2018 Operational Plan

Saving One Million Lives Programme for Results (SOML PforR)

Benue State Ministry of Health

The "Saving One Million Lives Programme for Results" (SOML-PforR) is a major Nigerian health initiative, backed by the World Bank, focused on drastically improving Maternal, Newborn, and Child Health (MNCH) through results-based financing, targeting six key pillars (immunization, nutrition, malaria, HIV prevention, essential medicines, MNCH services) and technology/supply chain improvements. This operational plan is a consolidation of the planned activities (and costs) across these intervention pillars and the various key players responsible for implementing them in the year 2018.

Benue State Profile:

Socio-economic context

Benue State is located between longitude 7°20' N and Latitude $8^{0}45'$ E and with land mass of 34,059km^2 (13,150sq mi). It is in the North-Central region of Nigeria. The State is bounded by Taraba state to the North-East, Cross River State and Republic of Cameroun to the East, Enugu and Ebonyi States to the South, Kogi to the West, and Nasarawa state to the North.

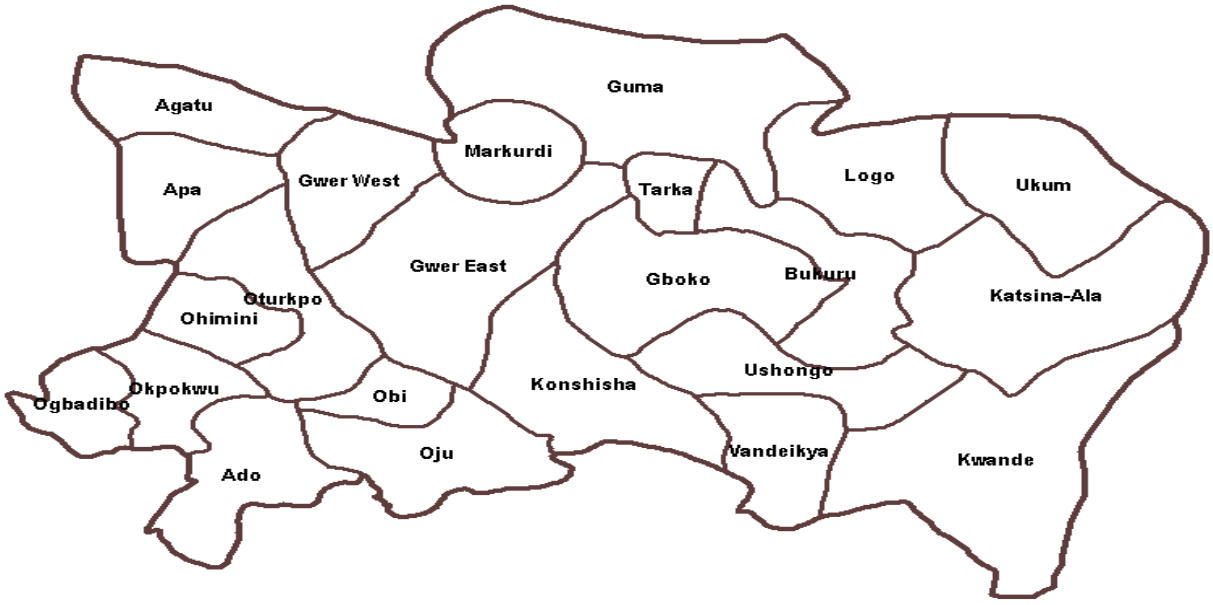

Figure 1: Map of Benue State

Ethnicity/Occupation: There are two main ethnic groups: Tiv and Idoma. Other ethnic groups are Igede, Etulo and Jukun. The State is in the rich plain of the Benue Valley with a rich fertile land for agricultural purposes. About 70% of the people are involved in agricultural production hence the state is aptly called the 'Food Basket' of the nation. Other occupations are fishing,

petty trading and civil service jobs. However, incessant conflict between herdsmen/ farmers is affecting farming activities across the State.

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

Governance: Democratic government has been in place in Benue State, uninterrupted since 1999. The State has 23 Local Government Areas through which it administered the State. The structure of machinery of the government in Benue state has been based on geo-political considerations. However, it is hoped that the current and future governments would rather consider efficiency and service delivery for improved governance and administration.

Budget: The standard requirement from the Abuja Declaration provided 15% of total State's budget for Health. In Benue state, this policy has fallen short in implementation. In 2016, only 8.7% of the state budget was provided for the health sector, previous years have been worse than 2016. In the same vein, release of budgetary provision for health has been very low (The percentage release to the SMoH was 25.45% inclusive of the SPHCB), thereby affecting implementation of health interventions and leading to poor health outcomes. All budgets across the health sector, the SMoH, and BSPHCB, are published in the Annual Benue State Budget Estimates according to Benue State Health Bulletin and Budget office (BSPC). However, a consolidated budget execution report has not been published to show total expenditures on primary health care in the State

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

Nutrition: Though described as the 'food basket' of the nation, 17% of children in Benue State are moderately underweight, 7% are moderately wasted while 26% are moderately stunted.

Proportion of households consuming adequately iodized salt is 73%. This calls for essential service packages for the prevention and management of childhood malnutrition.

Housing: Existing settlement patterns in some parts of the State hinder development of basic infrastructure. Access to affordable housing in the State is limited because Public-Private Partnership for housing development is not well developed in the State.

Water and Sanitation: Rural water supply is inadequate or nonexistent in most parts of the State. Use of boreholes is not wide spread. Only 47.7% of the population has access to improved safe drinking water supply while 25.5% have proper sanitary means of excreta disposal (UNICEF, 2014). Open defecation is a widespread practice in the State. Investments in safe drinking water and the hygienic disposal of human waste can have a major impact on the prevention of a wide variety of deadly infections.

Education: From 2005 to 2017, over 300,000 children were estimated to be out of school. Only 22% of under five children are attending organized childhood educational institutions. Net primary school completion rate is 81% in Benue State. There is poor funding, inadequate infrastructure, limited manpower and human resource base and politicization of education. There is no computer education in Public primary schools. However, there are 2,407 public primary schools. For tertiary education there are 3 Universities, 2 Colleges of Education, 1 College of Agriculture, 1 Polytechnic and 1 College of Advanced and Professional Studies. The hallmark of tertiary education in the state is poor infrastructure and high levels of social vices.

Table 1: Demographic Indices

Indicators Name	Yearly Projected Value					
	2016	**2017**	**2018**	**2019**	**2020**	**2021**
Projected population 2016-2021 based on 3% growth rate [Note: 2006 Cenus population count = 4,219,244]	5,670,311	5,840,420	6,093,575	6,196,101	6,381,984	6,573,443
Number of LGAs	23	23	23	23	23	23
Children under 1 year projections	226,812	233,617	238,680	243,743	248,806	253,869
Children under 5 years projections	1,134,062	1,168,084	1,193,399	1,218,715	1,244,030	1,269,346
Women of childbearing age (15-44yrs) projections	1,247,468	1,284,892	1,312,739	1,340,586	1,368,433	1,396,280
Expected deliveries projections	283,516	292,021	298,350	304,679	311,008	317,336
Expected life Births projections [Note: Fertility Rate = 5.7%]	255,164	262,819	268,515	274,211	279,907	285,603

Source: NPC, 2016

Health Service Provision and Utilization

The National Health Policy broadly mandates Federal Government with the responsibility for tertiary health care, State Government with secondary health care and Local Government with primary health care. However, in carrying out their responsibilities, each tier of government is involved in the other levels of health care other than the one allocated to it, thereby creating overlaps and ambiguity. This situation has been recognized as a major obstacle in health care delivery as there is considerable overlap of service provision and under-servicing in support and supervision.

The Health Sector which encompass all other providers, formal and informal, as well as the users themselves, has slowly evolved through the years. The public health sector provides various health services through a wide range of health facilities from a health post, health clinics, health centres, general hospitals, the Federal Medical Center and Teaching Hospital which are located in the State capital. In addition**,** Private health facilities are band in the State ranging from PHC clinics to hospitals offering range of health care services. Health care services are also provided by faith based organizations such as Catholics, NKST and Methodist churches and private for profit individuals.

Health care in the State is provided by the Federal, State, and Local Governments, Faith Based Organizations (FBOs), formal private providers, informal private providers and traditional healers. Formal private providers include hospitals, private doctors, nurse-delivered services (including birthing), pharmacists and other support services. Informal ones refer mainly to the traditional practitioners and itinerant drug sellers.

