NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

PRIMARY HEALTH CARE UNDER ONE ROOF IMPLEMENTATION SCORECARD III REPORT

Health Reform Foundation of Nigeria

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November 2015

MUHAMMADU BUHARI
PRESIDENT, COMMANDER - IN - CHIEF OF THE ARMED FORCES
FEDERAL REPUBLIC OF NIGERIA

PROF. ISAAC F. ADEWOLE FAS, DSC (HONS)
HONOURABLE MINISTER FOR HEALTH

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Honourable Minister of State for Health

PICTURES FROM SCORECARD 3 DEVELOPMENT

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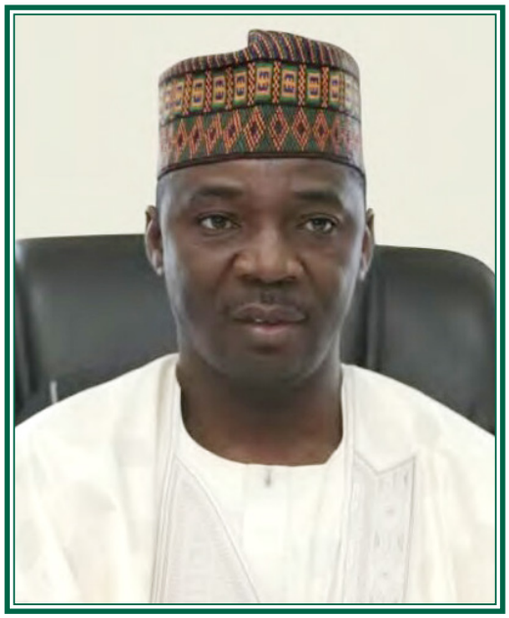


Primary Health Care (PHC) is based on clearly defined principles that will require to be translated into practice through the existence of structures and managerial processes. Consequently, primary health care organizational structure, determines how roles, power and responsibilities are assigned, controlled, and coordinated; and how information flows between different levels.

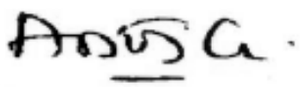
Unfortunately, over the years, the existence of multiple administrative structures (State MOH, the Ministry of Local Government and the Local Government Service Commission, and sometimes the Office of the Executive Governor), at the State level with concurrent and overlapping responsibility for primary health care had constituted significant challenges. In response to the foregoing, the National Primary Health Care Development Agency (NPHCDA) with the support of PRRINN-MNCH a DFID program, introduced the "Bringing PHC Under One Roof (PHCUOR)" initiative as part of a new governance reform designed to improve primary health care implementation.

While remarkable progress has been made in the new drive towards improved primary health care governance through the "Bringing PHC under One Roof" initiative with the establishment of State PHC Boards and Agencies in many States, there are significant challenges that have resulted in institutions and structures that are not in accordance with the national guidelines and standards.

The purpose of this scorecard is therefore to assess the adherence of States to the national guidelines on establishment of governance structures for implementing PHCUOR as well as identify areas in which States need further support. The scorecard further provides a platform for peer review on PHC reforms in Nigeria.

I wish to reiterate that "Bringing PHC Under One Roof" initiative is a reform process that would require sustained effort over a considerable period of time. I strongly recommend that States adhere to established "step-by-step" guidelines for PHCUOR, and put in place institutions and structures that conform to established standards.

I wish to assure the States of our highest commitment towards the principles guiding PHCUOR, and the improvement in the quality and coverage of health service delivery, and the promotion of a culture of transparency, accountability and participation by all stakeholders.



Dr. Ado J.G. Muhammad OON
Executive Director
National Primary Health Care Development Agency

Acknowledgments

The "Bringing PHC Under One Roof" initiative enables the roles of multiple MDAs to be streamlined such that the Ministries of Local Government and the Local Government Service Commission and the Office of the Executive Governor cease to have significant roles to play in primary health care implementation. However, the responsibility for primary health care implementation remains with the Local Government Health Authorities (LGHAs).

With this development, Nigeria is on the verge of a major reform in primary health care governance. Therefore, the PHCUOR scorecard is vital in monitoring progress and adherence of States to the guidelines for the reform.

Over the past decade during which the programme for the governance reform has been driven, much efforts have been put in by several organizations and individuals. On behalf of the Executive Director/CEO of the National Primary Health Care Development Agency, Dr. Ado J. G. Muhammad and his management team, we salute all those who have contributed in any manner to the success we have achieved.

We recall the foundational support by DFID through PRINN-MNCH and PATHS and most sincerely recognize and thank them. Furthermore, we acknowledge the efforts of HERFON, JHU-IVAC, UNICEF, PACT, and SCI whose technical and financial support made the Scorecard 3 project a reality.

This initiative was driven by the PHCUOR National Steering Committee chaired by Dr. Ben Anyene with the support of the secretariat led by Dr. Charles Mamman. To both of you, I say thank you.

I want to specially recognize and thank Dr. Obinna Ebirim and Mr Chukwunonso Umeh (both consultants with IVAC) and Mr Samson Bamidele of HERFON and Dr. Ejemai Eboreime for providing technical lead, interest and commitment throughout the project. They led the team that handled data analysis, report writing and editing of the report.

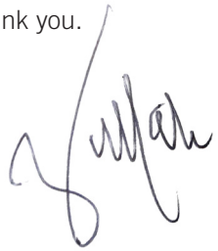
For their tireless effort, I also wish to recognize the commitment of the NPHCDA planning team led by Mr S.A. Adelakun and other members of the team –Dr. M.R.O. Onoja, Dr. Maimuna Hamisu, Dr. Ejemai Eboreime, Jamila Abubakar Umar and Aisha Yakubu Bello. To you all, we say well done.

There are others who also made significant contributions that space will not permit us to acknowledge individually here but are duly listed in the list of contributors.

We equally appreciate the staff of the department of planning research and statistics of the Agency for your contributions to this work.

This work was accomplished under the guidance and leadership of our team leader, Dr. Ado J.G. Muhammad (OON), the Executive Director and Chief Executive of the NPHCDA. His directives and inputs are highly valued, recognized and appreciated. We thank you for the opportunity to be part of this process.

Thank you.



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State Level Engagement for the 2014 National Health Act Implementation

Following the signing into law of the 2014 National Health Act (NHAct) by the President, attention of stakeholders and the general public have been focused on processes that will facilitate the implementation of the key provisions of the Act both at the federal and sub-national levels. At the recently-held Emergency National Council on Health (NCH) in March 2015, the Federal Ministry of Health being the custodian of the NHAct shared with stakeholders, the concrete steps it had taken to commence the NHAct implementation process. These include setting up the governance structures and mechanisms for the implementation of the Act, namely: the constitution of the National Steering Committee, the Technical Working Group (with its 5 sub-committees), and the Technical Review Committee respectively. At the NCH, the States' representatives also made commitments to support the implementation of the NHAct accordingly. While these efforts being made at the federal level are commendable, it is imperative that States are engaged to ensure their readiness to lead the ongoing implementation process and consultations, without which the implementation may be stalled at the State and LGA levels where the actual delivery of basic health care services (which the NHAct guarantees) are expected to take place. Recognizing the need for commitment and ownership of the entire process by State-level actors and stakeholders, the Health Sector Reform Coalition (HSRC) have expressed her willingness to collaborate with the Federal Ministry of Health and its relevant agencies to facilitate the State-level engagement process.

This document attempts to highlight some of the key steps and activities that would help prepare and get States ready for the implementation of the NHAct.

Objectives of the State-level Engagement Process:

- To establish a State level partnership and coordination forum (similar to the Health Sector Reform Coalition) to support the State level domestication of the NHAct in close collaboration with the State Ministry of Health and its agencies.
- To sensitize, enlighten and create awareness of key provisions of the NHAct among State-level stakeholders and the general public to ensure their active participation and ownership of the NHAct and its implementation processes.
- Orient duty bearers at the State-level on the NHAct Implementation process and the expected milestones and deliverables
- Support States to establish the necessary governance structures and policy frameworks (similar to the federal level structures) to fast-track the implementation of the NHAct .
- Support States to convene State-level Council on Health where decisions on the domestication of the NHAct key provisions can be deliberated on, and resolutions reached which takes into cognizance the unique contexts of each State.
- Support States to develop and adopt State-specific Health Acts which align with the NHAct.
- Sustain advocacy to the States for the implementation of the PHCUOR policy and the establishment of State Primary Health Care Boards/Agencies and Local Government Health Authorities and to enhance their eligibility to access the Basic Health Care Provision Fund (BHCPF).
- Establish accountability mechanisms for the monitoring of the NHAct implementation at the State level

The State specific Health Reforms Coalition Forum will collaborate with the SMOH to implement the following activities:

1. **Setting-up of Governance Structures:**

   State Technical Teams on NHAct: The States are to be encouraged to establish core technical teams that would provide technical leadership and oversight over the NHAct implementation at the State level. This will be under the leadership of the State Ministry of Health with membership from other line ministries and agencies such as State Primary Health Care Development Agencies/Board, Ministry of LGA and Chieftaincy Affairs, Ministry of Education, Ministry of Women Affairs, Ministry of Youth and Sports, Ministry of Finance and Economic Planning, Ministry of Information and Communication, Ministry of Justice, Development Partners, Civil Society etc. The team will be responsible for coordinating the awareness creation and advocacy engagements at the State level to ensure the smooth implementation of the NHAct.

2. **Stakeholder buy-in and Participation:**

Stakeholder mapping and Analysis: This will include the identification of key influencers, duty bearers and stakeholders at the State and LGA levels who will have roles to play in ensuring the smooth implementation of the NHAct.

Stakeholder Workshops and Round Tables: Under the leadership of the State Technical Teams, stakeholders' workshops need to be organized to ensure that the key players understand the provisions of the Act and the implications for the organization and delivery of health services in their States and to emphasize the need for establishing the necessary structures and institutional reforms needed.

Awareness Creation and Enlightenment Creation: This will entail the use of the mass media (especially radio) and other media platforms and community structures currently being used for social mobilization to reach people at rural areas and grassroots to inform them about the key provisions of the NHAct and the implications for their health rights – especially the right of access to basic healthcare services as provided in the NHAct. This would also include stakeholder meetings and workshops etc.

Development of IEC Materials: Efforts should be made to translate the key provisions into the local languages and pidgin for wider dissemination in the States. The States can be supported to also develop stakeholder-specific policy/advocacy briefs and media kits that can be used by the media and other stakeholders in their engagement processes.

3. **State-level Reforms (to be driven by the State Ministry of Health):**

States' Position on the NHAct and the Basic Package of Care: To ensure as well as encourage the States' ownership of the NHAct, the States need to critically review the key provisions of the NHAct and its implications for healthcare delivery in their respective States. One critical area is the definition of the 'Basic Minimum Package of Care' based on the peculiar disease burden and priority needs of each respective State. Thus States need to be encouraged to liaise with FMOH, NPHCDA and NHIS to come up with their positions on how to define the minimum package of care that will be provided at their primary health centres and selected secondary health facilities as provided in the NHAct.

Additionally, stakeholders in the respective States (and by extension, the LGAs) need to start discussions on how they intend to mobilize resources for the 25% counterpart funding for the BHCPF as prescribed by the NHAct. This might require advocacy and engagements with State Governors on how to develop innovative health financing mechanisms and strategies that take the unique contexts of each State into consideration.

Other opportunities to be explored include how to align the Saving One Million Lives Program-for-Results (PforR) initiative which seeks to change the behaviour of States to service delivery using some incentives and is expected to channel about 80% of program financing directly to States based on their performance measured through the 'Disbursement-linked-indicators' (DLI). Since this initiative is being supported through resources from the World Bank, it is imperative for the FMOH and the SMOHs to discuss on how to align this potential pool of resources with the BHCPF, where possible.

Drafting and Passage of State Health Acts: The States need to be supported to review the provisions of the NHAct and adapt or modify them in a bid to develop their own State-level legal framework for the organization and delivery of health services in the respective States. States can follow the example of Lagos State which has a Health Act.

Instituting the State Council on Health: States (and by extension, the LGAs) are to be supported to convene their respective State Council on Health meetings where the key stakeholders will deliberate on the key provisions of the NHAct and outline steps for its implementation and/or domestication. The assumption is that once States understand the benefits of the NHAct implementation in terms of improved service delivery and health outcomes, they would be motivated to institute the necessary reforms that would help them access the Basic Health Care Provision Fund (BHCPF).

Implementation of the PHCUOR Policy: States are expected to have functional State Primary Health Care Boards as one of the pre-requisites for accessing their allocations from the Basic Health Care Provision Fund. Different States are

at different stages in the implementation of the 9 Pillars of the PHCUOR policy, hence would require varying levels of support to get them ready to access the BHCPF.

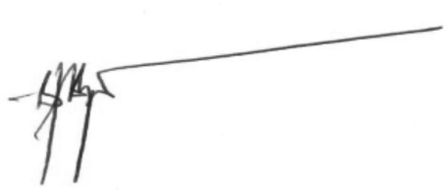
Aligning the State-Supported Health Insurance Scheme (SSHIS) with the BHCPF: At the last NCH, the memo for the establishment of State-Supported Health Insurance was adopted by all the State representatives. It is imperative that States be supported to fast-track the roll-out process, while exploring the possibility of aligning the minimum service package prescribed in the BHCPF with the States SSHIS. There is the need for the leadership of NHIS and FMOH to start discussions with the State Ministries of Health on the practical steps and processes for the establishment of the SSHIS. Lessons learned from the experiences of those States that are already implementing community based health insurance schemes will be documented and shared to others.

4. **Accountability Framework and Mechanisms:**

With the commencement of NHAct implementation at the federal level, it is important that an accountability framework and mechanism at all level of government, and at State level should be developed alongside the proposed governance structures. Efforts should be made to find ways to strengthen accountability mechanisms at the States and/or revise them to include elements for the NHAct implementation at the State level. This is against the backdrop of the establishment of State accountability mechanisms for health which incorporate both public and non-State actors through the support of some development partners. These mechanisms can be strengthened or realigned to incorporate specific strategies to strengthen NHAct accountability at the State and LGA levels. Accountability mechanism for PHCUOR (SPHCDA) should align with the NHAct.

Role of HSRC in the Engagement Processes:

The HSRC in collaboration with the FMOH and its Agencies will provide technical support to States, through the State specific HSRC, on a need-by-need basis and the specific details of what type of technical and/or financial resources needed for the State-level engagements will be worked out in due course. The capacity of the State specific groups will be strengthened to enable them to effectively support the role out processes in collaboration with the States.



Dr. Ben Anyene
Chairman PHCUOR National Steering Committee

List of Abbreviations

ADSPHCDA	Adamawa State Primary Health Care Development Agency
BHCPF	Basic Health Care Provision Fund
DFID	Department for International Development
DG	Director General
EC	Executive Chairman
ED	Executive Director
ES	Executive Secretary
FCTA	Federal Capital Territory Administration
FCTPHCB	Federal Capital Territory Primary Health Care Board
FMOH	Federal Ministry of Health
GHSB	Gunduma Health System Board
HERFON	Health Reform Foundation of Nigeria
HRH	Human Resource for Health
HRIS	Human Resource Information System
IMR	Infant Mortality Rate
ISS	Integrated Supportive Supervision
IVAC	International Vaccine Access Centre
LG	Local Government
LGA	Local Government Area
LGHAs	Local Government Health Authorities
LGSC	Local Government Service Commission
M&E	Monitoring and Evaluation

MCH	Maternal and Child Health
MDA	Ministries, Departments and Agencies
MICS	Multi Indicator Cluster Survey
MNCH	Maternal Neonatal and Child Health
MOLG	Ministry of Local Government
MSP	Minimum Service Package
NBS	National Bureau of Statistics
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
PATHS	Partnership for Transformation of the Health System
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PRINN-MNCH	Partnership for Reviving Routine Immunization in Northern Nigeria; Maternal Newborn and Child Health
SHDP	Strategic Health Development Plan
SMOH	State Ministry of Health
SPHCDA/B	State Primary Health Care Development Agency/Board
SPHCMB	State Primary Health Care Management Board
U5MR	Under-5 Mortality Rate
UHC	Universal Health Coverage
WMHCP	Ward Minimum Health Care Package

Executive Summary

Primary health care under one roof (PHCUOR) otherwise known as Integrated PHC Governance, is a primary health care (PHC) reform promoted by the Government of Nigeria to integrate the PHC structures and programs at sub-national levels, under one State-level body – the State Primary Health Care Development Agency or Board (SPHCDA/B) within the framework of a decentralized health system. The policy is based on the principle of "Three Ones"- i.e. one management, one plan and one monitoring & evaluation system.

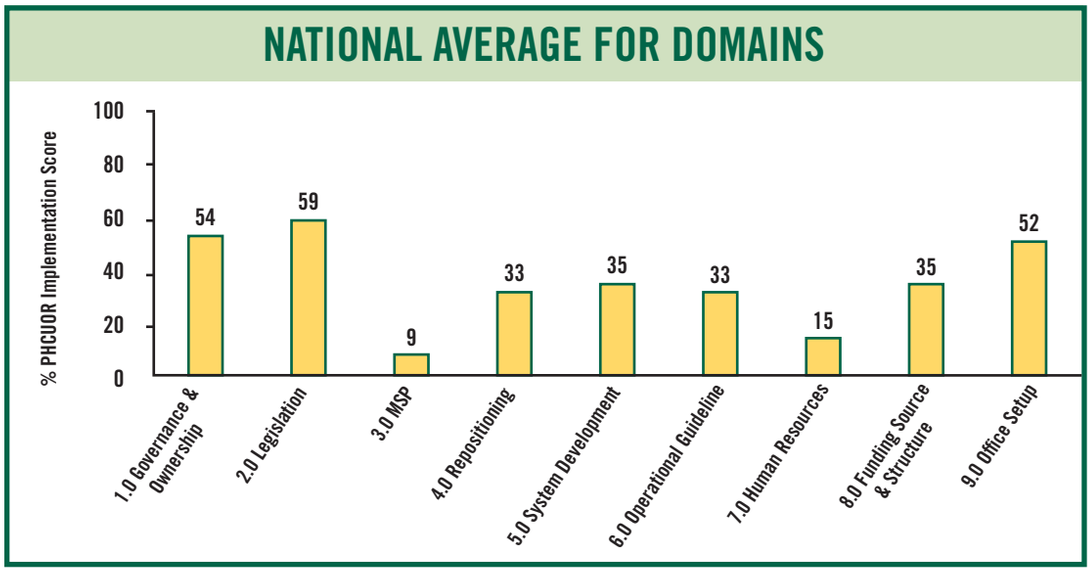
The PHCUOR initiative was initiated in 2005 with support from DFID funded project, Partnership for Transformation of Health Systems (PATHS). This was consolidated by another DFID funded program, the Partnership for Reviving Routine Immunization in Northern Nigeria: Maternal Newborn and Child Health Initiative (PRINN-MNCH). It became a national policy agenda following its endorsement by the 56th National Council on Health (NCH) in May 2011. The Council in its 58th Session in 2013 further approved the national guidelines for implementation as well as the policy document through its Resolution 29. The guidelines identify a conceptual framework for implementing the policy which consists of nine specific domains- Governance & Ownership, Legislation, Minimum Service Package, Repositioning, Systems Development, Operational Guidelines, Human Resources, Funding Sources & Structure and Office Setup. The guidelines further outline specific steps and approaches involved in establishing a functional SPHCDA/B. In spite of the adoption of the Policy by the NCH, progress with implementation has been slow with each State making varying degrees of advancement on each domain.

