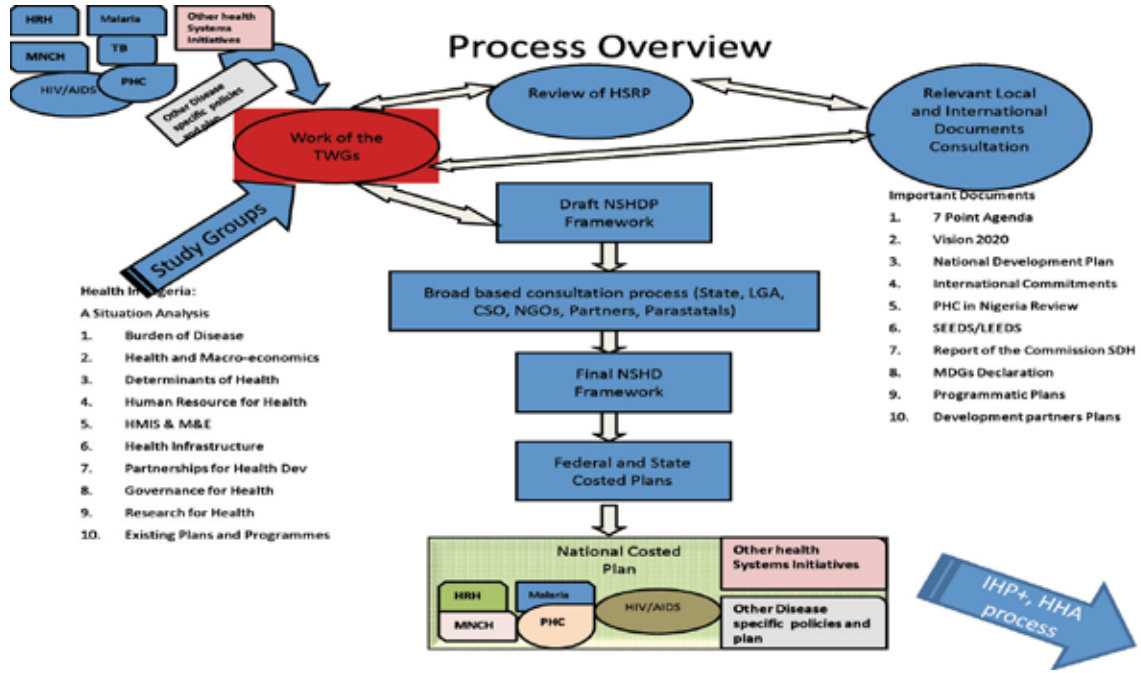
c. Identification of priority areas goals, strategic objectives, interventions and potential actions, and using these as the basis for the development of the NSHDP Framework.

4. Finalization of the NSHDP Framework from wide-stakeholder consultations involving key actors at Federal, State and LGAs;

5. Using the NSHDP Framework as a reference guide for the development of costed Federal, State and LGA health Plans; and

6. Collation of the Federal, States' and LGA health plans into the costed NSHDP.

Diagram 1: NSHDP development process



Terms of Reference and Deliverables

1. Develop a zero draft framework for the NSHDP by reviewing relevant policy documents/studies including the reports of the various background studies on the situation analysis of health in Nigeria
2. Process the Zero draft framework through the incorporation of the inputs from various consultations with all stakeholders at Federal, State and Local government levels and produce the framework for the development of the NSHDP.
3. Ensure the harmonization and integration of all existing plans into the NSHDP for the accelerated achievement of Mr. Presidents' seven point agenda and international goals and commitments
4. Ensure that the NSHDP is fully compliant with the principles of Paris Declaration on Aids Effectives, the Accra Agenda for Action, Ouagadougou declaration and the IHP+.
5. Provide Technical Assistance for the preparation of a Federal SHDP and assist States and LGAs in the development of their Strategic (Costed) Health Development Plans and consolidate all into one National Strategic Health Development Plan (NSHDP) document in collaboration with relevant stakeholders/partners.

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Participants at National Stakeholders Meeting

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