The Health Sector has slowly evolved through the years. The public health sector provides various health services through a wide range of health facilities from health posts, health clinics, health centres, general hospitals, the Federal Medical Center and Teaching Hospital which are located in the State capital. In addition**,** Private health facilities are band in the State, ranging from PHC clinics to hospitals offering range of health care services. Health care services are also provided by faith based organisations such as Catholic, NKST and Methodist churches and private-for-profit individuals. There is a weak coordination mechanism for the activities of health service providers in the State.

There is one Federal Medical Centre (Makurdi) and Benue State University Teaching Hospital, offering tertiary health care; as well as Twenty-three (23) functioning General Hospitals and one Family support Clinic (FSP Clinic, Makurdi) offering secondary care. These General Hospitals

are under Hospitals Management Board (HMB). Each of the General Hospitals is being supervised by Hospital Management Committee. The Family support Clinic (FSP Clinic, Makurdi), is a facility under the State Ministry of Health which offers maternal and child health services. They provide in-patient care services alongside out-patient services and are semi-autonomous in the sense that they generate their own funds and use it to run the health facility without direct subvention from the State Government.

Private Sector: Private health services have expanded throughout the State but remain too expensive for most people, especially the poor, to access. Also, many of these services are not properly regulated. A large majority of the population therefore receives little modern health care and has to rely on self-treatment, traditional healers or drug sellers to handle treatment of their ailments. This has contributed to high rates of death and illness in the State, particularly for the most vulnerable groups - mothers, infants and children.

The State Ministry of Health has statutory responsibility of formulating health policies and coordinating all stakeholders in relevant sectors in the State. It has four parastatals namely: Hospital Management Board (HMB), Benue State Agency for the Control of AIDS (BENSACA), Benue State University Teaching Hospital (BSUTH) and Benue State Primary Health Care Board (BSPHCB).

In line with the global development agenda, strategic investments in health infrastructure, key service delivery supports and social protection will be required. The State government is committed to reducing the burden of disease that is contributing to the poor national health indices.

Table 2 shows some key health indicators including doctors/nurses to patient ratio, life expectancy at birth, maternal and infant mortality rates, HIV prevalence, etc. between 2016 and 2018.

Table 2: Benue State Key Health Indicators (2016 and 2017)

Indicators Name	Value	2016	2017
Doctors to Patients ratio	351	1:12222	1:16639
Nurses to Patients ratio	2,281	1:2022	1:2561
Infant mortality rate (IMR)	74/1000	63.05	74/1000
Maternal mortality rate (MMR)	800/100,000	35.1	576/100,000
Child Mortality rate (CMR <5)	117/1000	14.2%	117/1000
Life Expectancy at birth	51yrs	53yrs	54yrs
Deliveries by trained health workers	93%		
Fertility rate	5.70%	5.5%	5.5%
Birth weights 2.500kg or above	75%	91.4%	91.4%
ANC attendance in Public facilities	55882	148,417	148,417
No of deliveries attended by health professionals	9004	19,612	19,612
Public HF based deliveries	9637	32,857	32,857
No of malaria cases in under 5	21913	66,523	66,523
HIV prevalence	10.60%	15.4%	15.4%

Source: SMOH/NDHS 2015

Table 3: Key Health Human Resources

Profession	Number
Doctors	325
Pharmacist	103
Nurse	2281
nurse Midwife	701
Midwife	30
EHO	143
CHEW	1656
JCHEW	929
Lab Staff	230
Health Attendants	1647
Pharm Tech	53

CHO	87
Medical laboratory scientists	24
Health Planning Research and Statistics	9
Health Records	63
Radiographer	9
OPTOMETRIST	4
INFORMATION AND COMMUNICATION TECHNOLOGY UNIT	3
HISTOPATHOLOGY	9
CHEM-PATH	10
HAEMATOLOGY	9
MICRO-BIOLOGY	9
PUBLIC RELATIONS	2
DENTISTRY	4
SURGERY (Plaster Technician)	1
SOCIAL WELFARE	5
STORES	23
WORKS AND MAINTENANCE	19
LEGAL UNIT	2
TRANSPORT	18
RADIOLOGY (Radiographers)	9
PHYSIOTHERAPY	5
PSYCHIATRY	1

Source: DPRS, SMoH - 2016

Situation Analysis

1. **Immunization (Penta3 for 0-11 months children)**

Immunization programmes provide opportunities to promote integrated services and improve the overall health of recipients. Penta vaccine is an antigen used for the prevention of diphtheria, whooping cough, Tetanus, Heamophilus Influenza and Hepatitis. Penta vaccine is being administered in 1,008 health facilities offering Routine Immunisation across the state.

Penta vaccine is given as intramuscular (IM) at 4 weeks' interval at 6weeks, 10weeks and 14 weeks. It is administered as 0.5 ml doses, intramuscularly on the left upper anterolateral (outer) thigh in infants. Penta vaccine should be stored at a temperature between +2C and +8 C and should not be frozen. In Benue state from 2015-2016 the IVA/DLI results shows PENTA 3

immunization coverage was 57.4% and 57% respectively - a negative drop rate of 0.4%. The reasons for low vaccination coverage of Penta 3 include: inadequate knowledge of mothers/caregivers, lack of time by mothers, lack of awareness, poor card retention and mistrust of health workers.

2. **Nutrition (Vitamin A for age 6-59 months children) + MNCHW Participation**

Malnutrition has continued to be a big problem, affecting both women and under five children in the state and there is need for continuous nutritional interventions to reduce it to the barest minimum. Maternal, Newborn and Child Health (MNCH) week is conducted biannually in the 23 LGAs, 277 wards using 831 health facilities in the State, supported by SOML, UNICEF and other NGOs, giving Vitamin A coverage of 43.4% (MICS 2016).

From growth monitoring surveys (SMART 2015), prevalence for Acute Malnutrition in under 5 years was 0.5% and underweight 7.7%; exclusively breast fed children - 20.3% while stunting was observed in 28.8% and wasting in 6.7% of the under 5 children (MICS 2016/2017).

Micronutrients powder supplementation was introduced in 2013 in the state on a pilot scale using only 5 LGAs (Agatu, Guma, Logo, Gwer West and Makurdi), for population under 2 years.

School feeding program for primary 1 to 3 pupils in public schools in the state is ongoing, supported by the Federal Government of Nigeria while the state is yet to support the program for primary 4 to 6 pupils. The programme has covered 1,465 schools out of 1,755 schools, giving coverage of 83.5%.

Infant and young child feeding (IYCF) support groups in the various LGAs of the state have remained dormant since the USAID/SPRING project closure from the state in 2016.

3. **Skilled Birth Attendance**

The projected number of women of child bearing age is about 1,284,892; while under-5 children are 2,780,041.

It is an established fact that the morbidity and mortality rate of women and children will reduce significantly if they can access health care services from skilled health care providers such as Midwives, Doctors, auxiliary nurses, CHEWs, etc. According to the MICS 2015 - 2016 survey, 271 women age 15-49 years with a live birth in the last two years were attended to by health care provider during the pregnancy for the last birth, out of which 29.1% (about 2.6% higher

than the national average of 26.5%) were medical doctors, 36.3% - nurse/midwives (about 1.4% higher than the country's average); 2.1% - auxiliary midwives; and 1.2% - Community Health workers. About 31.4% of pregnant women did not access antenatal care services, this percentage of women do not deliver with Skilled Birth Attendants.

It is important to note that in 2016, the Maternal, Perinatal Death Surveillance Response (MPDSR) intervention was introduced in an attempt to further reduced maternal death. In 2017 UNFPA sponsored the training of stake holders in nine (9) general hospitals in the three (3) senatorial zones of the state to report and review the causes of maternal death at both facility and state levels.

MICS 2015-2016, SBA for Benue was 82% in 2015 and 62.8% in 2016 – a drop of 19.2 %. Reasons for the negative difference in the SBA include: Continuous mass retirement of health care workers especially midwives and CHEWs in the state and non-replacement of same; Poor attitude of health care workers; and Preference of pregnant women delivering with TBAs for economic reasons.

In 2017, 49 CHEWs were trained on Modified Life Saving Skills (MLSS) in an attempt to build the capacity of SBA (Sponsored by SOML).