The PHCUOR scorecard was initiated in 2012 to assist States identify, in a systematic manner, areas within the PHCUOR framework in which they need support. The scorecard is also a peer review mechanism as well as an advocacy tool to governmental and non-governmental stakeholders for the purpose of facilitating symmetrical and synergistic implementation of the policy nationwide.
This scorecard assessment is an improvement on its two precursors. The assessment tool was refined to enhance sensitivity in comparison to the previous versions.

The 2015 PHCUOR scorecard 3 assessment revealed that 28 States now have State Primary Health Care Development Agencies or equivalent institutions with 26 of them having a legal basis for establishment. Content analysis, however, revealed that majority of the laws passed and the bills in process are not in conformity with the national guidelines. It was also observed that most States with SPHCDAs or equivalent structures, still struggle with repositioning and human resource management as staff are still being managed and paid by their parent MDAs. Furthermore, most States with SPHCDAs are yet to establish the Local Government Health Authorities (LGHAs), which are expected to be the implementing arm of the SPHCDAs. Findings reveal that only 8 States have collapsed the LGA health departments into LGHAs.

The weakest domain is the Minimum Service Package. Most States require support in this domain. North West zone was the highest performing geopolitical zone with a score of 55% while South East zone was the least performing geopolitical zone with a score of 19%. Across the States, the three best performing States were Jigawa (80%), Rivers (73%) and Bauchi (67%) while the least performing States are Bayelsa (5%), Akwa Ibom (0%), and Ebonyi (0%).

Although a rigorous approach was employed in this assessment, the process did not go without some limitations and challenges. States which did not produce evidence for any performance claims were not credited for such claims. While this was employed to ensure all accepted responses are valid, the implication is that some States may have been scored lower than they actually performed because they could not provide documents to back up their claims despite being provided with list of required documents at least a week before assessment. This report is the product of a cross-sectional assessment carried out between 28th August and 5th September, 2015. It should be noted, therefore, that there is a possibility that some States may have made further progress between the time of assessment and production of this report which are not captured here. It is hoped that Scorecard 4 will capture these more recent developments.



Background

Primary health care under one roof (PHCUOR) otherwise known as Integrated PHC Governance, is a primary health care (PHC) reform promoted by the Government of Nigeria to integrate the PHC structures and programs at sub-national levels, under one State-level body – the State Primary Health Care Development Agency or Board (SPHCDA/B) within the framework of a decentralized health system. The policy is based on the principle of "Three Ones": One Management, One Plan and One Monitoring & Evaluation System.

The PHCUOR was initiated with support from DFID funded projects- Partnership for Transformation of Health Systems (PATHS 2005-2008) and Partnership for Reviving Routine Immunization in Northern Nigeria: Maternal Newborn and Child Health Initiative (PRINN-MNCH 2008-2014), became a national policy agenda following its endorsement by the 56th National Council on Health (NCH) in May 2011. The Council in its 58th Session in 2013 further approved the national guidelines and the policy document, for implementation, through its Resolution 29. The guidelines identifies a conceptual framework for implementing the policy which consists of nine specific domains- Governance, Legislation, Minimum Service Package, Repositioning, Systems Development, Operational Guidelines, Human Resources, Funding Sources & Structure and Office Setup- and outlines specific steps and approaches involved in establishing a functional SPHCDA/B. In spite of the adoption of the Policy by the NCH, progress with implementation has been slow with States making varying degrees of progress on each domain.

In September 2012, a national stakeholders' workshop organized by the NPHCDA with technical support from PRRINN-MNCH resolved that partners should work with the NPHCDA to support the States in the implementation of PHCUOR in line with the national guidelines. In line with this, the National Steering Committee (NSC) for PHCUOR was established in 2012 for the purpose of supporting and monitoring the implementation of PHCUOR in States. The same year, the NPHCDA (with support from HERFON and PRRINN-MNCH) developed a checklist for monitoring PHCUOR implementation progress. This led to the development of PHCUOR Scorecard 1 in 2012. In October 2013, the NPHCDA (with support from IVAC, HERFON and PRRINN-MNCH) expanded the existing checklist into an assessment tool which was used in all States to develop a National Scorecard 2. In 2015, the PHCUOR NSC commissioned the development of Scorecard 3 and the assessment tool used in Scorecard 2 had to be revised to increase sensitivity and expanded to include a qualitative questionnaire for better understanding of the implementation process in the States. These assessment tools have been administered in all the States and FCT, its findings analyzed and the latest Scorecard 3 developed. Assessments of States were conducted by NPHCDA supported by partners - HERFON, IVAC, UNICEF, SCI and PACT.

Methodology

The Scorecard 3 Assessment involved the following activities:

1. Revision of assessment tools
2. Training of data collectors
3. Data collection
4. Data analysis
5. Report writing

Revision of Assessment Tools:
The pre-assessment stage involved the review of the scorecard 2 assessment tool which was adopted but reviewed with the plans of increasing the sensitivity of the tools as this was a huge gap for the scorecard 2 assessment of 2013. With the view of having an in-depth understanding of the core PHCUOR implementation approaches in the States, a qualitative questionnaire in addition to the quantitative assessment tool was developed. These tools (qualitative and quantitative) were rigorously reviewed by the scorecard PHCUOR NSC technical committee to ensure that they address the primary objectives of the scorecard 3. In ascertaining the reliability cum validity of the tools following the review, a pilot tool testing was carried out in the FCT. The tools were further reviewed by the technical team in line with lessons learnt/feedback from the tool testing exercise.

Training of Data Collectors:
Data collection team were drafted from the zonal offices of the NPHCDA, HERFON members in the States as well as officers from IVAC. For the purpose of consistency, the NSC secretariat endeavored to ensured that majority of the data collectors were drawn from a pool of assessors involved in the 2013 scorecard 2 data collection exercise. A 2-day orientation workshop was conducted for all data collector, to convey the new assessment approach as well as keep them abreast with their deliverables.

Data collection:
Data collection was carried out in all States between 28th August and 5th September, 2015. Prior to the deployment of data collectors, States were notified in writing about the exercise and the procedures. Qualitative questionnaires were also dispatched to the States ahead of the field visits. Two data collectors were assigned to each State. The teams were instructed to collect evidence for positive responses and also pay verification visits to three LGAs per State.

The States were scored quantitatively based on their responses and availability of provided evidences/documents to authenticate their responses. There was a rigorous process of double-blinded data entry, group data validation, domain weighting and analysis before this scorecard was developed.

The qualitative analysis provided a broader understanding of the responses in the quantitative assessment tool.

Data Entry and Analysis:
An Excel based tool was developed for the analysis of the data. Data entry was done by two persons independently and then compared and harmonized to avoid bias. A 4-day evidence review with content analysis of submitted documents was carried out to validate responses. Over 20 participants drawn from government and development partners were involved in the data analysis which was carried out in plenary sessions to ensure consensus. As a rule, any affirmative answer to the questionnaire which was not backed by documentary evidence was changed to a negative response. Furthermore, it was agreed that only evidence available as of the time of data collection and analysis will be accepted. Any progress made by any State outside the period under review was excluded from the process.

Weighted averages for each domain were agreed on by selected PHC experts using a modified Nominal Group Technique. (Details in process report)

Limitations:
Although a rigorous process was adopted for the exercise, there were limitations of underscoring States who have performed more in PHCUOR implementation but could not provide documents to back up their claims despite being provided with list of required documents days at least a week before assessment. It is note-worthy that PHCUOR is a dynamic process and there is a possibility that States have made progress between the time of assessment and production of this report. There were also observed insensitive or improperly framed questions in the course of this work which would be reviewed prior to the revision and production of subsequent scorecards. Irrespective of the above mentioned limitations, scorecard 3 used more evidence-based approach, ensured broader stakeholder involvement in all processes and enhanced data quality through various level of validation than its predecessors.

The scorecard 3 is envisaged to be a more formidable tool to drive high level advocacy in reinforcing the implementation of this reform in Nigeria's PHC system, while also serving as a pointer to guide States on domains/areas that would require more effort and support for effectively establishment and implementation of the PHCUOR in order to achieve universal health coverage.

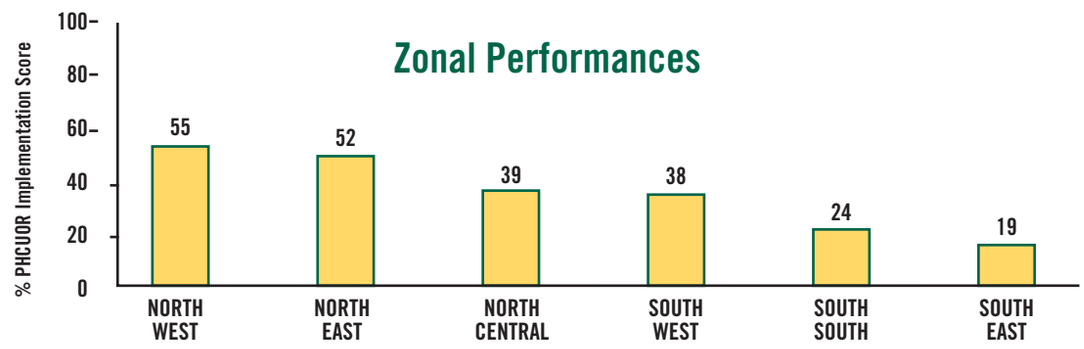
NATIONAL PHCUOR IMPLEMENTATION SCORECARD III

PERFORMANCE BY DOMAINS

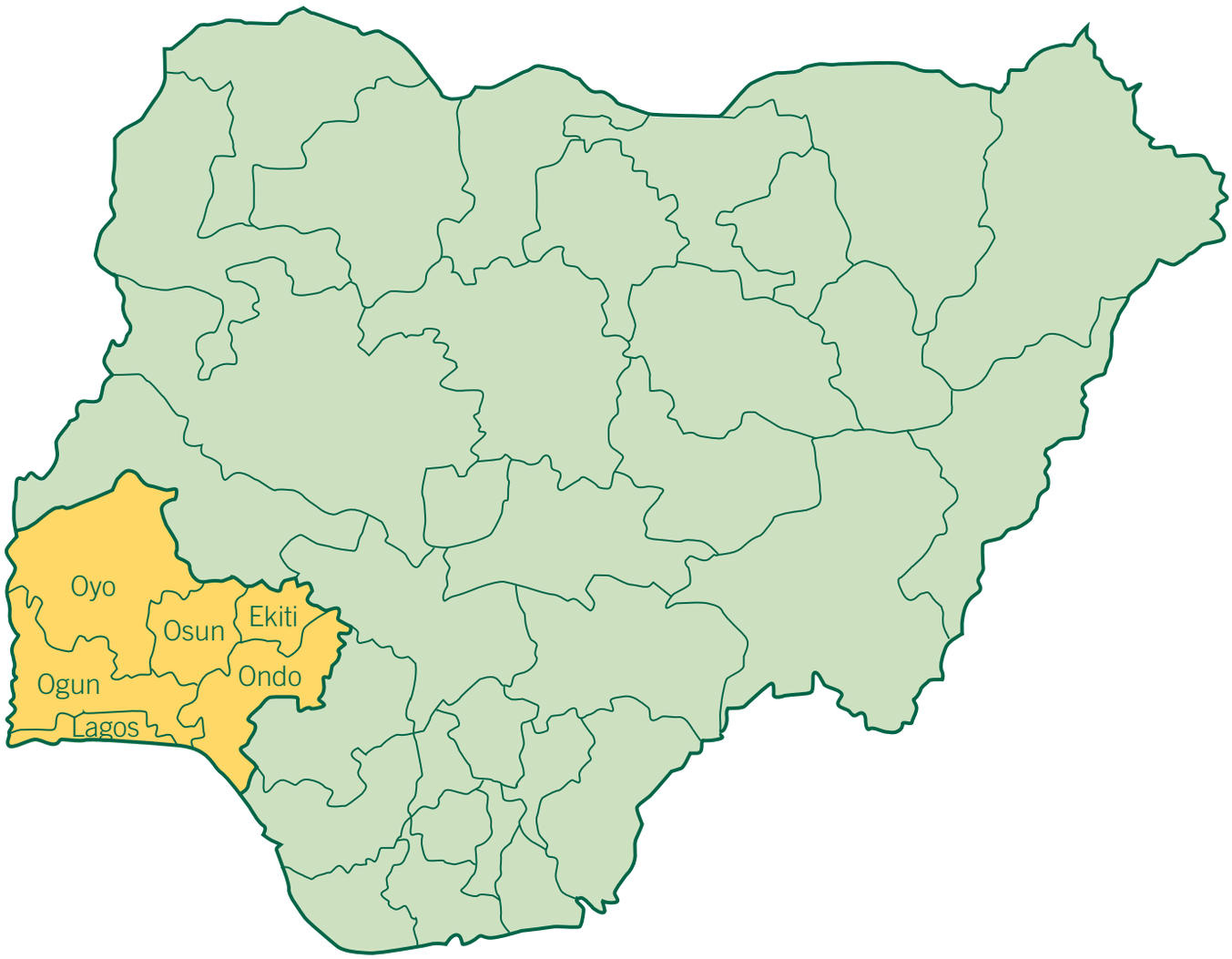
	State	GOVERNANCE & OWNERSHIP (%)	LEGISLATION (%)	MINIMUM SERVICE PACKAGE (%)	REPOSITIONING (%)	SYSTEMS DEVELOPMENT (%)	OPERATIONAL GUIDELINES (%)	HUMAN RESOURCES (%)	FUNDING SOURCES & STRUCTURE (%)	OFFICE SETUP (%)	AVERAGE PERFORMANCE (%)	ZONAL AVERAGE (%)
NORTH WEST ZONE	Jigawa	88	100	78	78	67	60	38	90	100	80	55
	Kaduna	75	50	11	44	83	60	13	40	67	46	
	Kano	63	100	11	78	58	40	25	30	83	57	
	Katsina	75	60	78	33	83	60	25	60	100	59	
	Kebbi	75	70	11	44	75	20	13	60	100	51	
	Sokoto	88	60	11	13	42	60	0	30	83	45	
	Zamfara	63	100	11	22	17	40	13	30	83	49	
NORTH EAST ZONE	Adamawa	75	70	11	67	33	60	38	70	100	59	52
	Bauchi	75	100	0	44	33	40	63	80	50	67	
	Borno	75	70	0	33	33	40	0	10	33	38	
	Gombe	75	60	0	78	92	60	50	60	100	59	
	Taraba	50	60	0	11	0	0	0	0	50	25	
	Yobe	100	90	0	78	67	60	13	70	100	66	
NORTH CENTRAL ZONE	Benue	50	70	0	0	8	40	0	50	67	29	39
	Kogi	63	60	11	33	14	100	20	0	50	41	
	Nasarawa	38	50	0	44	0	20	13	60	50	35	
	Plateau	25	60	0	11	0	20	0	40	17	28	
	Kwara	50	70	0	22	25	20	0	40	17	36	
	Niger	88	70	11	78	58	80	50	50	67	62	
	FCT	88	30	33	22	50	60	13	50	50	43	
SOUTH WEST ZONE	Lagos	63	70	11	56	75	60	13	50	33	50	38
	Ogun	63	60	11	22	42	60	0	60	100	44	
	Oyo	0	30	0	0	0	0	0	0	0	8	
	Osun	0	30	0	0	0	0	0	0	0	8	
	Ekiti	63	60	0	78	83	20	63	60	50	55	
	Ondo	88	80	11	89	83	40	38	70	83	66	
SOUTH SOUTH ZONE	Edo	0	50	0	0	0	0	0	0	0	13	24
	Delta	75	60	11	0	42	20	13	40	50	40	
	Rivers	100	90	11	56	100	100	50	60	100	73	
	Bayelsa	0	20	0	0	0	0	0	0	0	5	
	Akwa Ibom	0	0	0	0	0	0	0	0	0	0	
	Cross River	0	60	0	0	0	0	0	0	0	15	
SOUTH EAST ZONE	Abia	75	60	0	44	33	60	0	40	67	43	19
	Anambra	75	70	0	11	17	0	0	10	67	35	
	Imo	0	30	0	0	0	0	0	0	0	8	
	Enugu	13	30	0	0	0	0	0	0	0	10	
	Ebonyi	0	0	0	0	0	0	0	0	0	0	

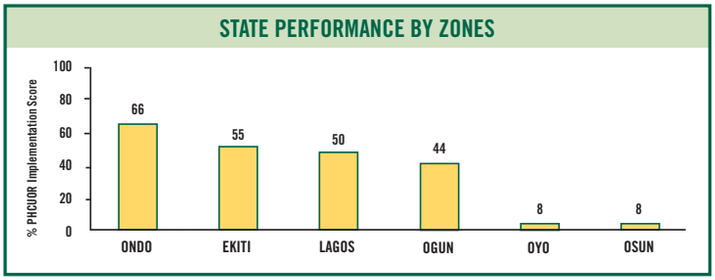
LEGEND
81-100%
51-80%
0-50%

GEOPOLITICAL ZONES PERFORMANCE



SOUTH WEST ZONE 38%





Ekiti State 55%

Background

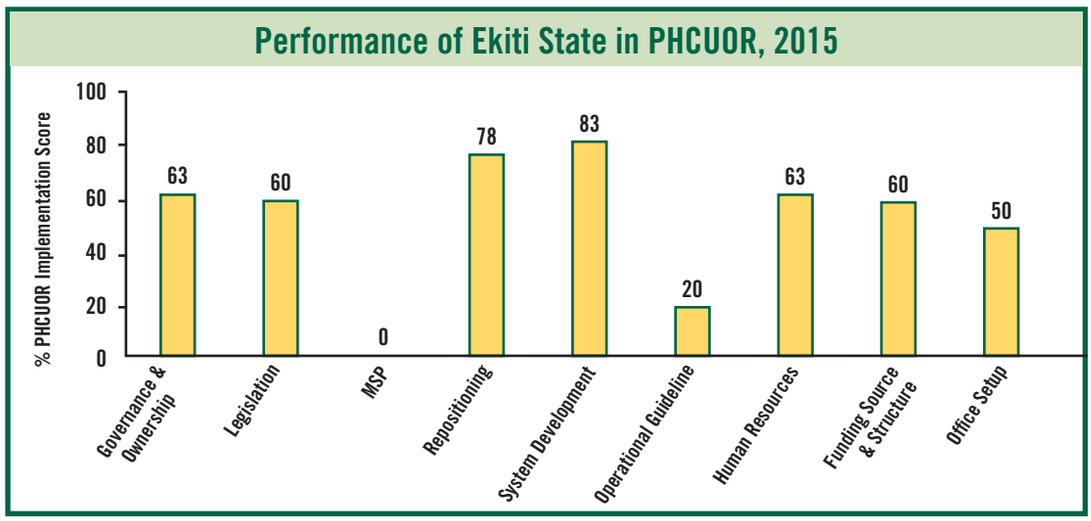
Ekiti State is one of the five States in the South-West geo-political zone in Nigeria and has its capital city as Ado Ekiti. The State was created on October 1, 1996 out of the old Ondo State and has 16 LGAs. The State is bounded to the East by Kogi State, to the West by Osun State, to the North Kwara State, and Ondo State to the South. Ekiti State has a 2015 projected population of 3,138,144 (NPC, 2006), with an area land mass of 5,435km2 (NBS, 2010).