4. Family Planning/ CPR

Family planning program in Benue State is implemented multi-sectoral, through a partnership between the State Government, private facilities, agencies and organizations. The family planning implementation cut across the 23 LGAs in 332 (23%) health facilities out of the 1,408. The 332 FP sites and facilities include Primary Health Care Centres, Secondary Health Care Centres and Tertiary Health Care, the maternal mortality rate (MMR) is 800/100,000 lives birth and FP Current Prevalence Rate (CPR) is 17.8 % (BSMoH 2017).

The State depends on review and resupply meetings to get FP commodities to the Service Delivery Points (SDPs). There is collaboration with the State Logistic Management Coordination Unit (LMCU) on data management with support from UNFPA. The Costed Implementation Plan (CIP) for family planning has been developed, signed and submitted to the Federal Ministry of health for implementation. In 2016, 120 out of 500 service providers in the State received some level of a step-down training on Long-Active Reversible Contraceptive (LARC) methods and

IUCDs. This was supported by society for Family Health (SFH), CIHP. We have an Unmet need for Family Planning 31.4% in Benue State.

5. Malaria Prevention

Malaria is one of the major public health problems in the State in spite of diverse strategies put in place to address the problem. The impact of the disease is felt more among the vulnerable groups, especially pregnant women and children u-5. The State government and partners have continued to implement preventive strategies in the state. Current situation indicates that 95.3% of households have at least 1 LLINs for 2 persons, 43% of pregnant women received LLINs during ANC visits and community distribution.5% of Children U5 attending clinic in public health facilities received LLINs, 18% of pregnant women received at least two doses of SP for IPT during ANC visits.

A SMART survey carried out in 2015 - 2016 shows a great improvement in net hanging from 34.1% in 2015 to 73.7% in 2016 (NBS).

6. PMTCT

Benue State has a high burden of HIV Prevalence of 15.4% (ANC, 2014 technical report FMOH). As at 2017, the estimated population of Pregnant Women in Benue was 292,021 (5% of 5,840,420 general population projection). Also, estimated population of HIV+ Pregnant Women is 44,971 (15.4% of the 292,021 pregnant women).

There are a total of 1,408 HCFs in the state, of which 460 offer PMTCT services (32.7%) in 2016 but 660 (46.9%) presently offer PMTCT services (2018). PMTCT coverage is 40%. Antenatal coverage is 40% (first visit only). Total fertility rate is about 5.9. Delivery by unskilled birth attendants is 49.3 % (DHIS, 2017). Willingness to do HIV test among pregnant women is about 100%. There is still the problem of Hard-to-reach areas and destruction of some HCFs due to herders-farmers clash.

Percentage of HIV positive mothers that received ART to prevent EMTCT = 30% (2015). Percentage of infants born to HIV positive women who receive ARV prophylaxis = 8% (PMTCT score card 2015) and less than 10% in 2017.

A total of 54.1% of pregnant women were tested in Benue during the 2015 MNCH week, of which 1,663 were positive out of 113,444(1.5% positivity rate) while in 2016, a total of 50% of

pregnant women were tested during the MNCH week, of the 41,198 pregnant women tested, 565 (1.4% positivity rate) were positive. In 2017, 92,770 pregnant women were tested of which 168 were positive (0.9% positivity rate).

7. Monitoring and Evaluation

Benue state has a total of 1,408 health facilities, out of which 1,367 (97%) are registered on the DHIS 2.0 platform**.** However, only 54.8% (749) of these facilities are reporting on DHIS 2.0 platform. Out of the 749 facilities reporting, 70.9% (531) are reporting timely. Currently, the Standardized NHMIS tools are in short supply in the State.

The quality of data produced in the State does not meet the standard for decision making; also Health information to relevant stakeholders in the State is inadequate.

Harmonization between National M&E framework and programmes is poor. Coordination between public and private health sector in data submission in the state is still poor. Currently, there is an inadequate number of trained data handlers at PHCs level in the State.

The NHMIS tools in use do not have data elements/indicators for some programmes and interventions. (ISS) and need to be revised, printed and distributed to at all health facilities.

8. Family Planning

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level of a step-down training on Long-Active Reversible Contraceptive (LARC) methods and (IUCD's). This was supported by society for Family Health (SFH), CIHP. We have an Unmet need for Family Planning 31.4% in Benue State.

Bottle-Neck Analysis of SOML Interventions/ Indicators

Interventions	Determinants	Baseline Indicators	Baseline coverage	Bottleneck	Possible causes	Proposed solutions
IMMUNIZAT	Coverage	% of fully immunize under 1 year	37% fully immunized	1. Non-Implementation of PUSH PLUS system of vaccine distribution 2. Inadequate implementation of Immunization Supply Chain (ISC) 3. Inadequate supply of Child Health Cards at HFs offering RI 4. Inadequate trained Health Workers /poor motivation. 5. Charges for RI services in disguise of vaccine collection from LGA 6. Lack of adequate Supportive supervision (Only Partner staff conduct RISS) 7. Hard to reach settlements	1. Inadequate social mobilization on the importance of RI. 2.Lack of trust of Health Workers 3.Insufficient knowledge of mothers and caregivers 4. Long distances to health facilities 5. Poor Cards retention	1. High powered advocacy needed from NPHCDA to Benue political leadership. 2. Adequate supply of Immunization Cards. 3. Increase scope of RISS (State and LGA teams to be supported for monthly RISS) 4. Monthly Outreach RI services in all HFs offering RI 5. RI Jingles in major Languages (Tiv, Idoma, Igede and English) to be aired quarterly in 277 wards. 6. Re-activate State Taskforce on Immunization. 7. To increase stakeholders participation in Immunization programmes. 8. Support for vaccines collection from state and LGAs by service providers

I				8. Poor funding of RI (Low political will) especially Our Reach services		
O		% of penta3 coverage	Coverage survey, PENTA3 57%	1. High powered advocacy needed from NPHCDA to Benue political leadership. 2. Adequate supply of Immunization Cards. 3. Increase scope of RISS (State and LGA teams to be supported for monthly RISS 4.Monthly Outreach RI services in all HFs offering RI to be sponsored by partners. 5.RI Jingles in major Languages (Tiv, Idoma, Igede and English) 7. State Government to increase stakeholders participation in Immunization programmed. 8.Support vaccines collection from state and LGAs by service providers	1.Inadequate social mobilization 2.Lack of trust of Health Workers 3.Insufficient knowledge of mothers and caregivers 4. Long distances to health facilities 5. Poor Card retention	1. Continued advocacy by BSPHCB in conjunction with NPHCDA to Benue political leadership. 2. Adequate supply of Immunization Cards for mothers and caregivers. 3. Increase scope of RISS (State and LGA teams to be supported for monthly RISS) 4. Monthly Outreach RI services in all HFs offering RI 5. Continued social mobilization in the 277 wards 6. RI Jingles in major Languages (Tiv, Idoma, Igede and English) to be aired quarterly in 277 wards. 6. Re-activate State Taskforce on Immunization. 7. To increase stakeholders participation in Immunization programmed. 8. Support for vaccines collection from state and LGAs by service providers
N	Availabilit y of cold chain facilities	% of LGAs with functional cold chain facilities	53% of wards are equipped with functional cold chain facilities.	In adequate supply of cold chain equipment in health facilities in the 23 LGAs. Inadequate training of cold chain officers on Plan Preventive Maintenance (PPM)	Non procurement and supply of the cold chain equipment for a long period of time by government. 2. Lack of proper maintenance. E.g. SDDs, freezers	Procure and distribute SDDs to following LGAs with electricity issues: Ogbadibo, konshisha, Guma, 2. Procurement of 35 freezers/ 10 SDDs for the vaccine storage. 3. Training of 23 LGAs cold chain officers on PPM

Interventions	Determinants	Baseline Indicators	Baseline coverage	Bottleneck	Possible causes	Proposed solutions
NUTRITION	Accessi-bility	% of wards with no stock out of Vit A in the last 6 months	Unknown	Routine services are not offered or supported in the health facilities	Avoidance of Vit A poisoning due to nonuse of immunization cards during campaigns.	Introduction of Vit A card use during campaigns, proper surveys and documentation for routine Vit A supplementation.
	Availability of human resources	% of health/nutrition promoters trained on the use of Vit. A at ward level	49.3%	Lack of funds to train and retrain health personnel and volunteer counselors	Inadequate training of health personnel, volunteer counselors.	State ownership of the program, support from partners, training of health personnel/volunteer counselors

	Accessibility to health centers	% of villages with access to at least health nutrition promoter trained on the use of Vit A supplements	59.1%	Poor awareness creation and bad terrain,	Inadequate mobilization factors such as staff, equipments (mega phones) and media use. SBC materials, etc. Poor/inaccessible road networks to health centers.	Provision and timely release of funds and adequate materials for social mobilization, use of the media (Tv, Radio etc) for awareness creation and sensitization, use of pluses to encourage caregivers to put in more effort to access services at the health centers.
	Initial Utilization	% of caregivers that routinely offer Vit A at 6 months of birth	Unknown	Lack of statistical data	No nutrition surveys conducted by the state, no tools for data collection and analysis.	Provision of statistical tools, conduct nutrition survey using smart tools and analyzing the results
	Timely continuous utilization	% of MNCH week conducted in the last 2 years	75%	Poor state ownership	Inadequate support from the state.	State should take ownership in order for the program to be sustained, continuous support from partners and well-meaning individuals is necessary.