There are a total of 459 health facilities in Ekiti State. Of this number, 395 (86%) are PHC facilities, 62 (14%) are secondary health care (SHC) facilities. Of the 395 PHC facilities, 294 (74%) are publicly owned and 101 (26%) are privately owned (FMOH, 2012). The State has an IMR of 48/1000 and U5MR of 71/1000 (MICS, 2011).

Ekiti SPHCDA was created in 2012 through a bill that was passed by State House of Assembly and signed into law by the Governor of the State.

Main Findings

Ekiti State has an overall score of 55%, which ranked it 11th nationally and 2nd out of the 6 States in the South-West geopolitical zone. The State scored best in the system development domain (83%) and had a zero score in MSP.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 63%

Ekiti SPHCDA has a building of its own and a management team headed by an ES who report to the Governor through the Honourable Commissioner for Health. The governing board is yet to be reconstituted after its dissolution in 2014. There is an organogram which shows clear lines of responsibilities and the management team meets regularly.

Legislation: 60%

The law that established the Agency was generated through a consultative process involving the engagement of major stakeholders and building consensus on the draft bill before it was passed by the State House of Assembly and assented to by the Governor in 2012. This law is yet to be gazetted.

Minimum Service Package (MSP): 0%

There is no evidence that the Ekiti State has a costed MSP.

Repositioning: 78%

The law clearly transfers all PHC structures and functions across all other MDAs to the SPHCDA, while defining the new roles and responsibilities of managers and personnel at the various levels. The different categories of staff have been re-orientated on these changes. However, there has not been any wider stakeholder engagement of affected MDAs to discuss the changing roles and the PHC department at LGAs is yet to be collapsed into the LGHAs.

Systems Development: 83%

The Agency has an annual operational health plan developed from the Strategic Health Development Plan (SHDP). To improve the monitoring of PHC activities and performance, the Agency carries out regular ISS visits to LGAs and health facilities. Ekiti SPHCDA has an institutional structure showing clear lines of accountability and has developed guidelines and policies for staff recruitment at all levels. There is no evidence of a developed operational health plan at the LGAs.

Operational Guidelines: 20%

Although the SPHCDA has the capacity to develop and implement its annual work plan independent of the SMOH, it is yet to develop its regulations and policy documents. Also, the Agency is yet to adapt the national implementation manual on PHCUOR for its use.

Human Resources: 63%

Ekiti's SPHCDA has an established HRH department and has developed a database to ensure appropriate staffing for PHC facilities. There are job descriptions developed for the different staff cadre with adequate plans to manage mal-distribution of staff. The Agency has also developed a costed capacity building plan for its staff. However, not all staff providing PHC services in the State are employees of the SPHCDA in line with the principles of PHCUOR.

Funding Sources and Structure: 60%

At the inception of the SPHCDA, take-off grant was released for its PHC activities, and subsequently, a dedicated budget process was developed. The Agency has the capacity to procure commodities and other items required for PHC activities although, funds released are not adequate to meet the approved work plan. Ekiti SPHCDA administers its staff benefits and pensions. The State is yet to develop a pool fund for its PHC programmes.

Office Setup: 50%

There is a designated SPHCDA office at the State level but this is yet to be replicated at the sub-State levels. This office is yet to be adequately equipped to meet the Agency's operational demands.

The observed strengths, weaknesses and opportunity in the implementation of PHCUOR in Ekiti State are:

Strengths:

- SPHCDA law assented to by the Governor.
- Management team headed by an ES.
- Annual operational work plan with regular ISS visits.

Weaknesses:

- Absence of Governing board.
- Lack of a costed MSP.
- Incomplete repositioning of PHC especially at LGA level.

Opportunity:

- Strong political will.

Recommendations:

- A governing board with balanced inclusion of relevant stakeholders should be re-constituted.
- Regulations to operationalize law should be developed.
- Seek assistance to develop a costed MSP.
- All PHC functions and departments should be completely detached from the various government agencies and collapsed into SPHCDA.
- Develop mechanism for joint funding of PHC activities through contribution from source to enhance increased funding.
- Set up and equip LGHA in all LGAs in the State.

Lagos State 50%

Background

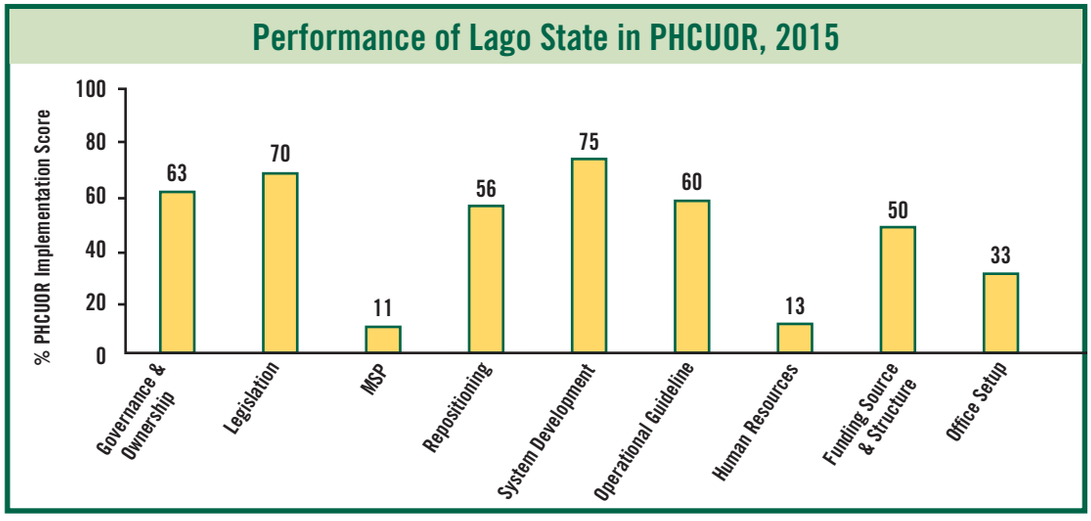
Lagos State with its capital city - Ikeja, is located in the South-West geopolitical zone of Nigeria and has 20 LGAs. With a 2015 projected population of 11,967,746 (NPC, 2006) and a land mass of 3,671km2 (NBS, 2010), Lagos State is one of the most densely populated States in Nigeria. It is bounded by Ogun State to the East and North, to the West is the Republic of Benin, to its South by the Gulf of Guinea.

There are 2,253 health facilities in **Lagos State** with 1786 (79%) PHC facilities and 460 SHC facilities. Out of the 1,786 PHC facilities, 257 (14%) are public owned while 1529 (86%) are private providers (FMOH, 2012). The State health indices shows an IMR of 45 per 1000 and an U5MR of 65 per 1000 respectively (MICS, 2011).

The State began the process of implementation of PHCUOR by inaugurating the SPHCB in 2009 through the integrated **Lagos State** Health Sector Law 2006.

Main Findings

The State has an overall score of 50% in the implementation of PHCUOR thus ranking 13th nationally and 3rd out of the 6 States in the South Western geopolitical zone of Nigeria. MSP (11%) was its lowest domain while it has the highest score in System Development domain (75%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 63%

There is a management team headed by a permanent secretary (PS) who reports to the Governor through the Honourable Commissioner for Health. The management team meets at least once a month. There is neither an evidence of a constituted governing board nor published periodic reports as part of accountability mechanism.

Legislation: 70%

The law establishing Lagos SPHCB is embedded in the integrated Lagos State Health Sector Law 2006. This law has been gazetted but the Board is yet to draft its regulations to implement the PHC segment of this law.

Minimum Service Package (MSP): 11%

The State has no costed MSP. However, it implements a special health care project that its delivery ought to be linked to a costed MSP.

Repositioning: 56%

The law establishing the Board does not clearly transfer all PHC functions to Lagos SPHCB as a result the PHC departments at the LGAs have not been repositioned as LGHAs. There is no evidence that different stakeholders affected by the PHCUOR reform were engaged to discuss the changing roles when the Board was established. Although there is a plan for reorientation of the various categories of Lagos SPHCB staff on the principles of PHCUOR, this plan is yet to be implemented.

Systems Development: 75%

Lagos SPHCB has an annual operational health plan developed from its SHDP. There are also developed operational health plans at LGAs of the PHC departments. The Board conducts regular ISS visit to LGAs and health facilities. However, the Lagos SPHCB is yet to develop its financial management policies separate from the civil service regulations.

Operational Guidelines: 60%

The operational policy and guidelines for PHCUOR implementation utilized by Lagos SPHCB makes provision for M&E, HRH, accounting and other operational procedures. There is no evidence that members of the management team have been recently trained on the principles of PHCUOR. The Board is yet to adapt the national implementation manual on PHCUOR for its use in the State.

Human Resources: 13%

Lagos SPHCB has a costed capacity building plan to address staff needs. Staff providing PHC services in the State are not all employees of the SPHCDA. There is no evidence that a recent PHC staff audit has been carried out. Job descriptions with procedures for recruitment for the different categories of staff, have not been developed.

Funding Sources and Structure: 50%

At the inauguration of the Lagos SPHCB in 2009, a startup fund was provided and thereafter a dedicated budget process was established with a mechanism to track fund release. The Board is able to plan and budget for PHC activities, like the procurement of commodities for health facilities, without external assistance. The funds released to the Board is insufficient to meet its approved work plan. There is no evidence of establishment of a joint fund mechanism for PHC activities. Salaries, pensions and other benefits of all PHC staff in the State is not administered by Lagos SPHCB.

Office Setup: 33%

Lagos State government has provided an equipped office for the SPHCB activities but it is yet to be replicated at the sub-State levels as there are no LGHAs.

The observed strengths, weaknesses, opportunity and threat in the implementation of PHCUOR in Lagos State are:

Strengths:

- Existence of a gazetted law establishing the Lagos SPHCB.
- Management team with an appointed PS.
- Evidence of a regular ISS visits to LGAs and health facilities.

Weaknesses:

- Lack of a Governing Board.
- Incomplete repositioning of PHC structure and HRH in the State and sub-State levels.
- Unavailability of regulations to operationalize the PHC segment of the Law.
- Inadequate funding of Lagos SPHCB to carry out their approved work plan.

Opportunity:

- Availability of numerous partners willing to support PHC system strengthening in the State.

Threat:

- Backlash by stakeholders affected by the PHCUOR reform due to inadequate engagement and orientation.

Recommendations:

- Amend the PHC segment in the Health Sector Law to completely transfer all PHC functions and structures to Lagos SPHCB.
- Constitute a governing board with a balanced inclusion of relevant stakeholders.
- Seek support to develop a costed MSP.
- Develop regulations to operationalize the law and strengthen HRH.

Ogun State 44%

Background

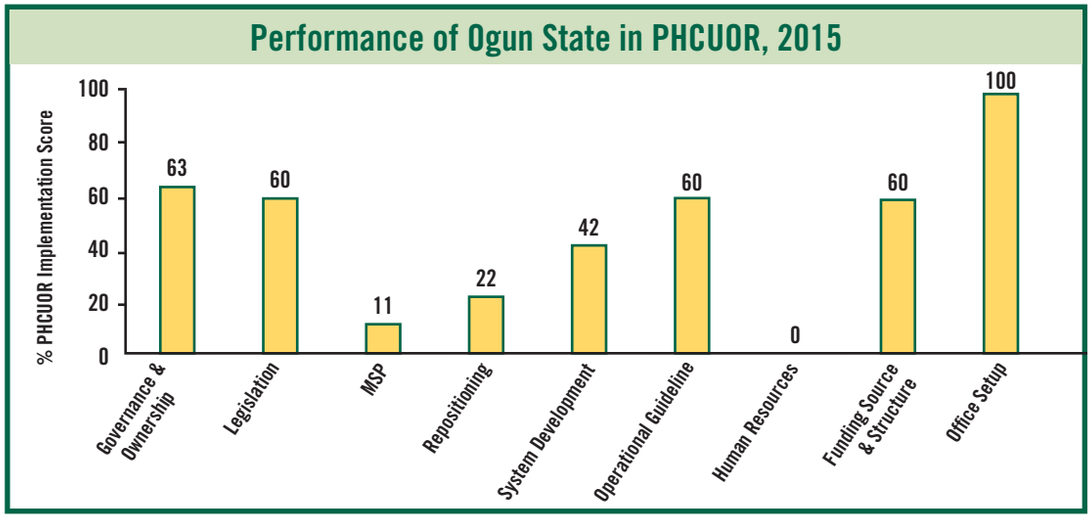
Ogun State is located in the South West Zone of Nigeria. Created in February 1976 from the former Western State, it borders Ondo State to the East, the Republic of Benin to the West, Oyo and Osun States to the North and Lagos State to the South. Abeokuta is the capital and largest city in the State. The 2015 projected population of the State is 4,993,330 (NPC 2006) distributed in 20 LGAs over a land mass of 16,400 (NBS, 2010).

1520 health facilities exist in the State of which 1375 (90%) are PHC facilities. 474 (35%) of the PHC are public while 899 (65%) are private (FMOH, 2012). Health Indices reveal IMR and U5MR of 67 and 105 per 1000 live births respectively (MICS, 2011).

The Ogun State Primary Healthcare Board was established in 2009. The Governing board is headed by a Chairman with an Executive Secretary who doubles as Chief Executive of the management board.

Main Findings

With an overall score of 44%, Ogun State occupies the 17th position nationally as well as the 4th in the South West geopolitical zone. It domain scores range from zero in Human Resources to 100% in Office Setup.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 63%

Ogun SPHCDA establishment has a legal backing with key officers and an organogram that streamlines authority by requiring the Executive Secretary of the SPHCDA to report to the Executive Governor through Honourable Commissioner for Health. The SPHCDA, however, had no governing board constituted as of the time of assessment. No evidence of published reports as part of accountability mechanism was available.

Legislation: 60%

The law establishing the Ogun SPHCDA has been gazetted, however, regulations are yet to be drafted for the Agency's operations.

Minimum Service Package (MSP): 11%

The State is yet to develop a costed MSP which is an economic blueprint for equitable and efficient PHC service delivery.

Repositioning: 22%

The SPHCDA law does not clearly transfer all PHC functions in the State to the Agency, consequently, with the exception of the SMOH, all parallel MDAs still run PHC departments. No evidence of stakeholder engagement to discuss changing roles and responsibilities in the establishment of the Agency, was found.

Systems Development: 42%

While the State has an SHDP, there is no evidence of the existence of annual operational plans at the State and sub-State levels. Although an ISS plan and tools are available, there is evidence that ISS is being implemented at the LGAs and health facilities.

Operational Guidelines: 60%

The SPHCDA has the capacity to develop and implement its work plan independent of the SMOH. There is also a policy that makes provision for PHC HRH, M&E, accounting and other procedures, however, key personnel are yet to be trained on this policy.

Human Resources: 0%

SPPHC staff are not employees of the SPHCDA and their salaries, pensions and benefits are still administered by their parent MDAs.

Funding Sources and Structure: 60%

Upon establishment of the Agency, a take-off grant was released, this was followed by the creation of a dedicated budget and fund release plan for PHC expenditure as well as a tracking system for released funds.

Office Setup: 100%

The Government has provided equipped offices for the SPHCDA at both State and LGA levels.

The observed strengths, weaknesses and opportunity in the implementation of PHCUOR in Ogun State are:

Strengths:

- Ogun SPHCDA backed by gazetted law.
- Dedicated offices provided for PHC operations.

Weaknesses:

- The SPHCDA law does not clearly transfer all PHC functions in the State to the Agency.
- No governing board in place.
- No regulations to guide SPHCDA operations.
- No costed MSP.

Opportunity:

- Partners available to provide support for the reform.

Recommendations:

- Amend the law to mandate transfer of all PHC functions and staff to the Agency.
- Develop the regulations for Ogun SPHCDA operations.
- Establish LGHA as the sub-State arm of the SPHCDA.

Ondo State 66%

Background

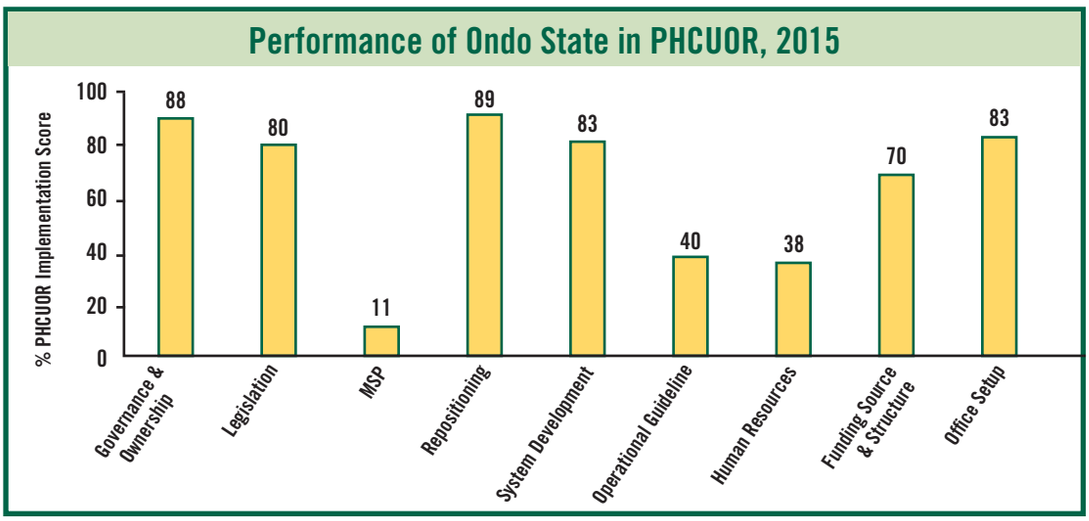
Ondo State, the sunshine State was created on 3rd February, 1976 and has Akure as its capital city. It is one of the six States in the south west geopolitical zones of Nigeria and comprises of 18 LGAs. It is bounded to the East by Edo State, to the West by Osun and Ogun States, to the North by Ekiti and Kogi States, and to the South by the Gulf of Guinea. With a projected 2015 population of 4,489,756 (NPC, 2006), spread across a land mass of 15,820km2 (NBS, 2010).