	Effective Quality	% Percentage of children aged 6-59 months who received at least one high dose vitamin A supplement within the last 6 months	43.4%	Unwillingness of care givers to turn out for Vit A supplementation occurring in the health facilities	Ignorance of benefits of Vit A to the child, long distance to health facilities and low morale of care givers to leave comfort of their homes.	Continued support from partners and the state government, appropriate sensitization of care givers, provision of pluses for uptake at health facilities.

Interventions	Determinants	Baseline indicators	Baseline coverage	Bottleneck/Constraint	Possible causes	Proposed solution
SKILLED BIRTH	Accessibility	% health centers with delivery supplies fetoscope BP app. and artery forceps in stock	55%	Inadequate medical equipment/supply Lack of maintenance of medical equipment	Non ICT compliant staff Government policy/bureaucracy Insufficient funding	Adequate budgetary provision and appropriate use
	Availability of human resources	% of PHC with skilled midwives	40%	Inadequate skilled manpower	Mass retirements of SBAs Embargo on employment	State government to recruit more SBAs Training and re training of staff on LSS/MLSS, etc.

ATTENDANCE	Accessibility of health centres	% families living within 10 km from a health facility offering delivery services daily	50%	Lack of functional PHCs in each ward Lack of infrastructure (poor working conditions, bad roads etc.) Bad terrain/HTRA to PHC facilities	Government policies Political will/ corruption Mass retirement of HCW without replacement	People oriented government policies Improvement in infrastructure Recruitment of HCW Creation of outreach centers for more effective distribution to HTRAs
	Initial Utilization	% deliveries assisted by a qualified health professional (midwife/nurse/ physician)	62.8%	High charges for ANC and delivery Poor attitude of care-givers Misconception to hospital delivery	Government policy Inadequate training of HCWs Ignorance/cultural beliefs	-Free/minimal charges for ANC and delivery Training and re-training of HCWs on change of attitude Improve awareness to safe delivery practices in health centers
	Timely continuous utilization	% deliveries assisted by qualified health professional (midwife/nurse/ physician) PNC and weighed at birth	60%	Poor communication and attitude of health workers at first visit Non availability of essential drugs Lack of community ownership	Inadequate training on communication skills	Training and re-training of care-givers on good comm. Skills an attitude Advocacy to community leader for involvement, participation and ownership
	Effective Quality	% deliveries assisted by qualified health professional (midwife/nurse/ physician) with life-saving skills	62.8%	Inadequate human manpower Inadequate medical supplies/equipment	Mass retirement of HCWs Inadequate budgetary provision	Recruitment of SBA Adequate funding

Interventions	Bottleneck determinants	Indicators	Baseline coverage	Bottleneck	Possible causes	Proposed operational strategies/ Control
FAMILY PLANNING	Availability essential commodities	%of service delivery points without stock out of modern FP commodities in the last 6 months (332 FP facilities)	95%	Some LGAs Focal Persons did not show up for review /resupply meeting	Staff attrition	Employment and replacement of Staff
	Availability human resources	% service delivery points with at least 1 staff trained on FP services (332 FP facilities)	45%	Lack of trained Staff/ Lack of budget line for FP	Inadequate funding	State/LG Government to Fund FP activities
	Accessibility	% of villages within 5 km of a functional service delivery points providing FP services (332 FP facilities)	45%	Long distance from the facilities	Inadequate facilities within the communities/hard to reach	Functional service delivery point for FP should be made available across the communities
	Initial Utilization	% of eligible users who have ever used any FP method (266,342)	18%	Myths and misconception	Low acceptability of FP commodities/ Shortage of Manpower	Awareness creation on Use of FP commodities/ Regular supply and availability of commodities in all the facilities
	Timely continuous utilization	% of eligible users currently using any FP method consistently for a	18%	Lack of transport to move commodities from State to LGAs	Inadequate funding	State/LG Government to Fund FP activities

		period of 2 years. (266,342)				
	Effective Quality	% of eligible users correctly using any modern FP (44,707)	15%	Myths and misconception	Stock out of FP commodities, Shortage of Manpower	Regular supply and availability of commodities in all the facilities/ Increase in awareness

Tracer Interventions	Bottleneck determinants	Coverage Indicators	Baseline coverage	Bottleneck identification	Possible causes	Proposed operational strategies/ Control
MALARIA(LLIN AT	Availability essential commodities	% of LLINs + insecticide in all LGAs in relation to need (692 out of 888 public health facilities have LLINs)	78% of public health facilities have LLINs.	Inadequate funding by the state Government	Inability of the State Government to take ownership in providing LLINs to the remaining health facilities.	State Government should make effort to release allocated funds for purchase of LLINs in the budget.
	Accessibility	Availability of JCHEWS/ CHEWS/CORPs in relation to need	CORPs in only 4 LGAs	Inadequate staffing in terms of skill mix and number	Retirement and death along with embargo on employment.	Strengthen task shifting strategy, scale up CORPs to all hard to reach areas in Benue State.
	Initial Utilization	% households with at least one mosquito net (treated or untreated)	95.3% of households have at least 1 LLINs	Insecurity in some parts of the State and hard to reach areas.	Farmers/ herders' crisis. Communal crisis.	Government should deploy armed personnel to affected areas and engage community volunteers to bridge the gap.

COMMUNITY&FAMILYLEVELS)			for 2 persons.			
	Timely continuous utilization	% children under 5 in HH using mosquito nets last night	73.7% hanging rate (SMART Survey)NBS	Inadequate information on the use and benefit of LLINs.	Myths and misconception on the use of LLINs.	Scale up ACSM activities on malaria in all the communities.(compound meetings, town hall meetings)
	Effective Quality	% pregnant women using insecticide treated nets	43% of pregnant women received LLINs during ANC visits and community distribution.	High cost of ANC, low ANC attendance by pregnant	Poverty, ignorance,	Free ANC attendance should be advocated to policy makers, scale up awareness in all the communities through sustained compound meetings, radio jingles, and continue advocacies to gate keepers.

Interventions	Bottleneck determinants	Indicators	Baseline coverage	Bottleneck	Possible causes	Proposed operational strategies/ Control
HIV TESTING & COUNSELING SERVICE	Availability essential commodities	% HC with sufficient stocks of HIV tests, nevirapine, cotrimoxazole. and ARVs (660/1408)	46.9% with sufficient stocks of HIV tests, nevirapine, cotrimoxazole and ARVs	53.1% not being supported by government as expected	Government not taking ownership of HIV/AIDS response as expected	Government to make budgetary allocation and releases for provision of essential commodities
	Availability human resources	Availability of registered nurse/midwives in relation to need	625 registered nurses out of 1,776 needed	Insufficient HCWs	Embargo on employment Lack prioritization by the government	Task shifting and training and re-training of HCWs
	Accessibility	% HCs offering regular PMTCT plus services (660/1408)	46.9% offering regular PMTCT plus services	53.1% not being supported by government as required	Lack of ownership and sustainability of HIV response	Government to take full ownership and sustained response