The State has 811 health facilities out of which 769 (94%) are PHC facilities and 40 are SHC facilities. 460 (60%) of the PHC facilities are public owned while the remaining 309 (40%) are private owned PHC (FMOH, 2012). The health indices of the State show an IMR of 55 per 1000 live births and an U5MR of 82 per 1000 (MICS, 2011).

Ondo SPHCDB was introduced after the assent to by the governor on 4th October, 2012 and is headed by an ES.

Main Findings

OSPHCDB had an overall average score of 66% which made them joint 4th best performing State in Nigeria with Yobe State and thus ranking 1st among the six States in the south west geopolitical zone. Their best performance was in Repositioning domain (89%) while their least performance was in MSP domain (11%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 88%

The law establishing the OSPHCDB clearly specifies the role of the governing board as distinct from the role of the management team. The Board has a management team that meets regularly, and is headed by an ES who reports to the Governor through the Honourable Commissioner for Health. Ogun SPHCDB publishes periodic reports as part of their accountability mechanism. However, the governing board is currently dissolved.

Legislation: 80%

A technical committee was constituted to draft the bill, and there was adequate stakeholder engagement to build consensus on key elements before transmitting it to the house. The law establishing Ondo SPHCDB was passed by the State House of Assembly and assented to by the governor in 2012. Although, the Board has drafted its regulations for operationalizing the law, however, there is no evidence to show that these regulations have been signed by the Honourable Commissioner for Health and the law is yet to be gazetted.

Minimum Service Package (MSP): 11%

Ondo State operates some special health projects aimed at improving access to basic health services. However, the State has no costed MSP to guide efficient implementation of PHC programmes.

Repositioning: 89%

The law establishing the SPHCDA in the State clearly transfers all PHC functions from other MDAs to the Agency. At the inception of the Agency, a forum was organised to engage and reorient stakeholders and staffs on the changing roles and responsibilities. The department of PHC at the State ministry of health, ministry of local government and all 21 local government areas in the State have been collapsed into the Agency and its LGHAs. However, the LGSC still promotes staffs of the SPHCDA and pays their salary contrary to the national guidelines on PHCUOR.

Systems Development: 83%

Ondo State primary health care development board has a four-year strategic plan from which she develops her annual operational plans. It was noted that there are specific financial management policies separate from the State civil service financial regulations that guides PHC programs in the State. The SPHCDA consistently plans and carries out ISS visits to health facilities. The institutional structure of the Agency, clearly shows line of accountability and there are laid down guidelines for recruitment of staffs. There was neither evidence of guidelines for operations at all levels nor an operational plan at the LGAs.

Operational Guidelines: 40%

Although the SPHCDA has the capacity to develop and implement its work plan independent of the State ministry of health, the State policy does not provide for HRH, M&E and accounting procedures.

Human Resources: 38%

While Ondo SPHCDA established a human resource committee that looked at the documentation and transfer of PHC human resource, a comprehensive staff audit is yet to be conducted. There is no evidence that an orientation on human resource information system and MSP for the HR committee has been conducted. Neither is there an implementation plan for addressing issues related to mal-distribution of staffs as required. The Agency is yet to develop a costed capacity building plan but is in the process of developing job descriptions for health managers and workers.

Funding Sources and Structure: 70%

At the inception of OSPHCDB, the government released a take-off grant of N50million. This was followed by the establishment of a dedicated budget process that funds planned PHC expenditures in the State and internal/external audits are carried out to track funds released. SPHCDA is able to effectively plan and budget for its activities without external assistance and one of these activities is the planning for the procurement of commodities and other items required at the health facilities for effective health care delivery. There is no evidence that Ondo State has developed a mechanism for Pool Funding for PHC activities as required, further, it was observed that the fund usually allocated to the Agency is not commensurate with its approved plans.

Office Setup: 83%

There are well furnished and equipped office complex being used by the Agency State level. Although there are designated offices at the LGA level for the operations of the LGHA, only 6 out of 18 offices are in use.

The observed strengths, weaknesses, opportunity and threat in the implementation of PHCUOR in Ondo State are:

Strengths:

- Strong political will of the State governor.
- Functional Management team.
- Functional LGHA in some LGAs.

Weaknesses:

- Dissolved governing body of SPHCDA.
- Non-integration of salaries & pensions under the Agency by LGSC.
- Lack of a costed MSP to guide efficient investments in PHC.

Opportunity:

- The World Bank funded NSHIP project provides an opportunity to strengthen PHCUOR implementation in the State.

Threat:

- Lack of collaboration by LGA-level stakeholders on repositioning of PHC in the State.

Recommendations:

- Ensure that all PHC structures, functions and personnel are fully brought under the management of the SPHCDA.
- A costed MSP should be developed to guide PHC investments and management.
- Ensure that the remaining 12 LGHAs begin to utilize their designated offices.

Osun State 8%

Background

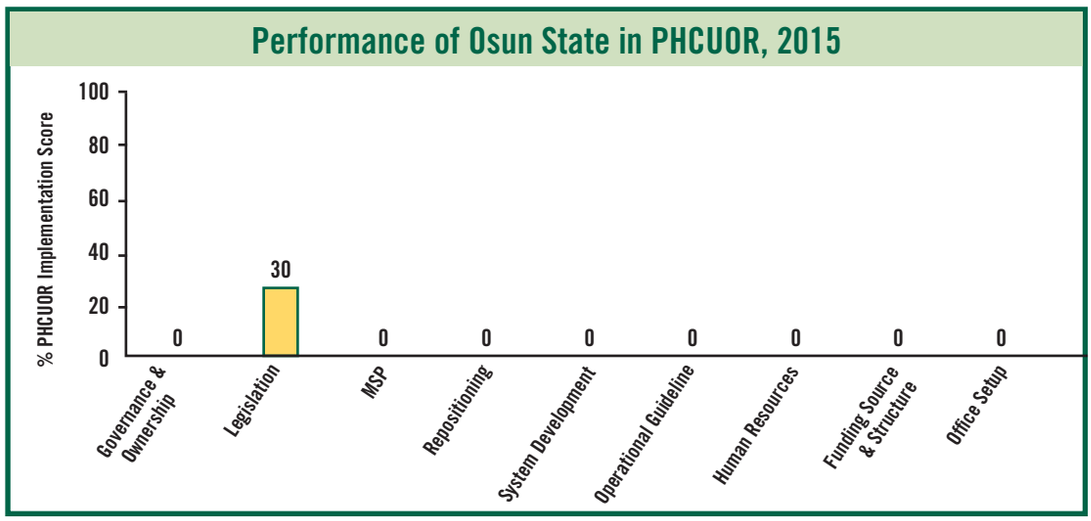
Osun State with its capital city – Osogbo, is in the South Western part of Nigeria. The State was created in 1991 with 31 LGAs. It is bounded by Ondo and Ekiti States to the East, Oyo State to the West, to the north by Kwara State and the south by Ogun State. There is a 2015 projected population of 4,545,609 (NPC, 2006), with a land mass of 9,026km2 (NBS, 2010).

There are a total of 1095 health facilities out of which 1031 (94%) are PHC facilities and 60 are SHC facilities. 678 (66%) are public PHC owned while the remaining 353 (34%) are private PHC providers (FMOH, 2012). The health indices in the State show an IMR of 40 per 1000 and an U5MR of 56 per 1000 respectively (MICS, 2011).

Osun State has not yet established a SPHCDA/B. However, a bill has been passed to the State House of Assembly for deliberations and assent to law before the 3rd quarter of 2016.

Main Findings

The overall score of Osun State in the implementation of PHCUOR is 8% thus placing it 32nd nationally and 6th out of the six States in the South West geopolitical zone of Nigeria. The State has its only performance in the Legislation domain (30%) and zero score in the remaining domains.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 0%
Osun State has not yet established a SPHCDA/B that should oversee the implementation of all PHCUOR activities.

Legislation: 30%
Though the bill establishing the Agency or Board has been drafted and transmitted, with a broad group of stakeholder engagement to build consensus, the draft bill has not yet been passed by the State House of Assembly.

Minimum Service Package (MSP): 0%
Osun State is yet to develop a costed MSP to optimize service delivery and allocation of resources for its PHC activities.

Repositioning: 0%
PHC system remains under various MDAs in Osun State since there is no PHCUOR structure.

Systems Development: 0%
Standard guidelines and protocols for PHCUOR are yet to be implemented in the Osun State.

Operational Guidelines: 0%
Osun State is yet to adopt national guidelines for integrated PHC governance.

Human Resources: 0%
PHC HRH is yet to be repositioned in line with PHCUOR policy thus PHC staffs are managed in a disjointed system under SMOH, MLOG and LGSC leading to poor delivery of PHC services.

Funding Sources and Structure: 0%
There is no integrated PHC funding system in Osun State.

Office Setup: 0%
The national guidelines on PHCUOR require States to provide well equipped offices at the State and sub-State levels for the operation of the SPHCDA and LGHAs respectively.

Recommendations:

- Osun State government should prioritize PHCUOR implementation by speeding up the passage of the bill before the State House of Assembly.

Oyo State 8%

Background

Oyo State is located in the South-West geopolitical zone of Nigeria and its capital city is Ibadan. It was created in 1976 and has an area mass of 26,500 km2 (NBS, 2010). The State has a 2015 projected population of 7,554,750 (NPC, 2006) spread across its 33 LGAs. It is bounded by Osun State to the East, Republic of Benin to the West, Kwara State to the North and Ogun State to the South.

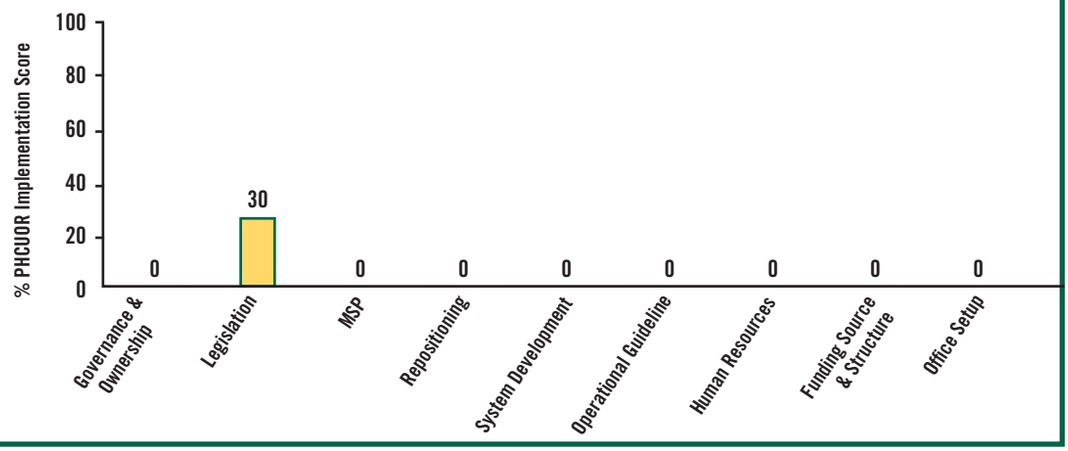
There are 1237 HF in the State out of which 763 (62%) are PHC facilities and 470 are SHC facilities. 677 (89%) of the PHCs are public owned while 86 (11%) are private owned (FMOH, 2012). Oyo State has an IMR and U5MR of 70 and 110 per 1000 respectively (MICS, 2011).

The State is yet to establish its SPHCDA as the bill seeking the establishment of the Agency was presented to the State House of Assembly in July 2015.

Main Findings

Oyo State has an overall score of 8%. Consequently, the State jointly ranked 32nd nationally with Osun and Imo States nationally and 6th in the geopolitical zone. It only has a score in the Legislation domain (30%).

Performance of Oyo State in PHCUOR, 2015



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 0%
The State is yet to establish SPHCDA that will be responsible for the governance of all PHC structures in Oyo State in accordance with national guidelines.

Legislation: 30%
Although Oyo State has drafted the SPHCDA bill and transmitted it to the State House of Assembly, there was no evidence that stakeholders were engaged to build consensus on the key element of the bill.

Minimum Service Package (MSP): 0%
There is no costed MSP in Oyo State.

Repositioning: 0%
Oyo State is yet to consolidate the fragmented PHC structures present in various MDAs.

Systems Development: 0%
There is no system of integrated PHC governance in Imo State.

Operational Guidelines: 0%
The national manual on PHCUOR can be adapted and used to guide the implementation of this reform.

Human Resources: 0%
PHC human resource are currently scattered in the various MDAs with PHC department.

Funding Sources and Structure: 0%
Funding of PHC activities in the State is currently through the MDAs where the PHC departments are domiciled.

Office Setup: 0%
The State government is yet to designate an office for SPHCDA activities at the State and Sub-State levels.

The observed strength and weakness in the implementation of PHCUOR in Oyo State are:

Strengths:

- The SPHCDA bill has been sent to the State House of Assembly.

Weaknesses:

- There was no evidence of stakeholder engagement to build consensus around key element of the bill before it was sent to the State House of Assembly.

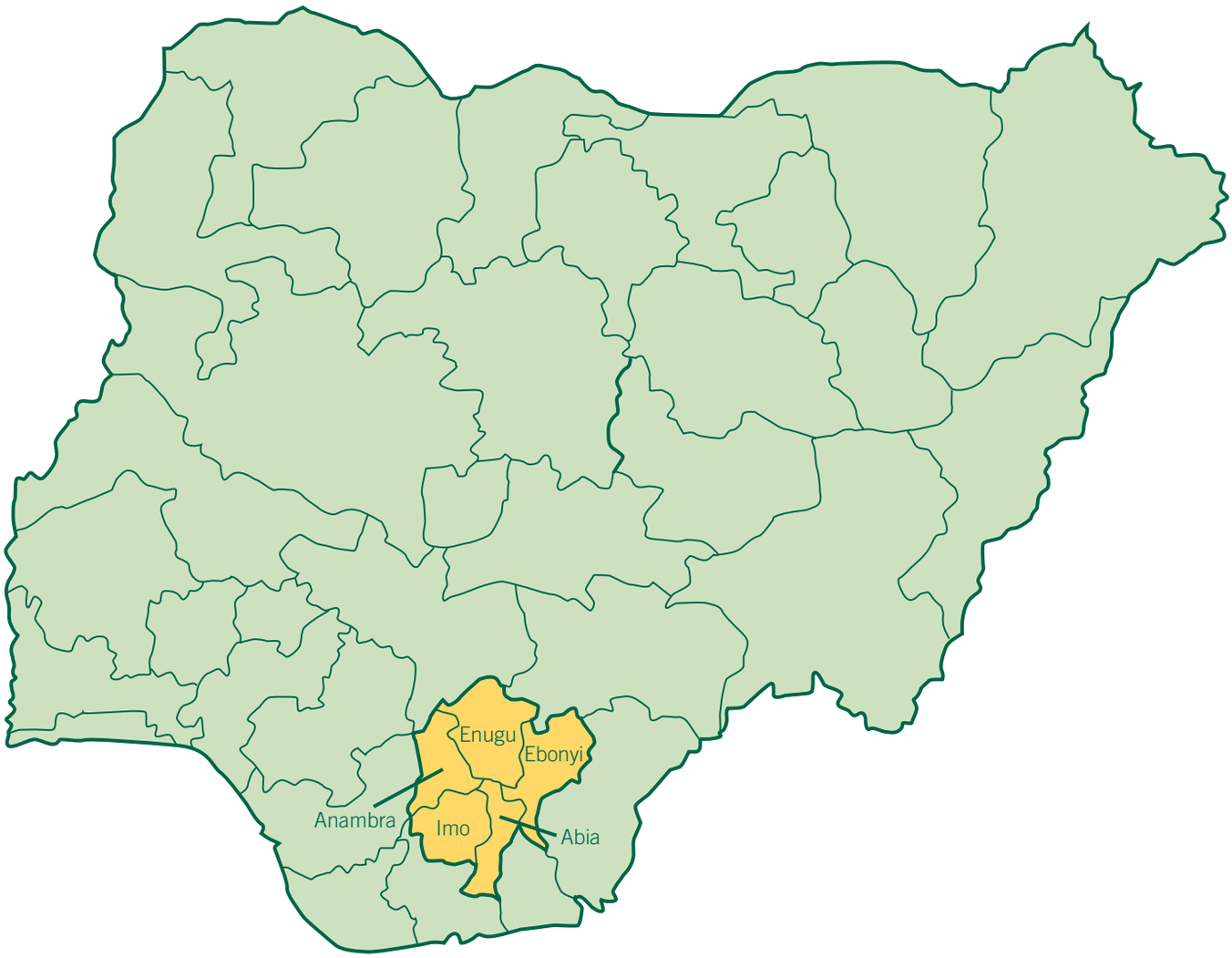
Opportunity:

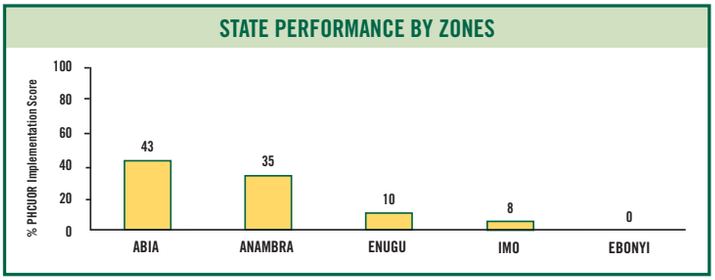
- Partners available to provide support for the reform.

Recommendations:

- Advocacy to the Oyo State legislative arm of government to ensure timely passage of the SPHCDA bill.