S D U R I N G A N C (E - P M T C T)	Initial Utilization	% pregnant women receiving counseling, being tested and when positive receiving nevirapine (3,266 received NVP).	100% due to the test and treat approach	NIL	NIL	Continuous sustainability
	Timely continuous utilization	% infants from HIV + mothers receiving cotrimoxazole prophylaxis	96.5% (3,152 infants from HIV +ve mothers received cotrimoxazole out of 3,266)	Poor knowledge of the importance of HCT among women of reproductive age; Low number of pregnant women having male partners testing in ANC due to male partners shyness and preference to be tested in conventional HCT sites	Poor awareness creation on HCT in the community ; No enlightenment program to educate pregnant women male partners on the importance of testing in ANC	Male involvement in PMTCT program. Mentor mothers to create awareness on benefits of PMTCT. Training of HCWs to provide PMTCT
	Effective Quality	% mothers and infants with AIDS receiving ARVs	40%	Awareness gap	Lack of awareness on benefits and community participation in PMTCT	Create awareness on PMTCT

2018 Activity Framework

CODE	THEMATIC AREAS
1.0	Immunization (Penta3 for 0-11 months children)
2.0	Nutrition (Vitamin A for age 6-59 months children) + MNCHW Participation
3.0	Skilled Birth Attendance
4.0	Family Planning / CPR
5.0	Malaria (LLIN utilization for under-5 children)
6.0	Pregnant Mother to Child Transmission of HIV (PMTCT)
7.0	Monitoring and Evaluation
8.0	Cross-cutting Activities (System Strengthening, Procurements and Programme Management activities)

Thematic Area 1.0: Immunization
Objective 1.1: To ensure children aged 0-11 months are fully immunized with Penta 3 in 2018.
Indicator: Proportion of children aged 0 –11 months who received the third dose of Penta 3 vaccine before the survey.
Baseline: Coverage is 57%
Target: 70% by 2018

Activity Code	Broad Activities	Sub-activities	Inputs	Activity Cost	Timeframe				Responsible person	Monitoring Indicators
					Q1	Q2	Q3	Q4		
1.1.1.1	Training on Plan, Preventive Maintenance(PPM)	A 2 day residential State level training for 23 LGA Cold chain officers on PPM(30 participants)	Hall PAS Projector Stationery	See Budget	x				SCCO/SIO	No of persons trained Attendance of participants

			Workshop Materials Accommodation Tea break Lunch 3 Facilitators Transport for participants Facilitators fees/DSA/ Transport DSA for participants							
b1.1.1.2	Mentoring and supervision of routine immunization	Conduct a 2 day mentoring and supervision for R.I in the 23 LGAs in Benue State for 2018	Supervisory checklist, Transport DSA for state level officer Snacks for LGA team	See Budget	x	x	x	x	ES SPHCB	No of LGAs to be monitored and supervised
1.1.1.3	Advocacy and sensitization meeting with church leaders to enhance performance coverage of immunization	To conduct a 2 day non-residential state level meetingfor 60 NUT officers on the importance of routine immunization(75 participants)	Hall Hire PAS Projector Workshop materials Stationery Tea break Lunch	See Budget	x				SIO/SCCO	Reports/ Pictures/

			3 Facilitators Facilitation fee/DSA/Transport Transport for 17 state team and 60 NUT officers							
1.1.1.4	Orientation for RI focal persons on private health facilities offering routine immunization	To conduct 2 dayZonal orientation meeting on routine immunization for 340 private health facilities offering R.I(680 participants.3 batches of zone A,B and C).(685 participants)	Hall Hire PAS Stationery Projector Workshop materials, Transport for LGA participants DSA/ transport for state team) Lunch Tea break	See Budget		x			ES SPHCB	No of private health facilities oriented on R.I reports
1.1.1.5	Quarterly meetings with traditional rulers on immunization	Conduct a one day state levelquarterly meeting with 69 traditional leaders on routine immunization (80 participants)	Hall Hire PAS Projector Transport for participants, Tea break Lunch Workshop materials Stationery	See Budget	x	x	x	x	ES SPHCB	Reports/Pictures

			Transport for state level							
1.1.1.6	To enhance availability of vaccine antigens	1008 HF supplied with vaccines using Last mile Strategy	Transport Drivers Conveyors Store officers SCCO/ASCCO	See Budget	x	x	x	x	SCCO/SIO	No of facilities that have bee Weekly Navision Dashboard/ ledgers
1.1.1.7	To sensitize the populates about the importance of routine immunization	Develop and air jingles on immunization in English and the 3 major languages of Tiv, Idoma and Igede	Media producers Translators Air @ 2 slots per week x Radio programme managers	See Budget	x	x	x	x	ES SPHCB/GM Radio Benue	Reports /Records
1.1.1.8	To enhance coverage of R.I through community mobilization	To hold a day sensitization meeting in 277 community immunization focal persons(CIFPs) to support coordinate and mobilize caregivers and mothers for increase immunization uptake by communities	Transport DSA Task force on immunization members, LIOs Traditional Leaders, Posters, Leaflets, Banners		x	x	x	x	SMO	No of community focal persons sensitized.
1.1.1.9	To conduct 4 rounds of National Immunization Plus Days(NIPDs)	To supervise NIPDs activities in 23 LGAs	Supervisory checklist Transport DSA	See Budget	x	x	x	X	ES SPHCB	Reports/ pictures

Thematic Area 2: Nutrition

Objectives :

- To ensure that 65% of children aged 6-59 months receive at least one high dose vitamin A supplement in 2018
- To ensure that 75% of households are reached with MNCHW services in 2018

Indicator:

- Proportion of children aged 6-59 months who received at least one high-dose vitamin A supplement within the last 6 months.
- Proportion of households reached with MNCHW services in the last 6 months.

Baseline:

- 43.4% of children aged 6-59 months who received at least one high dose vitamin A supplement within 6 months
- 59.1% of households reached with MNCHW services in the last 6 months.

Target

- 65% of children aged 6-59 months receive at least one high dose vitamin A supplement in 2018
- 75% of households reached with MNCHW services in 2018

Activity Code	Broad Activities	Sub-activities	Inputs	Activity Cost	Timeframe				Person Responsible	Monitoring Indicators
					Q1	Q2	Q3	Q4		
6.1.1.1	7-days capacity building of 854 health personnel from the wards at Zonal levels on Vitamin A supplementation and other nutritional needs for under -5.	1-day non-residential preparatory planning meeting with 23 NFPs from the 23 LGAs, 3 facilitators, 10 state nutrition team members and 2 IPs (38 persons).	Transportation Hall Refreshment Communication	See Budget	X				SNO	No of persons present at the meeting
6.1.1.2		Conduct a 7-days non-residential capacity building for 854 (3 persons per ward, 23 NFP from the 23 LGA) health personnel, residential for 6 nutrition	Honorarium Hall DSA Transportation Workshop materials Stationeries	See Budget		X			SNO	No of people trained/ report

		team and 3 facilitators (total persons 861) at LGA levels.	Tea break Lunch Car hire Communication							
6.1.1.3		Conduct non-residential quarterly review meetings with 23 NFPs from the 23 LGA and 17 other stakeholders (total of 40 persons) on Nutrition activities and Vitamin A supplementation for under-5s.	Hall Transportation Tea break Lunch Communication	See Budget	X	X	X	x	BFI	No of persons present/report.
6.2.1.1	Biannual Maternal Newborn and Child Health Week (MNCHW)	Conduct 3 preparatory planning meetings for MNCHW twice in the year (40 persons).	Refreshment Stationeries Communication Hall	See Budget		X		X	SNO	No of persons present/minutes
6.2.1.2		Train LGA MNCHW focal persons to develop work plans, ensure adequate support to health facilities for implementing vitamin A supplementation, deworming, iron folate supplementation (2-days state, LGA and ward level training for focal persons, health workers and town announcers to support effective planning and supervision of campaign). Total number of persons 5170 (184 LGA team,277 ward supervisors, 4155 health	Hall Transportation Workshop materials Stationeries Tea break Lunch Communication Honorarium DSA	See Budget		X		X	DPHC/SNO	No of persons trained/report

		workers, 554 Town announcers)								
6.3.1.1		Conduct community sensitization in the 23 LGAs on the uptake of Vit A, MUAC, GMP, Deworming and Iron folate via rallies (2 per LGA), flag off, jingles in 4 languages, community dialogues, advocacy visits, radio talk shows.	Banners Transportation Refreshment Airing (jingles and talk shows) Jingle production Car hire (flag off)	See Budget		X		X	SHE/SNO	Minutes/reports
6.3.1.2		Orientation of 23 monitors and 23 supervisors (46 persons)	Refreshment	See Budget		X		X	SNO	No of persons oriented
6.3.1.3		Conduct 5 days bi-annual maternal new born and child health week (MNCHW) in May and November rounds involving 23 supervisors, 23 monitors, 161 LGA team, 23 state technical facilitators (STF), 4155 health workers, 554 town announcers and 10 coordinators	DSA Transportation Drugs Data tools MUAC Tapes Scissors Hand towels Polythene	See Budget		X		X	SNO	Reports/check lists/attendance
6.3.1.4		Post review meetings of MNCHW activities involving 69 LGA team, 23 STFs and 30 state team (totaling 122 persons)	Transportation Tea break Lunch Hall	See Budget		X		X	SNO	No of persons present

Thematic Area 4: Family Planning
Objective: Ensure that 38% women of child bearing age (14-49 years) use modern contraceptive across the 23 LGAs
Indicator: Proportion of women age 15-49 years currently married or in union who are using (or whose partner is using) a modern contraceptive method.