SOUTH EAST ZONE 19%





Abia State 43%

Background

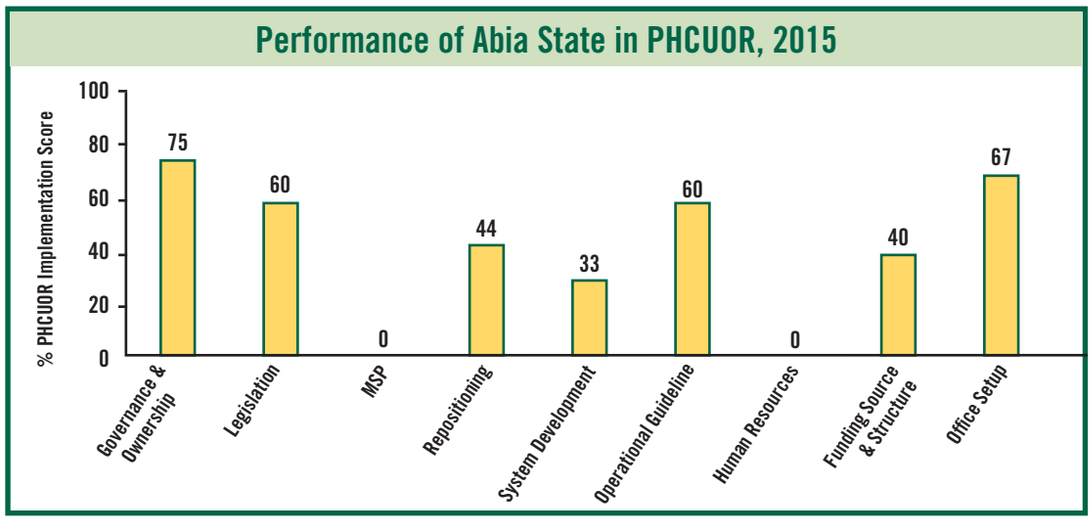
Abia State is in the South Eastern part of Nigeria, created in 1991 from part of Imo State. The capital is Umuahia and the major commercial city is Aba. The State has an estimated population of about 3.6 million people (Projected NPC 2015), a land mass of 4,900km2 (NBS, 2010), 17 LGAs and 147 Wards. It is bounded in the East and South East by Akwa Ibom and Cross River States, in the West by Imo State, in the North and the North East by Anambra, Enugu and Ebonyi States, and in the South by Rivers State.

The total number of health facilities in the State is 615 out of which 518 (84%) are PHC facilities and 96 are SHC facilities. 481 (93%) of the PHC facilities are public owned while the remaining 37 (7%) are privately owned (FMOH, 2012). The health statistics of Abia State shows an IMR and U5MR of 74 and 116 per 1,000 respectively (MICS, 2011).

Abia State commenced the implementation of PHCUOR in 2012 while the bill which led to the establishment of SPHCDA from the PHC department of SMOH, was passed in May 2015.

Main Findings

Abia State has an overall score of 43%, which placed it 18th nationally and 1st out of the 6 States in the South East geo-political zone. The State has its best performance in Governance & Ownership (75%) and least in Human Resource and MSP with a zero score.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%

Abia SPHCDA has a designated building for its operations with an organogram that has a management team headed by an ES who is appointed by the Executive Governor and reports through the Commissioner for Health. The top management of SPHCDA in the State has key officers and holds their meeting monthly. Although there is no Governing Board for the agency, the law establishing SPHCDA defines the roles of the Governing Board as distinct from that of the management. During the assessment, there was no submitted evidence of monthly, quarterly or annual report as an accountability mechanism.

Legislation: 60%

Having established a technical committee that drafted the bill, there was stakeholders' engagement to review and build consensus around the key elements of the bill. The bill was then transmitted to the State House of Assembly, passed in May 2015 and assented to by the State Governor. However, the Law has not been gazetted and the SPHCDA is yet to develop regulations for operationalizing the Law..

Minimum Service Package (MSP): 0%

The State has not developed a costed MSP that classifies the different services provided by the various health facilities which can be used as a basis for resource mobilization and allocation.

Repositioning: 44%

The law that established Abia SPHCDA clearly transfers all functions of PHC from SMOH, MOLG, LGSC and LGA to SPHCDA and defines their new roles and responsibilities. Managers and personnel in the Agency understand what their new roles and responsibilities are in relation to the new structure. However, there was no evidence of minute of meeting of different stakeholders' forum discussing the changing roles and responsibilities after the SPHCDA was established. Also, the department of PHC still exists under the control of SMOH, MOLG, LGSC and LGA.

Systems Development: 33%

The SPHCDA has an annual operational health plan at the State and LGA levels. They also have an ISS plan, though there was no evidence of its implementation. There are guidelines for recruitment into the SPHCDA. The State and sub-State structures show lines of accountability. There are guidelines and protocols for operations at different levels.

There was no evidence of Strategic Health Development Plan for the State. The State does not have financial management policies separate from the civil service financial regulations to guide its programs.

Operational Guidelines: 60%

The State policy on PHCUOR has provisions for HRH, M&E, Accounting and other procedures. The Agency has the capacity to carry out its operations independent of SMOH. There is no evidence that key personnel (management team) were trained on the mandate of SPHCDA using the State policy guidelines. The State is yet to adapt the national implementation manual on PHCUOR for its use.

Human Resources: 2%

The State has established a HRH department with requisite staff though there is no evidence of PHC staff audit and development of PHC HRH database. All staff providing PHC services at health facilities are employees of SPHCDA. Abia State is yet to establish a high level Human Resource Committee for documentation and transfer of all PHC human resources in the State. There is neither an Implementation plan for managing issues related to mal-distribution of staff nor a job description for health facility managers. Abia SPHCDA has no clear procedure for recruiting staff and a costed capacity building plan to address staff needs.

Funding Sources and Structure: 40%

The SPHCDA is able to effectively plan and budget for its activities without external assistance which includes procurement of commodities and other items required by PHCs. There is a dedicated budget process and fund release for planned PHC expenditures and a system that tracks fund release but little fund has been released since the creation of the Agency. There is no evidence of joint funding for implementing PHC programmes and services in line with the provisions of implementing MSP. Salaries, pensions and other benefits of PHC workers are not paid by the Agency.

Office Setup: 68%

Abia has a designated office for SPHCDA operation at the State level but none at the LGA level. The office is furnished with basic amenities and operational vehicles provided for PHC duties.

The observed strengths, weaknesses, opportunities and threats in the implementation of PHCUOR in Abia State are:

Strengths:

- Existence of SPHCDA law.
- A clear management structure.
- Furnished office structure at the State level.

Weaknesses:

- The law establishing Abia SPHCDA has not been gazetted.
- Lack of governing board for PHC operations.
- Non-existence of LGHA.

Opportunities:

- Strong political will of government.
- Availability of development partners and civil coalition.
- Presence of operational plan at the State level.
- Availability of skilled human resource for PHC operations.

Threats:

- Presence of PHC departments in other government agencies.
- Poor funding for PHC activities.
- Unavailability of published reports to buttress accountability mechanism.

Recommendations:

- State government needs to set up a governing board with balanced inclusion of relevant stakeholders.
- Need to ensure regular publications of reports by SPHCDA to show evidence of performance of PHC responsibilities.
- State should develop regulations to clearly define the requirements of the law and its gazetting for operationalization.
- The State should get a costed MSP for its PHC operation.
- All PHC functions and departments should be completely detached from the various government agencies and collapsed into SPHCDA.
- Quick implementation of system issues such as mechanism for implementing ISS, capacity building plan for HRH, financial management policy and Operational Guidelines for sub-State structures.
- Develop mechanism for joint funding of PHC activities through contribution from source to enhance increased funding.
- Strengthen the human resource department of SPHCDA by developing job descriptions, clear recruitment procedures and plan for addressing staff mal-distribution.
- Set up and equip LGHA in each of the 17 LGAs in the State.

Anambra State 35%

Background

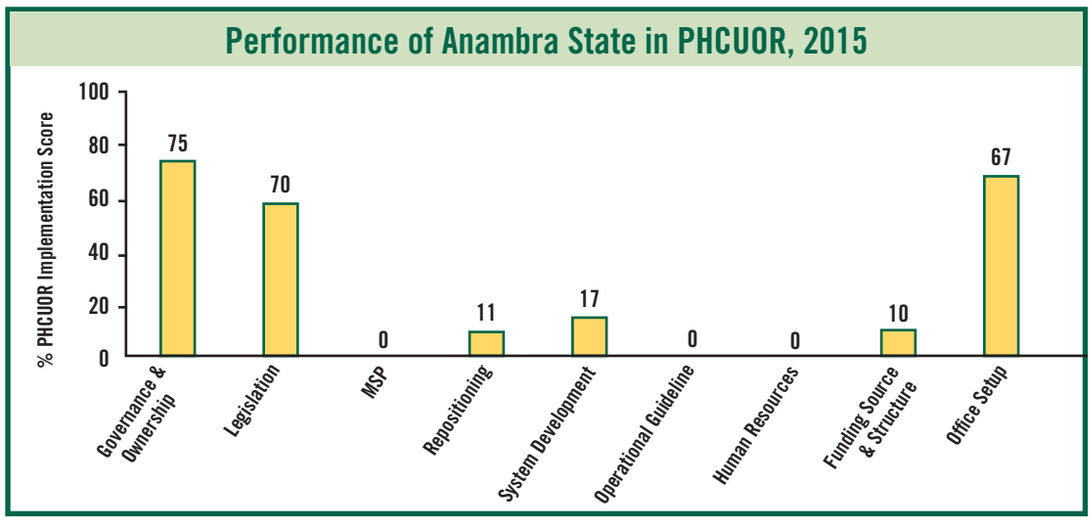
Anambra State is located in the South East geo-Political zone of Nigeria. It was created on 27 August, 1991 with Awka as the State capital. The State has 21 LGAs and commonly referred to as "Light of the Nation". It has a 2015 projected population of 5,361,982 (NPC, 2006) spread over a land mass of 4,865km2 (NBS, 2010). It is bounded by Enugu State to the East, Delta State to the West, Kogi State to the North with Imo and Rivers States to the South.

There are 1,485 health facilities in the State of which 1,360 (92%) are PHC facilities, consisting of 392 public and 968 private PHC facilities (FMOH, 2012). The State has an IMR of 71/1000 and U5MR of 111/1000 (MICS, 2011).

The implementation of PHCUOR in the State commenced in 2011 with the presentation of a bill to the State House of Assembly. The bill was eventually passed in 2014 and assented to by the Governor and gazetted in 2015. However, this process has been halted by a court action instituted by some categories of health workers.

Main Findings

Anambra State came 24th nationally with an overall score of 35% and 2nd in the south East geopolitical zone. The State performed well in Governance & Ownership domain (75%) and least with zero scores in MSP, Operational Guidelines and Human Resource domains.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%
Anambra State has a functional governing board with a management team headed by an ES, but key officers are yet to be deployed. There is an organogram which shows lines of responsibilities and accountability.

Legislation: 70%
The Law establishing Anambra SPHCDA was passed in 2011 after wide consultation with stakeholders to build consensus on key aspect of the bill drafted by a technical team. The law came into effect in 2015 and has been gazetted. However, the regulation is yet to be drafted.

Minimum Service Package (MSP): 0%
The State is yet to develop a costed MSP to guide the allocation and distribution of resources for PHC activities.

Repositioning: 11%
Although the law establishing the agency in the State clearly transfers all PHC functions to the SPHCDA, this provision of the law is yet to be implemented as the impending court injunction restrained the agency from further actions. There has not been any forum for engaging the different stakeholders to discuss the changing roles and responsibilities following the establishment of SPHCDA in the State.

Systems Development: 0%
There is no system of integrated PHC governance in Anambra State.

Operational Guidelines: 0%
The State is yet to develop Operational Guidelines or policy to guide the implementation of PHCUOR.

Human Resources: 0%
The recently established Anambra SPHCDA is yet to establish a HRH department or unit with requisite staff. Furthermore, the State is yet to establish a high level HRH committee for the transfer of PHC staff from parallel management structures.

Funding Sources and Structure: 10%
The law establishing the SPHCDA provides a 60/40 funding ratio from the LGA and the State government respectively, but this is yet to be implemented. Moreover, the agency is yet to receive a take-off grant.

Office Setup: 67%
Anambra SPHCDA has a designated office structure at the State level and equipped for its activities. The existing PHC departments at LGA level is required by law to be converted to LGHA offices but this is yet to be implemented.

The observed strengths, weaknesses, opportunities and threat in the implementation of PHCUOR in Anambra State are:

Strengths:
- Existence of SPHCDA law.
- Presence of a governing board and an appointed ES.
- Furnished office structure at the State level.

Weaknesses:
- Full management team yet to be constituted.
- No regulations to operationalize the SPHCDA bill.
- Insufficient stakeholder engagement.

Opportunity:
- Strong political will.
- Presence of development partners and civil coalition.

Threat:
- PHCUOR implementation stagnated by a court case instituted by aggrieved health workers.

Recommendations:
- Institute broader stakeholder engagement to resolve all grievances and build consensus on PHCUOR implementation.
- The management team should be fully constituted.
- The State should seek assistance for the development of a costed MSP.
- Provide adequate funding for SPHCDA operations.

Ebonyi State 0%

Background

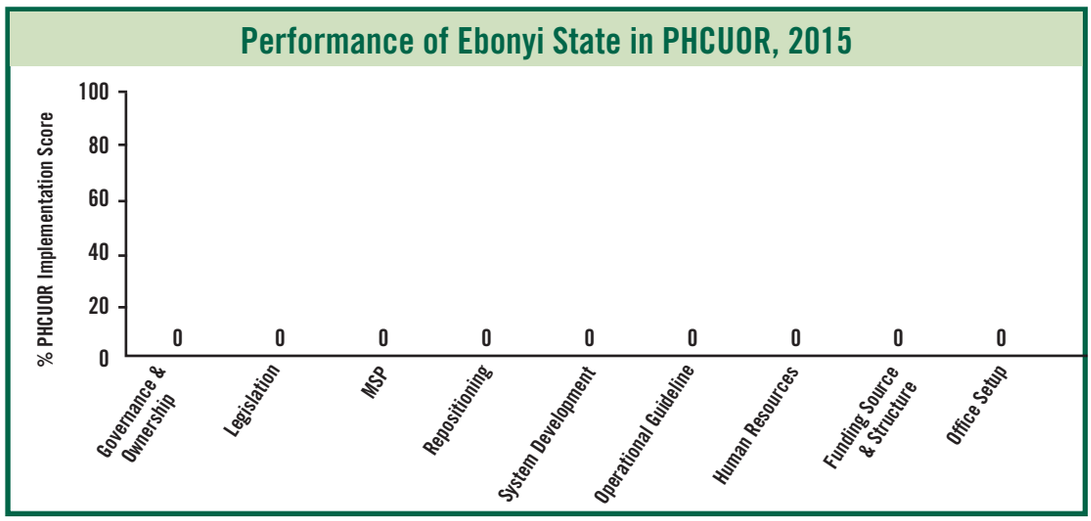
Created on the 1st October 1996 from Enugu and Abia States, Ebonyi State has its capital city as Abakaliki. It is one of the six States in the South-East geo political zone and has a landmass of 6,400km2 (NBS, 2010). The 2015 projected population is 2,786,749 (NPC, 2006), spread across 13 LGAs of the State.

There are a total of 567 health facilities out of which 516 (91%) are PHC facilities. There are 383 (74%) public and 133 (26%) private PHC facilities (FMOH, 2012). Ebonyi State has an IMR of 77/1000 and U5MR of 122/1000 (MICS, 2011).

Ebonyi State is yet to commence the implementation of PHCUOR.

Main Findings

The State had no score in all domains, making it one of the least performing States nationally.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 0%
Ebonyi State has not established a SPHCDA to coordinate all PHC activities.

Legislation: 0%
A bill for the establishment of a SPHCDA in the State is yet to be drafted.

Minimum Service Package (MSP): 0%
Ebonyi State has no costed blueprint to optimize PHC service delivery.

Repositioning: 0%
The repositioning of PHC governance in the State is yet to commence.

Systems Development: 0%
Standard guidelines and policies for PHCUOR implementation are yet to be instituted in Ebonyi State.

Operational Guidelines: 0%
The State is yet to adopt national guidelines for integrated PHC governance.

Human Resources: 0%
The PHC HRH structure in the State is still fragmented.

Funding Sources and Structure: 0%
The non-implementation of PHCUOR is a setback for sustainable PHC financing in the State.

Office Setup: 0%
There is no office structure for integrated PHC governance both at State and sub-State levels.

Recommendations:

- A technical committee should be urgently constituted to commence the process of implementation of PHCUOR in the State which starts with the drafting of the SPHCDA bill.

Enugu State 10%

Background

Enugu State was created on the 27th of August, 1991 and is located in the South-East geo-political zone of Nigeria lying between Latitude 6o 30' North and Longitude 7o 30' East. Its capital town is Enugu. The State shares boarders with Ebonyi State to the East; Anambra State to the West; Benue State to the North-East, Kogi to the North West; Abia and Imo States to the South. Based on the 2006 National Population Census, Enugu State has a projected 2015 population of 4,250,035 (NPC, 2006) and covers a land size of 7,534 Km2 (NBS, 2010). It has a total of 17 LGAs.

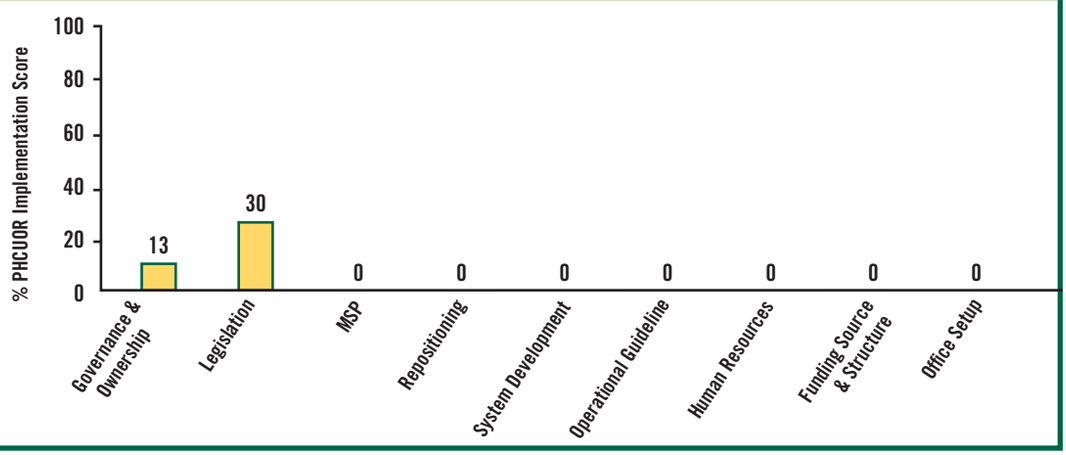
Enugu State has a total of 868 health facilities across. Of this number, 524 (60%) are PHC and 342 (39%) SHC facilities. Of the 871 PHC facilities, 322 (37%) are public owned. The remaining 549 (63%) are private providers (FMOH, 2012). The State's health indices reveal an IMR of 81/1000 and U5MR of 129/1000 (MICS, 2011).

The State has a non-functional District Health System.

Main Findings

Enugu State with an overall score of 10%, ranked 31st nationally and 3rd in the South-east geopolitical zone. The State has its only score in the domains of Governance & Ownership (13%) and 30% Legislation, while it scored zero in all other domains.