Baseline: 18% CPR

Target: 38% women of child bearing age (14-49 years) use modern contraceptive across the 23 LGAs in 2018.

Activity Code	Broad Activities	Sub-activities	Inputs	Activity Cost	Timeframe				Responsible person	Monitoring Indicators
					Q1	Q2	Q3	Q4		
4.1.1.1	Capacity building of 300 Nurses/Midwives CHEWS on LARC to Implement task sharing among health workers to increase family planning accessibility in rural and underserved population so as to scale up service delivery.	1. Planning meeting with Facilitators	Refreshment	See Budget		x	x		FP Coordinator	Number of planning meetings held
		2. Five (5 Days) Zonal (Residential) training for 34 Nurses/Midwives per Zone [100 total] (2 facilitators and 1 secretarial staff per zone x 3 TOTAL = 118 persons	2. Hall Breakfast/Tea break Lunch DSA Workshop materials	See Budget		x	x		FP Coordinator	No of Nurses /midwives trained

			Job Aid Transport Stationeries Banners Honorarium for facilitators							
4.1.1.2		Planning meeting of FP Coordinator and Facilitators	Refreshment	See Budget						
		1. Five (5) Days training of 40 CHEWS per CLUSTER) training for 40 CHEWS per Cluster [200 total] (2 facilitators and 1 secretarial staff per zone x 5 clusters; TOTAL = 218 persons	1. Hall Breakfast/Tea break Lunch DSA Workshop materials Job Aid Transport Stationeries Banners Honorarium for facilitators	See Budget	x		x		FP Coordinator	No of CHEWS trained
4.1.1.3	Ensure additional / functional SDPs in every community in the 23 LGAs	1 Conduct outreaches to,. activate 112 more FP service delivery points. Total number of persons 2 per facility.	Human resource Modern FP commodities. stipends	See Budget	x	x	x	x	FP Coordinator	No of functional SDPs added
		2. Purchase and supply of FP consumable to 332 supported Health Facilities in the State	Transport, DSA, Lunch	See Budget		x	X		FP Coordinator	No of facilities supplies with consumables

		3. Quarterly Last mile distribution of FP commodities to the Health Facilities	Transport. DSA, Lunch,	See Budget	x	x	x	x	FP Coordinator	No of Facilities supplied with commodities
4.1.1.4	Create awareness and sensitization in the State on FP services	1. Conduct Community dialogue and information sharing with men and women in 277 wards 3 xs per ward. (3 pers X 277 community)	Letters for notification Transport Refreshment Job Aid facilitators Refreshment for 2,500 participants	See Budget	x	x	x	x	FP Coordinator	No of meetings held/persons reached
		3. Production of Billboards in 4 native languages to create awareness on importance Modern contraceptive	Production or Billboards	See Budget			x	X	FP Coordinator	No of Billboards produced
		4. production and airing of 3 native media messages on Radio to support FP awareness	Production of Jingle Airing of jingle	See Budget		x	x	x	FP Coordinator	No of jingle produced and aired
		5. Quarterly live in Radio programs to support FP	Transport to 3 participants Payment for	See Budget	x	x	x	x	FP Coordinator	No of Radio programs held
		6. Production of 10,000 copies of FP I.E.C materials		See Budget	x	x	x	x	FP Coordinator	No. of I.E.C Materials produced
4.1.1.5	Quarterly supervision to monitor and evaluate FP implementation of modern contraceptives in the State.	Conduct quarterly supportive supervision involving five teams of two people covering 90 facilities per quarter. 10 persons x 5 days	DSA Transport Printing of checklist	See Budget	x	x	x	x	FP Coordinator	Number of supervision made

4.1.1.6	Advocacy visit to Opinion leaders to support and create budget line for family planning in the State	Advocacy visit to the CoH, CoF, Director of Budget, House committee on Health, Special Adviser BLG&CA and to create budget line for family planning	Transport/stipend	See Budget		x	x		FP Coordinator	No of advocacy made
		Conduct one day meeting with development partners to provide financial and technical support to strengthen family planning services. Total of 5 persons	Tea break, Stationeries,	See Budget		x	x	x	FP Coordinator	No of meeting conducted

Thematic Area 2: Malaria Interventions

Objective: To ensure that 80% of children under 5 years sleep inside a net in 2018.
Indicator: proportion of children under 5 years who slept inside a mosquito net the previous night.
Baseline 73.7% of children under 5 years sleep inside a mosquito net the previous night (NBS, 2016).
Target: 80% of children under 5 years sleep inside a mosquito net.

Activity Code	Broad Activities	Sub-activities	Inputs	Activity Cost	Timeframe				Person Responsible	Monitoring Indicators
					Q1	Q2	Q3	Q4		

2.1.1.1	Conduct continuous distribution of LLINs in health facilities, community.	Printing of 1,000,000 net slips	Funds for printing of nets slips	See Budget		x			Case mgt Officer	Number of net slips produced and supplied
2.1.1.2		Distribution of net slips to health facilities.	Trucks for transportation	Ref to cross cutting		x			SMEP Mgr	number of nets slips distributed
2.1.1.3		Monthly monitoring of distribution of LLINs from health facilities and communities by 5 SMEP Members	Car Hire Feeding Photocopying of monitoring tools	11,940,240	x	x	x	x	SMEP Mgr	Report of monthly monitoring
2.2.1.1	Training on MIP at State Level	1 day Planning meeting for 9 persons(3 persons per cluster)	Hall Tea Break Lunch Projector Stationeries	159,500	x				Case Mgt Officer	Minutes of meeting
2.2.1.2		Conduct 3 days residential training on MIP for 384 HCWs in unsupported health facilities in 6 clusters.	Hall 2Tea Break Lunch DSA for 3 facilitators per cluster DSA for 384 participants Honorarium for facilitators PAS Projector Stationeries , facilitators 3 secretariat staff Workshop materials	40,900,000	x				Case Mgt Officer	Number of HWs trained on MIP

			Certificates							
	Training of 554 volunteers on net hanging at LGA level	1 day planning meeting with 25 ACSM members	Lunch Stationary Hall PAS	200,000	x				ACSM Officer	Minutes of meeting
2.3.1.1	.	Conduct 2 day training of 554 volunteers on net hanging (i.e. 2 per ward in the 23 LGAs.	Hall Tea lunch Transport Stationeries PAS Projector Workshop -materials DSA for ACSM 23 members	22,402,000	x				ACSM OFFICER	Number of volunteers trained
2.3.1.2	Air Radio jingles as well as support community intervention activities.	Quarterly airing of 3 jingles on Radio Benue in 3 languages on LLINs use.	Cost of airing of jingles.	1,350,000	x	x	x	X	ACSM Officer	Number of jingles aired
2.3.1.3		1 day monthly planning meeting for 25 ACSM members.	Hall Tea break Lunch Stationeries Projector PAS	3,090,000	x	x	x	X	ACSM Officer	Minutes of meeting
		Conduct 23community dialogues and 23 compound meetings monthly.(46 wards per month)	Refreshment for 80 participants. Transport and feeding for 23 SMOs.	22,421,520	x	x	x	x	ACSM Officer	Number of community dialogues conducted

			Transport and feeding for 23 ACSM members. Communication for 46 persons. Photocopying of attendance sheet Communication for SMEP ACSM officer.							
		Quarterly coordination meeting of 50 ACSM members.	Tea break for 50 persons. Lunch for 50 persons. Transport for 23 SMOs. Transport for 23 ACSM members. Photocopying of attendance sheet and minutes. Communication for SMEP ACSM officer.	1568,000	x	x	x	x	ACSM Officer	Minutes of meetings
		Conduct monthly coordination meeting of 23 MFPs and 10 members of SMEP	Hall PAS Projector Tea break Lunch Transport for 23 MFPs Transport for 10 SMEP members	4,529,760	x	x	x	x	SMEP Mgr	Minutes of number of meetings held.