Performance of Enugu State in PHCUOR, 2015



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 13%

There is currently no SPHCDA in Enugu State. The State-operated District Health Board does not give the full compliments of PHCUOR.

Legislation: 30%

Enugu State has drafted a bill for the establishment of a SPHCDA having consulted widely with stakeholders. However, the bill is yet to be presented to the State House of Assembly.

Minimum Service Package (MSP): 0%

The State has no costed Minimum Service Package.

Repositioning: 0%

Since there was no operational SPHCDA at the time of assessment no issue relating to repositioning was carried out.

Systems Development: 0%

The State has no current functional PHC Plan.

Operational Guidelines: 0%

No Operational Guidelines were developed for use in managing PHCs.

Human Resources: 0%

No human resource committee for transfer of HRH has been established.

Funding Sources and Structure: 0%

There is no integrated PHC funding system in Enugu State.

Office Setup: 0%

Currently the State and sub-State levels have no building or structure for operationalizing integrated PHC governance.

TThe observed strengths, weaknesses, opportunities and threat in the implementation of PHCUOR in Enugu State are:

Strengths:

- There is a draft bill for the establishment of Enugu SPHCDA.
- The State workforce has good experience from the District Health Board to be able operationalize SPHCDA.

Weaknesses:

- Delay in presentation of the SPHCDA bill to the State House of Assembly for deliberation.
- No costed MSP to guide PHC resource allocation.
- No guidelines for PHC Human resource management.

Opportunities:

- Ready workforce to implement PHCUOR.
- High level of PHCUOR awareness in the State House of Assembly.

Threat:

- Conflict of interests among stakeholders may threaten PHCUOR implementation.

Recommendations:

- Facilitates legislative processes towards implementing PHCUOR.
- Finalize the legal framework for the operationalization of the SPHCDA including the guidelines on human and financial resources.
- Involve all key stakeholders and office holders in the process for the establishment of the Enugu SPHCDA, especially the Permanent Secretary of SMOH.

Imo State 8%

Background

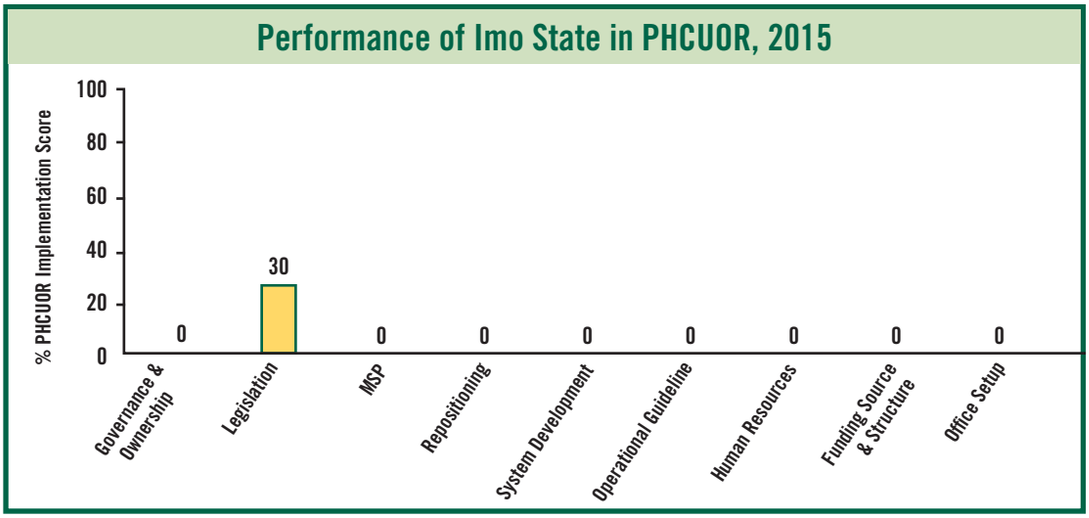
Imo State, the eastern heartland was created on 3rd February, 1976 and has Owerri as its capital city. It is one of the five States in the south east geopolitical zones of Nigeria and bounded to the east by Abia State, to the west by Delta State and the River Niger, to the north by Anambra State and to the south by Rivers State. The State has a total 2015 population of 5,224,573 projected from 2006 census (NPC, 2006), a total land size 5,288km2 (NBS, 2010) and made up of 18 local government areas.

There are 1337 health facilities in the State of which 805 (60%) are PHC facilities, 530 (40%) are SHC. The government owns 416 (52%) of all PHC facilities in the State while there are 389 (48%) privately owned (FMOH, 2012). The health indices of the State show that out of every 1000 children born in Imo State, 116 infants will die before their 1st year birthday and 194 children will not see their 5th birthday (MICS, 2011).

Imo State is yet to establish SPHCDA.

Main Findings

Imo State scored 8% overall which place it on the 32nd position nationally and 4th out of the 5 States in the South East geopolitical zone. Its only performing domain was legislation where it scored 30%.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 0%
Imo State is yet to set up SPHCDA.

Legislation: 30%
A technical committee setup for the drafting of the SPHCDA bill came up with the first draft following stakeholder engagements and consensus building on key aspects of the bill. The bill is yet to be transmitted to the State House of Assembly at the time of this assessment.

Minimum Service Package (MSP): 0%
Imo State is yet to adopt a costed MSP.

Repositioning: 0%
Management of PHC in Imo State is still fragmented.

Systems Development: 0%
There is no system of integrated PHC governance in Imo State.

Operational Guidelines: 0%
Guidelines on PHCUOR are yet to be adopted by the State.

Human Resources: 0%
HRH in Imo State is yet to be coordinated under a single authority.

Funding Sources and Structure: 0%
PHC financing in Imo State is yet to be appropriately coordinated for efficiency in line with national policy.

Office Setup: 0%
There are no designated offices for SPHCDA and LGHAs in Imo State.

The observed strength, weakness, opportunity and threats in the implementation of PHCUOR in Imo State are:

Strength:

- A technical committee in place for drafting the SPHCDA bill.

Weakness:

- Nonexistence of an SPHCDA law.

Opportunity:

- Available partners to support PHC.

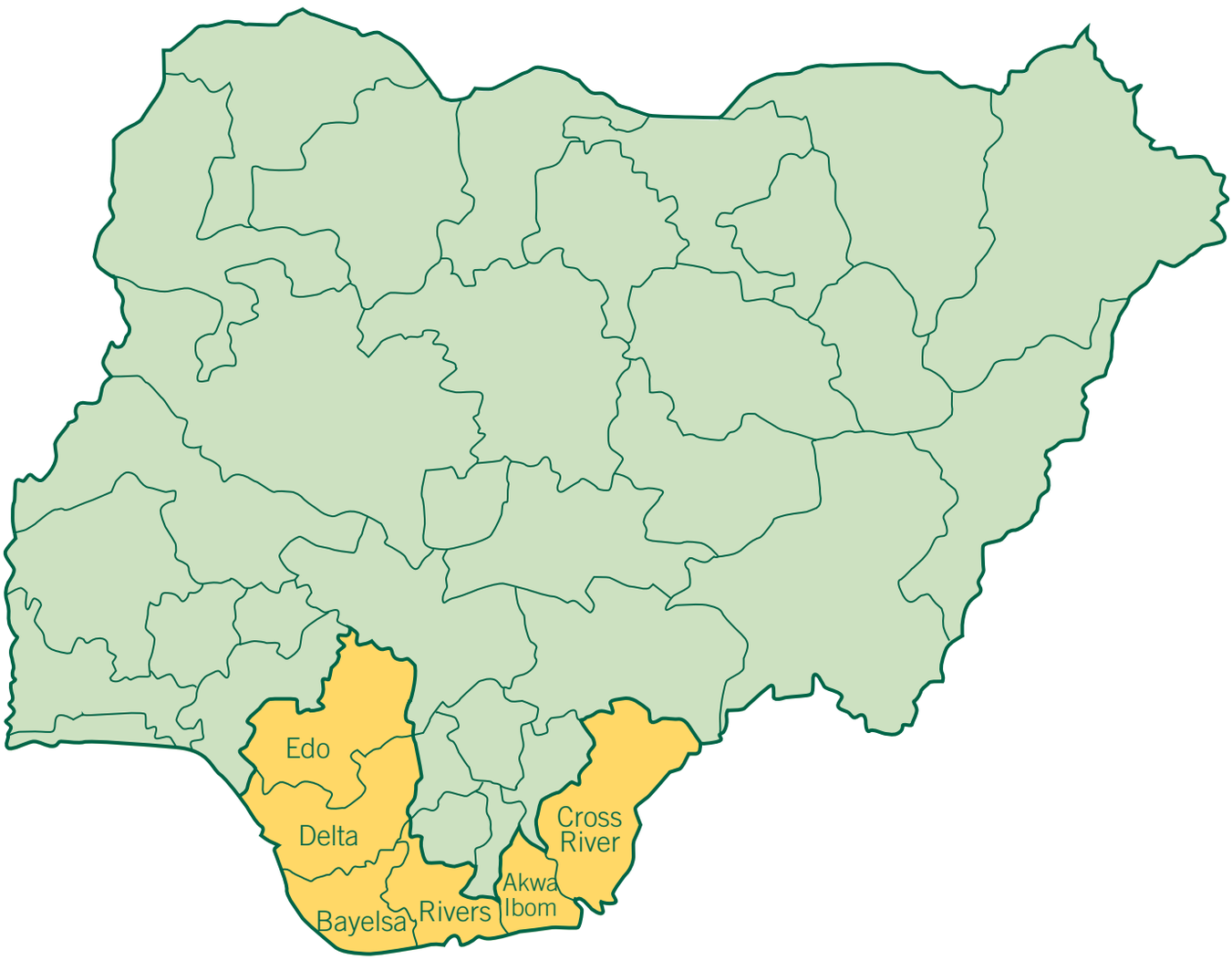
Threats:

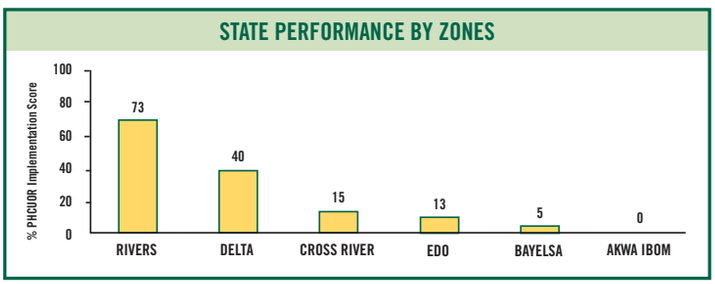
- Poor political will to drive PHCUOR implementation.
- Plans by State government to privatize all PHC facilities in the State is a threats to equitable access to basic health services.

Recommendations:

- The State government should prioritize PHC reforms by first transmitting the SPHCDA bill to State House of Assembly as an executive bill.
- In the spirit of ensuring universal access to basic health services, the State government should be encouraged to halt ongoing plans to privatize PHC.

SOUTH SOUTH ZONE 24%





Akwa Ibom State 0%

Background

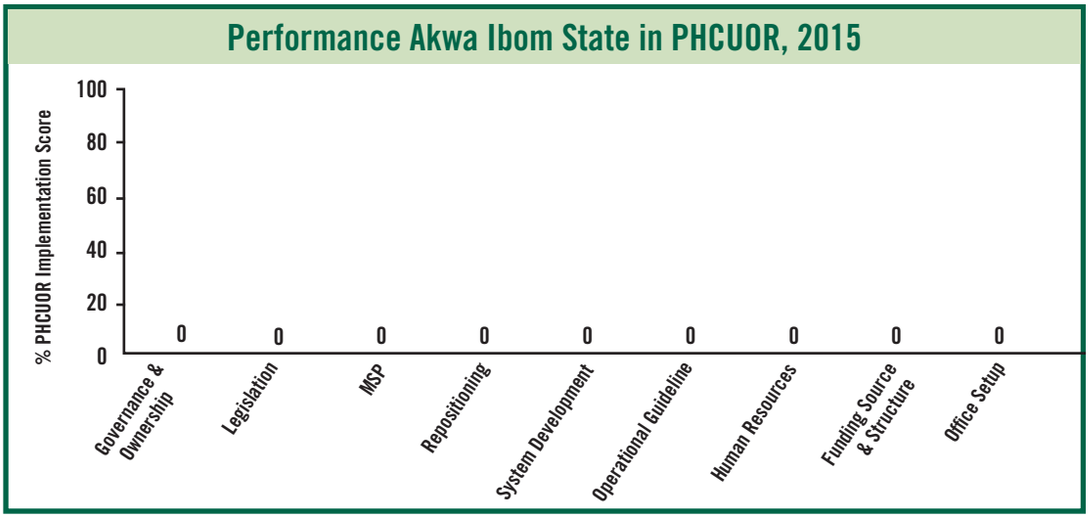
Akwa Ibom State was created on the 23rd September, 1987 out of Cross-River State. It is situated in the South-South geo-political zone of the Federal Republic of Nigeria. The State has a land mass of 6,900km2 (NBS, 2010) and a 2015 projected population of 5,296,561 (NPC, 2006). The State has 31 LGAs with Uyo as its capital city.

There are a total of 543 health facilities in the State out of which 355 (65%) are PHCs (FMOH, 2012). Akwa Ibom State has an infant mortality rate of 72/1,000 and an under-five mortality rate of 113/1,000 (MICS, 2011).

The primary healthcare board has not yet been established in Akwa Ibom State but a memo has been presented to the State Executive Council for consideration.

Main Findings

Akwa Ibom had an overall zero score.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 0%

The State has not yet established a State Primary Health Care Board (SPHCB) that should oversee the implementation of all PHC activities.

Legislation: 0%

The State is yet to draft a bill for the establishment of a SPHCDA which is the first step in the implementation of the PHCUOR.

Minimum Service Package (MSP): 0%

Akwa Ibom State has no MSP which is the blueprint for organizing the health sector to optimize service delivery and quality.

Repositioning: 0%

Since there is no PHCUOR structure in the State Primary Health Care remains fragmented under different lines of authority.

Systems Development: 0%

Standard guidelines and policies for PHCUOR are yet to be instituted in the State.

Operational Guidelines: 0%

Akwa Ibom State is yet to adopt national guidelines for integrated PHC governance.

Human Resources: 0%

Human Resource for PHC in Akwa Ibom State is still under SMOH, MLOG and LGSC leading to poor delivery of PHC services.

Funding Sources and Structure: 0%

The unstructured PHC system is a disincentive for sustainable PHC financing in the State.

Office Setup: 0%

Since there are no formal steps to implement PHCUOR, the government has not set up an office.

Recommendations:

- A technical committee should be urgently constituted to commence the process of implementation of PHCUOR in the State which starts with the drafting of the SPHCDA bill.

Bayelsa State 5%

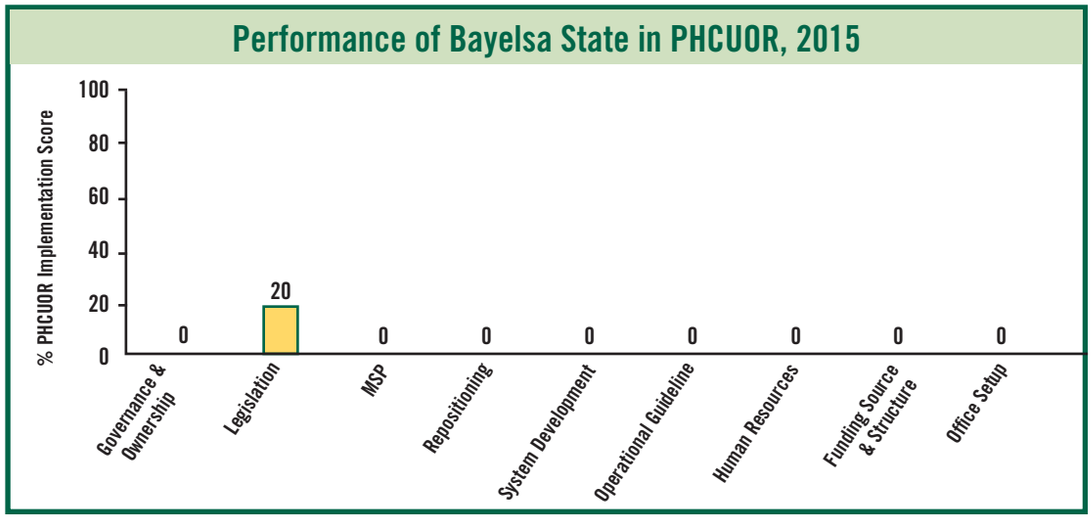
Background

Bayelsa State is one of the six States that make up Nigeria's South-South geopolitical zone. It has interState boundaries with Rivers State to the East and North East, Gulf of Guinea to the West and South, and Delta State to the North. In 1996, Bayelsa State, with capital – Yenagoa, was carved out of Rivers State. The State covers an area of 9,059 Km2 (NBS, 2010) distributed across the 8 LGAs of the State. The 2015 projected population for the State is 2, 203,151 (NPC, 2006).

A total of 232 health facilities are. Of this number, 172 (74%) are PHC facilities and 59 (25%) are SHC facilities. All the 172 PHC facilities are public owned (FMOH, 2012). The health indices show an IMR and U5MR of 107 and 178 per 1000 respectively (MICS, 2011).

Main Findings

With an overall score of 5%, Bayelsa is the 3rd least performing State nationally and 5th in the South-South zone. The only domain Bayelsa State has a score is in Legislation (20%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 0%
Bayelsa State is yet to establish a SPHCDA that should oversee the implementation of all PHC activities.

Legislation: 20%
Though a Bill to establish the State's PHCDA has been drafted and has reached the State House of Assembly, it has yet to be passed by the legislative arm of the government.

Minimum Service Package (MSP): 0%
The State has no costed MSP which is the blueprint for organizing the health sector to optimize service delivery and quality.

Repositioning: 0%
The non-implementation of PHCUOR in the State means that PHC governance remains fragmented under different lines of authority.

Systems Development: 0%
Standard guidelines and policies for PHCUOR are yet to be instituted in the State.

Operational Guidelines: 0%
Bayelsa State is yet to adapt the national guidelines for PHCUOR implementation.

Human Resources: 0%
In Bayelsa State, PHC HRH is yet to be repositioned in line with PHCUOR policy thus staff are managed in a fragmented system under SMOH, MLOG and LGSC.

Funding Sources and Structure: 0%
The non-implementation of PHCUOR is an impediment for sustainable PHC financing in the State.

Office Setup: 0%
The national guidelines on PHCUOR require States to provide furnished offices at the State and sub-State levels for the operation of the SPHCDA and LGHAs respectively.

The observed strength and weakness in the implementation of PHCUOR in Bayelsa State are:

Strength:

- The SPHCDA Bill has been sent to the State House of Assembly.

Weakness:

- The delay in the passage of the SPHCDA Bill.

Recommendation:

- The State government should prioritize PHCUOR implementation by facilitating the passage of the bill before the State House of Assembly.

Cross River State 15%

Background

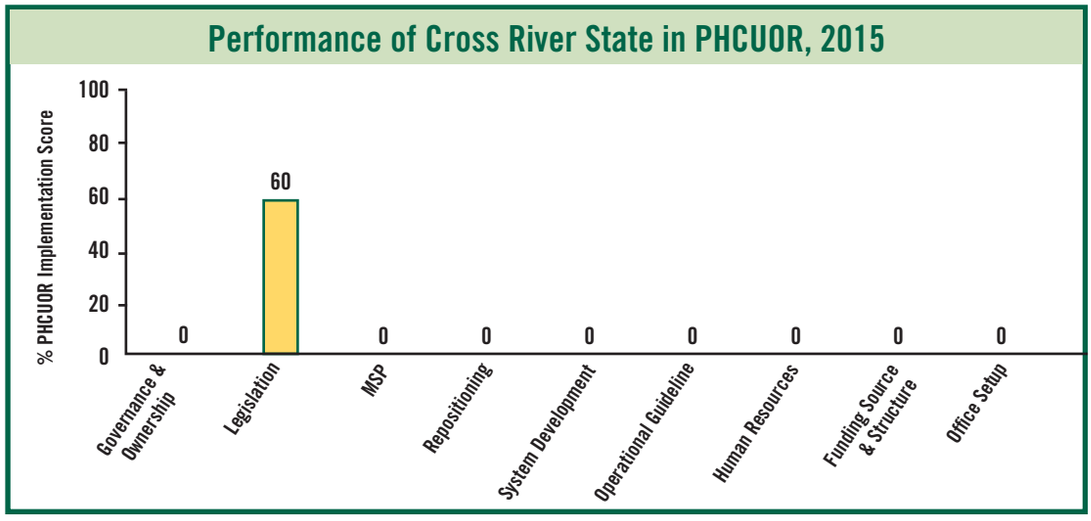
Cross-River State is one of the six States in the South-South geopolitical zone of Nigeria. The State has 18 LGAs and its capital city is Calabar. The State was created in 1967 from the former Eastern region of Nigeria and has a land size of 21,787 km2 (NBS, 2010). The State is bordered with the Republic of Cameroun to the East, Ebonyi and Abia States to the West, Benue and Akwa Ibom States to the North and South respectively. The State has a 2015 total population of 3,736,637 projected from 2006 census (NPC, 2006).

A total of 734 health facilities exist in the State out of which 593 (81%) are PHC facilities. 139 (19%) are SHC facilities. 575 (97%) are public and 18 (3%) are private facilities (FMOH, 2012). The State has an IMR of 80/1000 and U5MR of 127/1000 (MICS, 2011).

The State has no SPHCDA or recognizable equivalent rather, the "Department of Community and Primary Health Care" supported by Tulsi Chanrai Foundation, currently coordinates PHC in the State. Cross River State started the process of integrating PHC governance in 2011.

Main Findings

With an assessment score of 8%, the State ranked 29th out of 37 States in the Federation and 3rd in its geopolitical zone. The only domain the State had a score was Legislation (60%) due to its current efforts to amend the law.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 0%

The State is yet to establish the SPHCDA or its equivalent to drive the implementation of all PHC activities in accordance with national policy and guidelines.

Legislation: 60%

Cross River State has drafted a bill following a series of consultations with a broad group of stakeholders to gain consensus. The bill has been passed by the House of Assembly and is awaiting the Governor's assent.

Minimum Service Package (MSP): 0%

The State is yet to adopt costed MSP to optimize service delivery and quality.

Repositioning: 0%

No PHCUOR structure has been established yet and as a result there have been no shifts in roles and responsibilities across the different PHC agencies.

Systems Development: 0%

The State is yet to establish an integrated PHC governance system.

Operational Guidelines: 0%

Cross River State does not have the necessary guidelines in place for the implementation of PHCUOR.

Human Resources: 0%

PHC HRH is yet to be repositioned in line with PHCUOR policy thus staff are managed in a fragmented system under SMOH, MLOG and LGSC.

Funding Sources and Structure: 0%

There is currently no joint funding mechanism in the State.

Office Setup: 0%

Since SPHCDA is yet to be established, the government is yet to setup offices at the State and sub-State levels.

The observed strength, weakness, opportunity and threat in the implementation of PHCUOR in Cross River State are:

Strength:

- Ongoing effort to amend a law to establish SPHCDA.

Weakness:

- The non-conformity of the amended bill to national guidelines.

Opportunity:

- A new government in place to enliven PHC reforms.

Threat:

- The institutionalizing of the department of community health as a perceived equivalent of SPHCDA.

Recommendation:

- Ensure that the amended SPHCDA bill is in line with the national implementation guidelines on PHCUOR, followed by a quick assent by the governor and subsequent implementation of other aspects of this policy.

Delta State 40%

Background

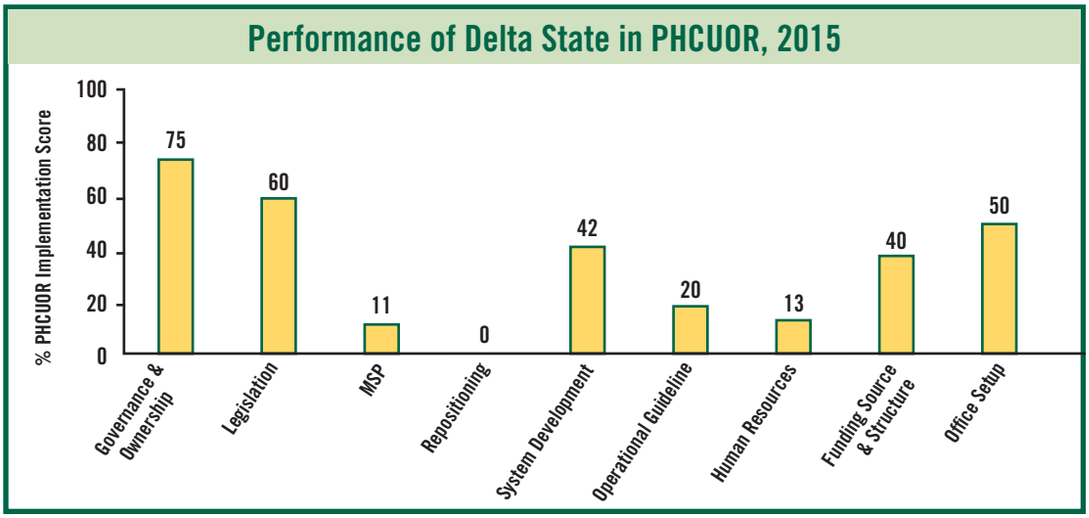
Delta State is located in the oil rich Niger Delta region of Nigeria and the South South Geo-political Zone. The State with its capital city – Asaba, was created on 27 August, 1991 from the old Bendel State. It has 25 LGAs, a landmass of about 17,108 km² (NBS, 2010), and a 2015 projected population of 5,441.650 (NPC, 2006).

Delta State has a total of 908 health facilities out of this 804 (89%) are PHC facilities and 102 (11%) are SHC Facilities. Out of the 820 PHC facilities in the State, 437 (53%) are publicly owned and 383 (47%) are privately owned (FMOH, 2012). Delta State has an U5MR of 112/1000 and an IMR of 72/1000 (MICS, 2011).

The enactment of the PHC Agency/Authority Law on the 17th day of November 2004 marked the commencement of the implementation of PHCUOR in Delta State.

Main Findings

With an overall score of 40%, Delta State ranked 21st nationally and 2nd in the south-south geopolitical zone. The State scored best in Governance & Ownership domain (75%) while scoring zero in the Repositioning domain.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%
The SPHCDA management team is headed by an ES who reports to the Governor through the Honourable Commissioner for Health however, as at the time of this assessment, no governing board was in place. The Agency's management team meets regularly and publishes periodic reports as part of its accountability mechanism.

Legislation: 60%
There is a law establishing Delta SPHCDA which originated following wide consultation among key stakeholders to build consensus. However, the law is yet to be gazzetted and regulations for its operationalization are yet to be drafted.

Minimum Service Package (MSP): 11%
While the State operates a free MNCH programme there is no costed MSP to guide effective implementation.

Repositioning: 0%
In spite of the existence of a SPHCDA, PHC governance is still fragmented in the State as parallel MDAs are responsible for the implementation of various PHC components.

Systems Development: 42%
Delta SPHCDA currently has an annual operational plan developed from its SHDP. Guidelines and protocols for practice are in use at the health facilities. Despite having an ISS tool, no provision was made for ISS in the current operational plan.

Operational Guidelines: 20%
The SPHCDA operates with sufficient independence from the SMOH such that it has the capacity of developing its own operational plans. In spite of this, the State is yet to adapt guidelines for operationalizing PHCUOR.

Human Resources: 13%
Even with a costed capacity building plan in place to address staff needs, Delta State is yet to establish a high level HRH committee to facilitate the transfer of PHC staff to the agency. Furthermore, the SPHCDA is yet to develop job description for HF staff.

Funding Sources and Structure: 14%
Delta SPHCDA was adequately funded at its inception in 2004. The agency has a dedicated budget and fund release process for PHC and a system for tracking released funds. The State is yet to establish a pool fund for implementing PHC programmes. Furthermore, the agency is incapable of independently procuring commodities required for PHC activities.

Office Setup: 50%
A Structure has been provided but Delta State is yet to designate specific offices for the operations of LGHAs at the LGA level.

The observed strengths, weaknesses and opportunity in the implementation of PHCUOR in Delta State are:

Strengths:
- The SPHCDA is established by law and has a management team in place.
- Presence of an equipped office at the State level.
- The State has its operational plan and protocols in place at State and LGA levels.

Weaknesses:
- Fragmented PHC management in the State.
- LGHA not yet in place in the State.
- No costed MSP.

Opportunity:
- The State is governed by a health professional with a good understanding of PHCUOR.

Recommendations:
- The law should be amended to clearly transfer all PHC functions and personnel to the SPHCDA.
- Seek support to develop a costed MSP.
- Setup pool funding mechanism for PHC and adequately fund SPHCDA.
- Establish and designate offices for LGHAs.
- Grant autonomy for SPHCDA operations.

Edo State 13%

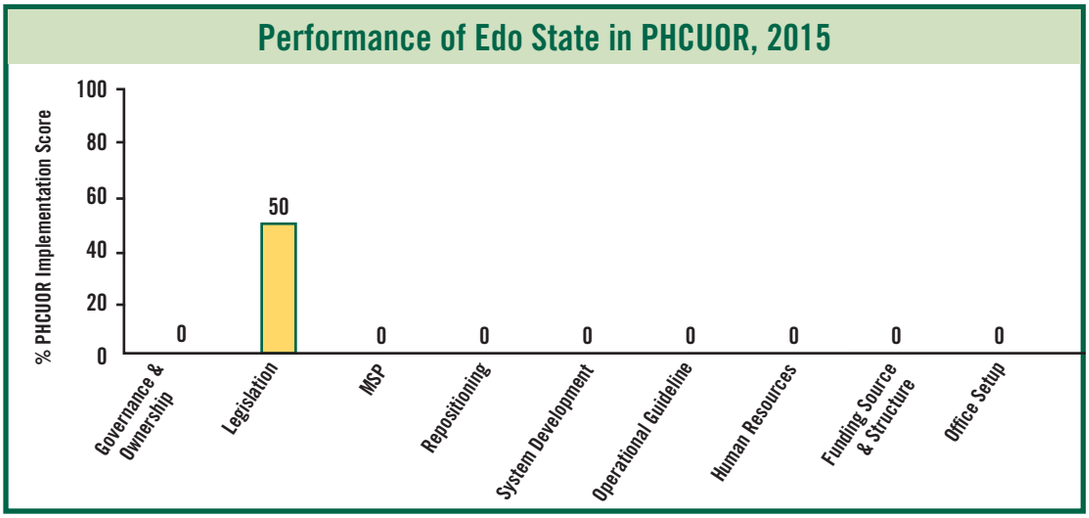
Background

Edo State was created on the 27th August, 1991. The State is located in the South-South geopolitical zone of Nigeria and its capital town is Benin-city. Edo State has a total land mass area of 19,187.93 km2 (NBS, 2010). Edo State has 2015 projected population of 4,090,391 (NPC, 2006) spread across its 18 LGAs. The State is bounded by River Niger to the East, Ondo State to the West, Kogi State to the North and Delta State to the South.

There are 724 health facilities in the State. Out of this number, 672 (93%) are PHC facilities and 46 are SHC facilities. Of the 672 PHC facilities, 380 (52%) are public owned and 292 (48%) are owned by private individuals or organizations (FMOH, 2012). The State is one of the oldest health system in Nigeria, having been in existence since 1963, the health indices shows an IMR of 69/1000 and U5MR of 107/1000 (MICS, 2011).

Main Findings

Result of the 2015 national assessment of PHCUOR in all the States of Nigeria shows that Edo State has an overall score of 13%. The State ranked 30th nationally and 4th in the South-south geopolitical zone of the country. The only domain with a PHCUOR implementation score was in Legislation (50%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 0%
The State is yet to establish an Agency that will coordinate PHC activities in the State. Most PHC activities are currently governed by MDAs.

Legislation: 50%
A 10-man technical committee was established for the drafting of the bill to establish the SPHCDA. A PHC bill was drafted, transmitted and passed by the State House of Assembly. This bill is yet to receive the assent of the Governor in order for it to become a law.

Minimum Service Package (MSP): 0%
The State is yet to develop MSP that is costed and classified into the different health facility categories. The SMOH is aware that the WMHCP cannot suffice or double as the MSP.

Repositioning: 0%
PHCUOR policy demands the repositioning of all PHC activities at the State level under the SPHCDA, which is yet to be established in Edo State.

Systems Development: 0%
Standard guidelines and policies for PHCUOR are yet to be instituted in the State.

Operational Guidelines: 0%
There is no SPHCDA in the State and the SMOH which currently leads the MDAs coordinating PHC activities, did not produce relevant Operational Guidelines and policy documents for operating PHC.

Human Resources: 0%
HRH provision in the SPHCDA bill is weak and unable to meet the specific dynamics of PHC staffing in the State. The emphasis on all staff controlled by one agency as provided for in the PHCUOR protocol should be reflected.

Funding Sources and Structure: 0%
The State is yet to operate a SPHCDA. It therefore has no budget or take-off grant for a SPHCDA.

Office Setup: 0%
There is no office building yet for the Agency either at State and sub-State levels.

The observed strength, weakness, opportunity and threat in the implementation of PHCUOR in Edo State are:

Strength:
- SPHCDA bill passed by State House of Assembly.

Weakness:
- Bill yet to be assented to by the Governor.

Opportunity:
- Willingness of public service stakeholders to embrace the PHCUOR reforms.

Recommendations:
- The Governor should assent to the bill for the establishment of SPHCDA.
- Establish the Agency and designate an office for its operations.
- Provide required financial support for SPHCDA start-up.

Rivers State 73%

Background

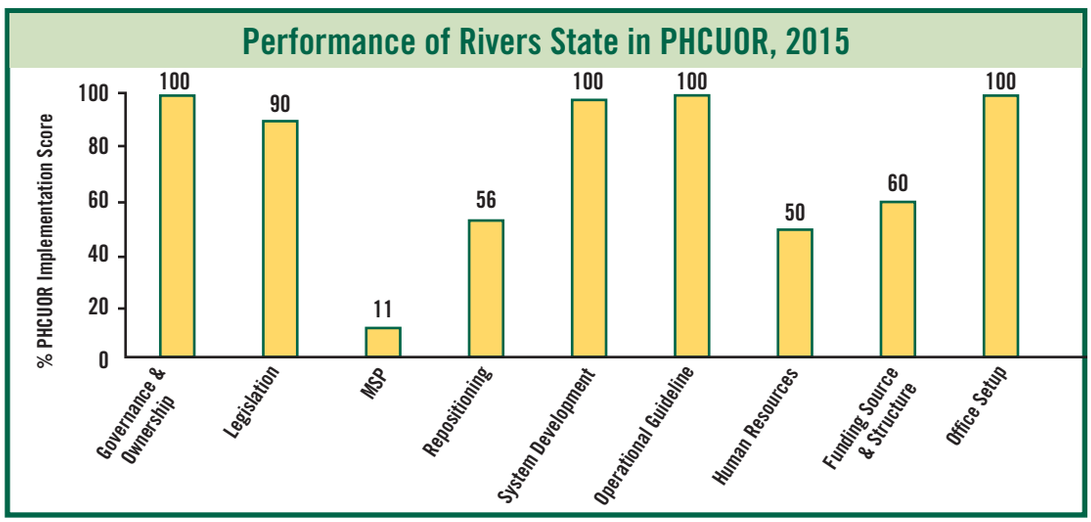
Rivers State is located in the South-South geopolitical zone of Nigeria with its capital in Port Harcourt. Created in 1967, the State is bounded to the East by Akwa Ibom State; to the West by the Bayelsa and Delta States; to the North by the Anambra, Imo and Abia States and to the South by the Atlantic Ocean. It has an estimated landmass of 10,575km2 (NBS, 2010) with a 2015 projected population size of 7,005,951 (NPC, 2006). Rivers State is made up of 23 local government areas (LGAs) and 319 wards.

There are a total of 476 health facilities in the State. Of which, 417 (88%) are PHC facilities and 54 (12%) are Secondary health facilities. 380 (91%) of the 417 PHC facilities are public owed, while 37 are private facilities. Rivers State has an IMR of 63 deaths per 1,000 live births and U5MR of 97 deaths per 1,000 live births. (MICS, 2011).

The Rivers State Primary Health Care Management Board (RSPHCMB) was established into law in November 2010, but inaugurated in July 2011.

Main Findings

Rivers State recorded an overall score of 73% on progress of PHCUOR implementation, ranking the best in the South South zone and 2nd nationwide. The State scored 100% in Governance & Ownership, Systems development, Operational Guidelines, and Office setup domains. Rivers State lowest score is in Minimum Service Package domain (11%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 100%

RSPHCMB has a Governing Board distinct from the management team and an organogram that streamlines authority requiring the ES to report to the Governor through the Honourable Commissioner for Health. The Management team is led by the ES, and holds top management meetings at least once a month. As part of an accountability mechanism, the RSPHCMB publishes annual reports that document PHC activities in the State.

Legislation: 90%

The RSPHCMB has the appropriate legal backing to function after the bill and regulations establishing the Board was passed by the State House of Assembly, and assented by the Governor on the 24th of November, 2010. This was achieved by establishing a technical committee that drafted the bill and a consultative process engaging stakeholders to build consensus on the key elements of the bill. The law establishing the RSPHCMB and regulations has not been gazetted.