			Communication for SMS Photocopying of minutes							
	Training of HCWs in unsupported public health facilities on malaria case mgt.	1 day planning meeting for 9 persons.	Hall Tea break Lunch Stationeries Projector	183,500		x	x	X	Case mgt Officer	Minutes of meeting
		Conduct 3 days residential training of 384 HCWs in public health facilities on malaria case mgt in 3 tranches.	Hall 2 Tea Break Lunch DSA for 3 facilitators DSA for participants Honorarium for facilitators PAS Projector Stationeries Workshop materials Certificates	43,991,000		x	x	x	Case mgt Officer	Number of HWs trained on malaria case mgt
TOTAL	5	13		157,735,520						

Thematic Area 5: PMTCT

OBJECTIVE: To ensure 100% of women 15-49 years have a live birth in the next 1 year and receive antenatal care during their pregnancy of the most recent birth, report that they are offered and accept an HIV test during antenatal care and receive their results

INDICATOR: Proportion of women 15-49 years who had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they were offered and accepted an HIV test during antenatal care and received their results

BASELINE: number of women who did HIV tests during ANC/total number of women who attended ANC =98.5% of women 15-49 years had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they were offered and accepted an HIV test during antenatal care and received their results

TARGET: 100% of women 15-49years have a live birth in the next 1 year and receive ante natal care during their pregnancy of the most recent birth, report that they are offered and accept HIV test during Antenatal care and receive their results.

Activity	Broad Activities	Sub-activities	Inputs	Activity Cost	Timeframe				Person Responsible	Monitoring
					Q1	Q2	Q3	Q4		

Code										Indicators
5.1.1.1	Training and re-training of 184 HCWs on PMTCT PLUS SERVICES to cover the shortfall of registered nurses/midwives across the state to provide PMTCT PLUS services	Planning meeting for training	None (Desk work)	See Budget		X	X	X	SASCP Coordinator	Number of Planning meetings held
		Reprinting of 200 copies of PMTCT trainee manual	Printing of manuals	See Budget	X				SASCP Coordinator/P	Number of PMTCT

									M SOML	trainee manual
		Conduct a 5 day residential training and re-training of 184 HCWs (JCHEWs and CHEWs) – 4 batches of 46 per batch on PMTCT PLUS SERVICES to cover the shortfall of registered nurses/midwives across the state to provide PMTCT PLUS services [2 facilitators; 1 secretariat per batch]	Accommodation Hall Facilitators fee/transport Refreshments DSA for participants Transport for participants Lunch Tea break Training materials/ Stationeries PAS	See Budget		X	X	X	SASCP Coordinator	Number of HCWs trainers

			Banners							
5.1. 1.2	Air radio jingles to create awareness on ANC and PMTCT	Quarterly airing of 3 jingles on Radio Benue in 3 Languages on importance of ANC and PMTCT	Cost of developing the Jingles Cost of translation of the Jingles in 3 languages Cost of airing jingles on ANC and PMTCT	See Budget	X	X	X	X	SASCP Coordinator	Number of Jingles aired
		Bi-annual Airing of Phone-in Program on demand creation for PMTCT	Cost of Phone-in program	See Budget		X		X	SASCP Coordinator	Number of Phone-in programs done

5.1.1.3	Training of 46 Focal PMTCT Personnel on ‘’Differentiated Care Model’’ to providing ART/PMTCT services	Planning meeting for step down training	None (Desk work)	See Budget		X			SASCP Coordinator	Planning meeting held
		Printing of 50 copies PMTCT trainee’s manual	Printing of 50 manuals	See Budget	X				SASCP Coordinator	Number of PMTCT trainee manual
		Conduct a 2-day residential Step Down Training for 46 Focal PMTCT Personnel on ‘’Differentiated	Accommodation Hall Facilitators fee/transport	See Budget		X			SASCP Coordinator	Number of persons trained

		Care Model'' to providing ART/PMTCT services	Refreshments DSA for participants Transport for participants Lunch Tea break Training materials/Stationaries PAS Banners							
5.1.1.4	Conduct PMTCT/PREVENTION/ART quarterly TWG meeting	Conduct PMTCT/PREVENTION/ART quarterly TWG meeting for 25 participants	Hall Lunch Transport Communication/recharge card	See Budget	x	x	x	x	SASCP Coordinator	Report of the activity

	for 25 participants		Stationeries							
5.1.1.5	HTS Outreaches in 23 LGAs of the State during MNCH week	Micro-planning meeting for the outreach	Hall Lunch Transport for participants Communication	See Budget		x		x	SASCP Coordinator	Micro-planning meeting held
5.3.1.6		Conduct 2 rounds of HTS Outreaches in 23 LGAs of the State during MNCH week	DSA (for supervisors transport for supervisors Transport for counselor-testers	See Budget		x		x	SASCP Coordinator	Number / rounds of outreaches held

Thematic Area 7: Monitoring and Evaluation

Objectives: **1.** To ensure collection of quality health data and its utilization
2. Ensure quarterly conduct of ISS visits to at least 644 health facilities by December, 2018.

Targets: **1. E**nsure collection and dissemination of quality health data to stakeholders by December, 2018.
2. Ensure quarterly conduct of ISS visits to at least 644 health facilities by December, 2018.

Activity Code	Broad Activities	Sub-activities	Inputs	Activity Cost	Timeframe				Person Responsible	Monitoring Indicators
					Q1	Q2	Q3	Q4		
Specific Objective 7:1: **To ensure collection of quality health data and its utilization**										
7.1.1.1	Conduct of monthly coordination meeting of M & E officers	Conduct one day nonresidential monthly M&E coordination meetings for 40 persons to review data submission and data quality.	Venue (small) Transport allowance Tea break Lunch Communication	**6,780,000**	x	x	x	x	HMIS officer	Number of Meetings held.
7.1.1.2	Conduct of quarterly DQA in health facilities.	Conduct 5 day quarterly DQA in 224 health facilities involving 15 persons (Including 2 report writing days = 6 days total)	DSA Transport allowance Intra LGA transport (during field work) Tea Break (during team report writing) Lunch (during team report writing) Local transport (during team report writing)	**8,880,000**	x	x	x	x	HMIS officer	Number of DQA reports from facilities visited.

7.1.1.3	Conduct of quarterly HDCC meeting.	Conduct quarterly 2 day nonresidential meeting for 30 persons	Hall, Lunch, Tea break	1,250,000	x	x	x	x	HMIS officer	Number of meetings held
7.1.1.4	Publication of 2016 & 2017 annual statistical health bulletin	Conduct of 4 day residential meeting of 30 technical persons to review data for publication.	Hall DSA for consultant and participants Tea Break Lunch Transport Allowance Transport (outside Benue) for consultant National Consultant fee	4,344,000		x			HMIS officer	Meeting held
		Publication of 300 copies of annual statistical bulletin	Printing cost	780,000		x			HMIS officer	Copies of annual statistical bulletin Produced.
7.1.1.5	Conduct of health data summit	Conduct of 3 day residential meeting on Health Data Summit for 150 participants.	Communication Hall Tea Break Lunch DSA Transport (participants, facilitators and consultant) facilitator fee stationery	16,659,500	x				HMIS officer	Health data Summit report

			Consultant fee workshop materials Banner (Flex)							
7.1.1.6	Training of Data handlers at health facilities on data tools in Benue State	Conduct of 4 day nonresidential training of data handlers involving 450 persons (8 batches)	Hall Tea break Lunch facilitators fee (state) Facilitator fee (co-facilitators) Transport (State facilitators) Transport (LGA officers and co-facilitators) DSA for state facilitators Stationery workshop materials	15,012,000		x	x		HMIS officer	Number of data handlers trained
7.1.1.7	Conduct of Quality Assurance training for health data handlers	Conduct of 4 day residential training for 40 persons on Data Quality Assurance.	Hall DSA for participants, support staff and facilitators Tea Break Lunch stationery facilitators fee (state) Transport (facilitators,	6,401,000		x			HMIS officer	Number of persons Trained on DQA

			participants and support Staff) workshop materials							
7.1.1.8	Conduct of training on DHIS2 for programme Officers (25).	Conduct 5 day nonresidential training on DHIS.2 for State programme officers (25) with two (2) consultants	Hall training materials Consultants (national) Transport for Consultants Tea break lunch Transport DSA PAS	3,829,000			x		HMIS officer	Number of Programme Officers trained
Specific Objective 7.2	**To Ensure quarterly conduct of ISS visits to at least 644 health facilities by December, 2018.**									
7.2.1.1	Conduct of quarterly Integrated Supportive Supervision to 644 health facilities.	Conduct of 5 day ISS involving 69 (3 persons per team) LGA staff and 46 (2 persons per team) state officers.	DSA - State team Intra LGA transport (during field work) for State and LGA team Transport (State to LGA) - for State team LGA Team's allowance	35,512,000	x	x	x	x	HMIS officer/DPRS	ISS report from facilities visited.
7.2.1.2	Conduct of quarterly ISS report writing.	Conduct of 2 day nonresidential meeting for report writing for LGA team involving 3	Hall lunch Tea break Transport	6,888,000	x	x	x	x	HMIS officer	Number of ISS report.

		consultants and 46 persons.	Consultants (State)							
		Conduct of 2 day nonresidential meeting for report writing for State team involving 3 consultants and 46 persons.	Hall lunch Tea break Transport Consultants (State)	4,072,000	x	x	x	x	HMIS officer	Number of ISS report.

1. **PMTCT**

INDICATOR – Proportion of women 15-49 years who had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they were offered and accepted an HIV test during antenatal care and received their results

BASELINE – 98.5%% of women 15-49 years had a live birth in the last 2 years and received antenatal care during the pregnancy of their most recent birth, reporting that they were offered and accepted an HIV test during antenatal care and received their results

OBJECTIVE –To ensure 100% of women 15-49 years have a live birth in the next 1 year and receive antenatal care during their pregnancy of the most recent birth, report that they are offered and accept an HIV test during antenatal care and receive their results

TARGET – 100% of women 15-49years have a live birth in the next 1 year and receive ante natal care during their pregnancy of the most recent birth, report that they are offered and accept HIV test during Antenatal care and receive their results.

2. MALARIA

INDICATOR – proportion of children under 5years who slept inside a mosquito net the previous night.

BASELINE – 73.7% of children under 5years who slept inside a mosquito net the previous night (NBS, 2016)

OBJECTIVE – To ensure that 80% of children under 5years sleep inside a mosquito net in 2018

TARGET - 80% of children under 5years sleep inside a mosquito net.

3. **NUTRITION**

Indicator:

- Proportion of children aged 6-59 months who received at least one high-dose vitamin A supplement within the last 6 months.
- Proportion of households reached with MNCHW services in the last 6 months.

Baseline:

- 43.4% of children aged 6-59 months who received at least one high dose vitamin A supplement within 6 months
- 59.1% of households reached with MNCHW services in the last 6 months.

Target

- 65% of children aged 6-59 months receive at least one high dose vitamin A supplement in 2018
- 75% of households reached with MNCHW services in 2018

Objectives:

- To ensure that 65% of children aged 6-59 months receive at least one high dose vitamin A supplement in 2018
- To ensure that 75% of households are reached with MNCHW services in 2018

4. SBA

Indicator- Proportion of women age 15-49 years with a live birth in the last 2 years who were attended to by skilled health personnel (Doctor/Nurse/ midwife/Auxiliary midwife) during their most recent live birth

Baseline: 50.8% of women ages 15-49 years with a live birth in the last 2 years who were attended to by skilled health personnel (Doctor/Nurse/ midwife/Auxiliary midwife) during their most recent live birth (Source: DHIS 2017)

Objective: To ensure that 70% of women ages 15-49 years with a live birth in 2018 are attended to by skilled health personnel (Doctor/Nurse/ midwife/Auxiliary midwife)

Target: 70% of women ages 15-49 years with a live birth in 2018 are attended to by skilled health personnel (Doctor/Nurse/ midwife/Auxiliary midwife)

5. MONITORING AND EVALUATION

Objectives

1. To ensure collection of quality data and its utilization.
2. Ensure quarterly conduct of ISS visits to at least 736 health facilities by December, 2018.

Monitoring and Evaluation Targets for 2018

1. Increase reporting rate from 55% to 100% (1,367) of all health facilities on DHIS2.
2. Increase timely reporting from 71% to 100% by December 2018
3. Conduct quarterly DQA in 304 health facilities in the State by December, 2018
4. Conduct monthly M&E coordination meetings to review data submission and data quality.
5. Conduct monthly supervisory visits to 224 health facilities and Quarterly ISS to 736 health facilities.
6. Conduct quarterly health data dissemination and publication of annual statistical bulletin.

6. **Immunization -** DPT3/penta3

- **Indicator:**

Proportion of children aged 12-23 months who received the third dose of DPT/Penta vaccine (DPT3/PENTA3)

- **Baseline coverage**

57**%** of children aged 12-23 months received the third dose of DPT/Penta vaccine (DPT3/PENTA3) [Source: 2016 SMART survey]

- **Objective**

To ensure that 95% of children aged 12-23 months are fully immunized with penta 3 in 2018.

- **Target**

95% of children aged 12-23 months fully immunized with penta 3 in 2018.

7. CROSS-CUTTING INTERVENTIONS

Objective

To enhance the administrative, management, collaboration, coordination, systemic, financial and accountability capacity of the State Ministry of Health to deliver efficiently on SOML interventions

Baseline: The State Ministry of Health does not have adequate administrative, management, collaboration, coordination, systemic, financial and accountability capacity to deliver on SOML interventions

Target: The State Ministry of Health strengthened with administrative, management, collaboration, coordination, systemic, financial and accountability capacity to deliver on SOML interventions

Implementation Framework for 2018 SOML PforR Operational Plan

This framework outlines the key features and concepts that will guide the implementation of the comprehensive operational plan for Saving One Million Lives Program for Results (SOML PforR) in Benue State in the year 2018. It will help maximize and synergize the efforts of all the diverse players and stakeholders involved in key intervention areas of SOML PforR.

3.1 Ownership of the Operational Plan: Benue State Government

3.2 Ministry Domiciled: Benue State Ministry of Health

3.3 Leadership: Honourable Commissioner for Health, Benue State

3.4 Scope and Coverage: It is ''Annual'' operational plan, which therefore implies that it captures all activities in the different intervention areas that will be implemented within one year (2018). Also, SOML interventions will be implemented across the 23 LGAs in the State, private and public health facilities of different tiers (tertiary, secondary and primary health facilities), different health programmes, departments, boards and agencies under the State Ministry of Health (including State Malaria Elimination Programme, State Primary Health Care Board, Department of Public Health, Department of Family Planning, State Agency for the Control of AIDS, etc.).

3.4 Core Intervention Strategies: The following core interventions for SOML PforR are as follows:

3.5 Collaboration

The Saving One Million Lives Programme for Results has a wide scope and is quite cost intensive, therefore, the responsibility of implementing activities and achieving results requires the collaborative efforts of different relevant stakeholders. Major collaborators include:

- State Ministry of Health (the key implementing and coordinating body for SOML PforR in the State). Relevant SMOH departments and agencies will be actively involved in the planning and implementation of SOML PforR interventions

3.6 Resourcing

3.7 Coordination

Benue State Ministry of Health will provide leadership, coordinate and harmonize the efforts of all players and stakeholders in order to achieve the desired results. The structural arrangements that will ensure these are:

- State Malaria Elimination Advisory Committee chaired by the Honourable Commissioner for Health

- Technical Working group chaired by the Director of Disease Control and Surveillance
- State Malaria Elimination Program consisting of the following key officers at the minimum:
    - State Malaria Elimination Programme Manager
    - M&E Officer
    - Central Medical Store Pharmacist
    - Community Directed Intervention Officer
    - Integrated Vector Management Officer
    - ACSM Officer
    - Logistics Officer
- State Forum for Partners Supporting Malaria Elimination in Jigawa State
- State-LGAs coordination meeting
- State Inter-sectoral Committee of Ministries, Departments and Agencies
- State Association of Civil Organization on Malaria, Immunization and Nutrition (ACOMIN)

3.8 Roll Out and Major Milestones

- Quarterly work planning and review meeting
- Mid-year review
- Engagement with private providers
- State-wide case management capacity building
- Integrated Supportive Supervision
- Maternal, Neonatal and Child Health Week
- Resource mobilization

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