Minimum Service Package (MSP): 15%

The poor performance in this domain is because the State has not adopted and costed the MSP for different facility types. It was noted that there is no funding for MSP implementation and the State monitoring team has also not evaluated the resource gaps for its implementation. While the Free Medical Care Programme has been implemented in the State since 2010, it has not been linked to the MSP.

Repositioning: 56%

The law establishing RSPHCMB clearly transfers all PHC functions from the SMOH, MOLG, LGSC and LGA into the RSPHCMB, but the State is yet to re-orient different stakeholders at these agencies of their new roles and responsibilities in relation to the Board. While the departments of PHC at the SMOH, MOLG, and LGSC have been collapsed into the RSPHCMB; the local government PHC department is still not integrated into the Board as part of the LGHA.

Systems Development: 100%

Rivers State has produced a 6 years Strategic Health Plan (2011-2015) and an accompanying annual operational plan for implementing PHC activities in the LGAs. Furthermore, supervisory visits to LGAs and health facilities are consistently conducted on a quarterly basis using the Integrated Supportive Supervision Plan and tools. There are also documented guidelines and procedures for PHC operations and staff recruitment at State level, and lines of accountability are clear.

Operational Guidelines: 100%

Operational Guidelines for the implementation of PHCUOR are available in Rivers State. The management team has been trained on how to use the guideline for their PHC activities. The policy document makes provision for human resource, monitoring and evaluation, accounting and other procedures. It is also noted that the RSPHCMB has the capacity to develop and implement its work plan independent of the SMOH.

Human Resources: 50%

Although Rivers State has established a HRH Committee responsible for documenting and transferring PHC human resources, these committee members are yet to be oriented on the HR Information System and MSP. The RSPHCMB has a staff database and recently carried out a staff audit in August 2015. However, not all the staff providing PHC services, especially at sub-State level, are employees of the Board. The PHC Board has procedures for recruitment of staff at health facilities, however, old LGA employed PHC staff remain in the employ of their parent bodies, even though the Board is responsible for recommending their promotions. The State has a costed capacity building plan for addressing staff needs, but there is no implementation plan in place for managing mal-distribution of staff.

Funding Sources and Structure: 60%

Rivers State government released a take-off grant for the RSPHCMB operations at its inception. Subsequently, the RSPHCMB established a dedicated budget process for funding planned PHC activities, as well as a system for tracking the funds released. Additionally, the Board effectively plans and budget for its activities without external assistance. However, there are funding gaps as the resources allocated to the Board are not commensurate with the approved plans. The Board cannot plan for the procurement of commodities and other items required at the health facility for effective service delivery. Rivers State is yet to establish a joint funding mechanism for implementing PHC activities. Currently, the LGA's financial contributions towards PHC activities are deducted from source. Furthermore, the RSPHCMB administer staff benefits and pension as stipulated in the PHCUOR policy, but do not pay the salaries of all health workers at the facility level.

Office Setup: 100%

There are designated offices provided by the government for the operations of the RSPHCMB and LGHAs at State and LGA level respectively. The State has also provided the Board with office equipment and installations such as furniture, computers, and internet access.

The observed strengths, weaknesses, opportunities and threats in the implementation of PHCUOR in Rivers State are:

Strengths:

- Availability of an enabling law establishing the RSPHCMB.
- Functional management team implementing all PHC activities.
- Operational Guidelines available.
- Agency has structures and systems at both State and LGA levels.

Weaknesses:

- Not adopting the MSP for different health facility types.
- Lack of implementation plan for managing mal-distribution of staff.
- The existence of an LGA PHC department parallel to the LGHA.
- Inadequate knowledge among SMOH, MOLG, LGSC on their specific roles under the new governance structure.

Opportunities:

- Partners and organizations can be leveraged for progression in PHCUOR implementation in the State.
- The existing technical committee can advocate to the new governor to continue strengthening progress on PHCUOR implementation in the State.

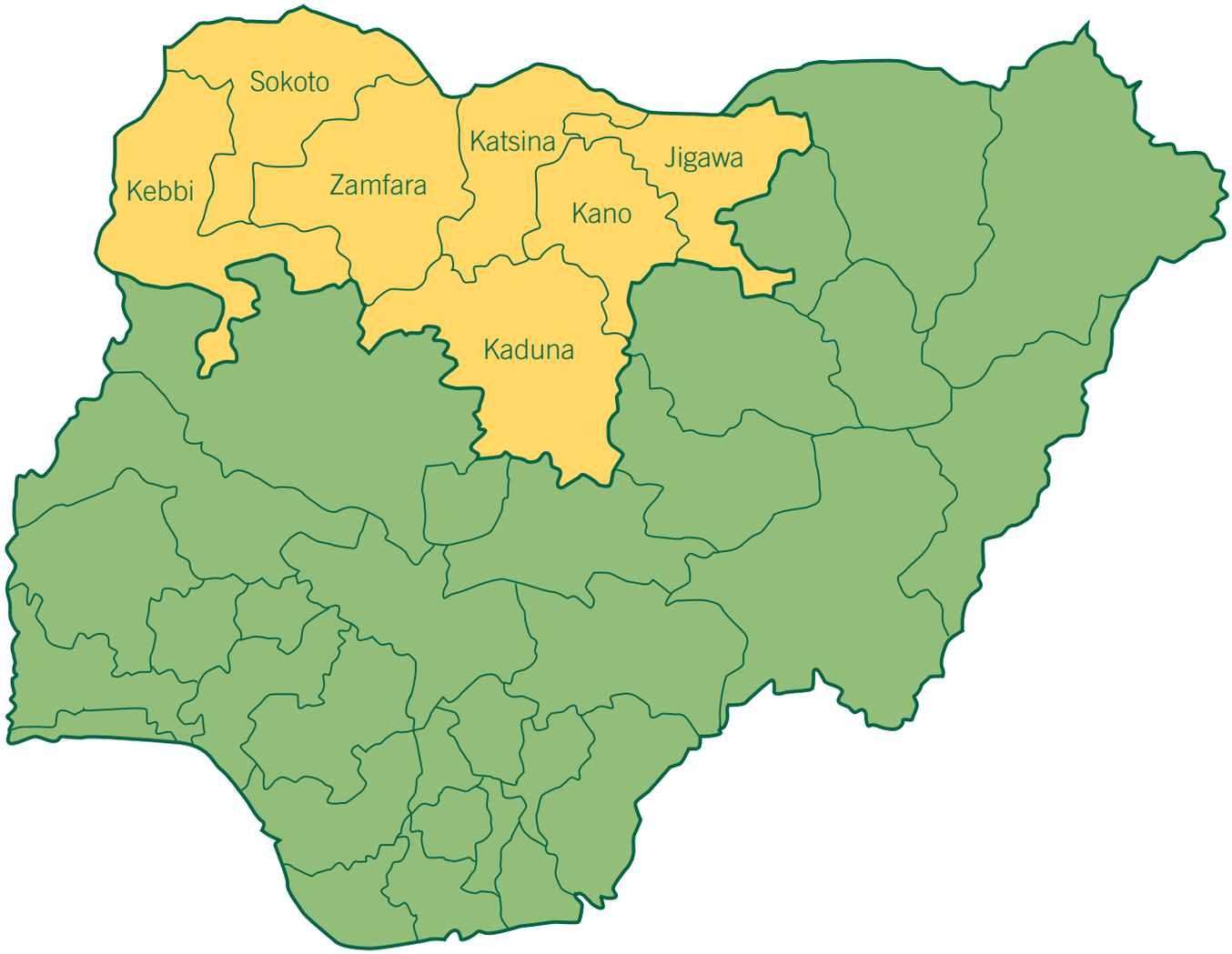
Threats:

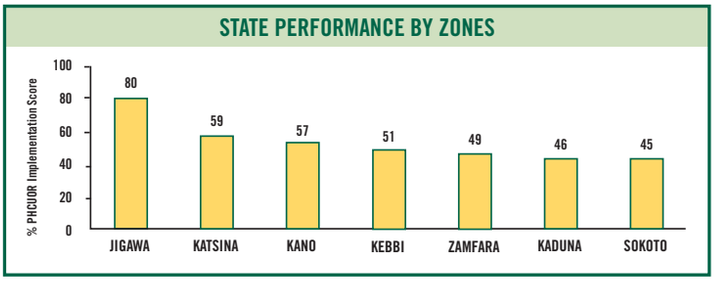
- Funding gaps.
- Implementation acceptance by Association of Local Government of Nigeria (ALGON) and National Union of Local Government Employees (NULGE).

Recommendations:

- Adopt and draft a costed MSP for different facility types to ensure effective and efficient service delivery.
- Develop an implementation plan for the re-orientation and capacity building of SMOH, MOLG, LGSC and LGA personnel to their new roles and responsibilities in relation to the Board.
- Organize trainings for the HR Committee members on HR Information Systems and MSP.
- Fully transfer PHC workers at the LGA level to the RSPHCMB. This should also include movement of their payment to the RSPHCMB to enhance productivity and enforcement of discipline.
- Co-opt all stakeholders including ALGON and NULGE in the orientation and repositioning processes for a successful implementation of PHCUOR.
- Develop strategies for managing issues related to mal-distribution of staff to ensure equity in service delivery.
- Establish a Pool-Funding mechanism for implementing PHC programmes and services.

NORTH WEST ZONE 55%





Jigawa State 80%

Background

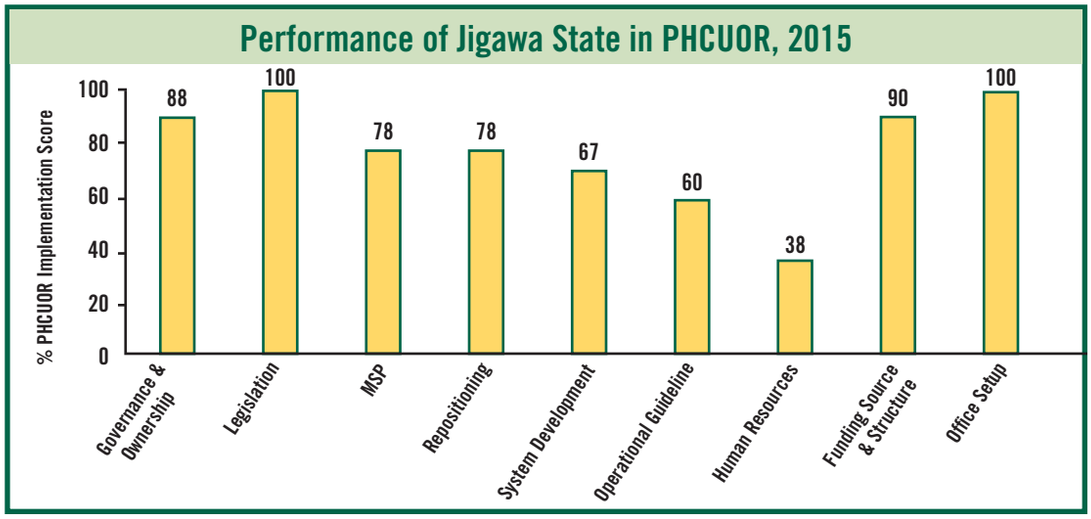
Jigawa State is located in the North-west geopolitical zone of Nigeria with its capital city as Dutse. The State has 27 LGAs with 2015 projected population of 5,624,614 (NPC, 2006) spread across its land mass of 23,287km2 (NBS, 2010). The State is bounded by Yobe to the North East, Bauchi to the East and South East, Kano to the West, Katsina to the North West and Niger Republic to the North.

There are 614 health facilities in the State with 598 (97%) PHC facilities and 14 (2.3%) SHC facilities. The PHC facilities are made up of 595 (99.5%) public and 3 private PHC facilities (FMOH, 2012). The IMR and U5MR in Jigawa State is 163 and 275 per 1000 respectively (MICS, 2011).

Jigawa State started a reform process of integrating PHC governance in 2007 through its Gunduma district health system which is coordinated by the Gunduma Health System Board (GHSB) - a recognised equivalent of the SPHCDA. This was prior to national PHCUOR policy formulation in 2011. GHSB combines the governance of both PHC and SHC in Jigawa State.

Main Findings

The best performing State in implementation of PHCUOR in Nigeria, Jigawa State came 1st both nationally and in the North West geopolitical zone with an overall score of 80%. Its best performance was in Legislation and Office Setup domains (100%) and has the least score in in Human Resource domain (38%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 88%

Jigawa State operates the GHSB with a well constituted governing board and management team whose distinct roles and responsibilities are clearly defined in the law establishing GHSB. There is an organogram which clearly shows the institutional structure with the management team led by the DG who reports to the governor through the Honourable Commissioner for Health. The board publishes periodic reports as part of accountability mechanism. There was no available evidence that the management team meets regularly, at least once a month.

Legislation: 100%

The Law establishing GHSB and its operationalising regulations has been gazetted. The regulations are consistent with this GHSB law.

Minimum Service Package (MSP): 78%

Jigawa State has a costed MSP that has been used to classify the various health facilities in the State. The availability and utilization of this costed MSP at health facilities has improved efficiency of health service delivery. This costed MSP is also linked to the provision of special health care projects in the State. The State is yet to establish a monitoring team to regularly evaluate resource gaps in implementing this MSP.

Repositioning: 78%

All PHC structures and functions in Jigawa State have been completely collapsed into the GHSB as required by law and this reposition has improved the PHC governance system in the State. There is however, no evidence of a plan for regular reorientation of GHSB staff on the principles of PHCUOR.

Systems Development: 67%

GHSB has an annual operational health plan developed from its SHDP. There are also developed operational health plans at sub-State levels. The board has its management policies separate from the civil service regulations to guide PHC programmes. However, there is no evidence of regular ISS visit to LGAs and health facilities.

Operational Guidelines: 60%

GHSB policy makes provisions for HRH, M&E, Accounting and other operational procedures. The board has shown, over the years, to have the capacity to carry out its operations independently. There is no evidence that key personnel (management team) has been recently retrained on the mandate GHSB the policy guidelines.

Human Resources: 38%

All staff providing PHC services in Jigawa State are employees of the GHSB. There is HRH committee for documentation of PHC human resource but there is no evidence that it has recently carried out a staff audit. This HRH committee has also not been trained on the HRIS. The Board has developed job descriptions for health facility managers and workers but there is no evidence of a documented procedure for staff recruitment. There is no costed capacity building plan to address staff needs.

Funding Sources and Structure: 90%

There is GHSB dedicated budget process and fund release for planned PHC activities. There are systems in place to track these released funds. The board is able to budget and procure commodities required for PHC services in the State without external assistance. The salaries, pensions and other benefits of PHC staffs are administered by the GHSB. However, there is no evidence of joint funding mechanism for implementing PHC activities in the State.

Office Setup: 100%

There are designated offices for the operations of GHSB both at the State and LGA level. These offices are well furnished and are being utilized.

The observed strengths, weaknesses and opportunity in the implementation of PHCUOR in Jigawa State are:

Strengths:

- A gazetted law and regulation.
- Constituted governing board and management team.
- Complete reposition of the PHC system in the State in line with PHCUOR policy.

Weaknesses:

- Inadequate Staff capacity building including periodic retraining and reorientation.
- Lack of evidence of regular ISS visits and monthly management team meeting.
- Absence of a pooled fund mechanism for PHC activities.

Opportunity:

- Strong political will.

Recommendations:

- Regular documented meeting of the management team, at least monthly.
- Establish a monitoring team to regularly evaluate resource gaps in implementing MSP.
- Regular Staff capacity building including periodic retraining and reorientation.
- Regular conduct and documentation of ISS visits.
- Develop a pooled fund mechanism for PHC activities with contributions from the State, LGAs and partners.

Kaduna State 46%

Background

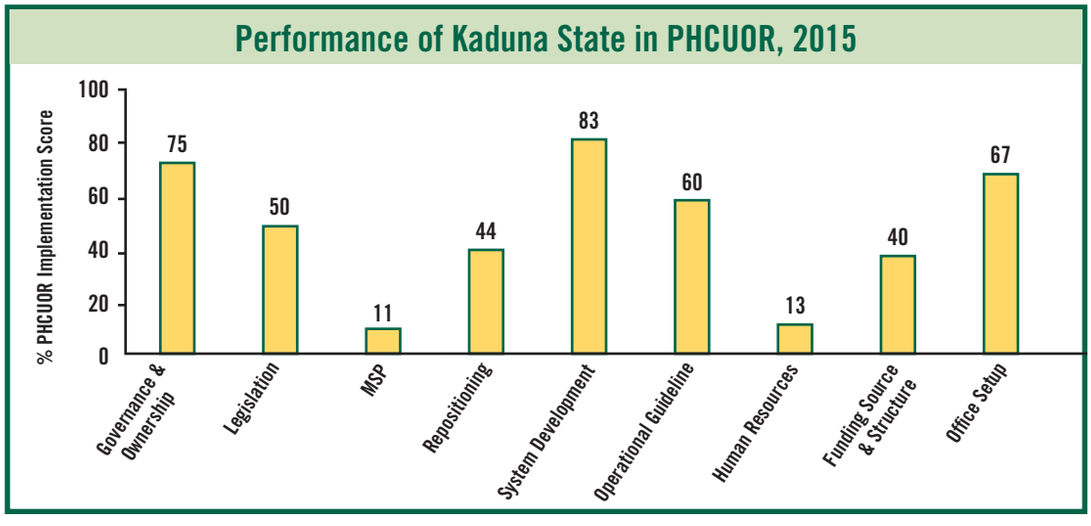
Kaduna State, located in the North West Zone of Nigeria, was created on May 27, 1967 with its capital city as Kaduna. The State has a 2015 projected population of 7,915,487 (NPC, 2006) distributed in 23 LGAs covering a total land mass of 42,481 Km2 (NBS, 2010).

As of 2012, the State had a total of 1,560 health facilities out of which 1523 (98%) are PHC facilities, 33 are SHC facilities. 1007 (66%) of PHC facilities are public while the remaining 516 (34%) are private facilities (FMOH, 2012). The State health indices reveal an IMR of 103/1000 and U5MR of 169/1000 (MICS, 2011).

Kaduna State SPHCDA was established in 2008 through an enabling law.

Main Findings

Kaduna State has an overall score of 46% in the implementation of PHCUOR thus ranking 15th nationally and 6th out of 7 States in the North West geopolitical zone. The State scored its highest in the System Development domain (83%) while MSP was its domain of least performance (11%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%

The State has a SPHCDA backed by law with defined lines of accountability and evidence of periodic report publication. However, as of the time of this assessment, Kaduna SPHCDA was headed by an Executive chairman who reports directly to the State governor contrary to national guidelines. The existing law does not distinguish clearly, the roles if the governing board from that of the management team.

Legislation: 50%

As of the time of data collection, Kaduna State was in the process of revising its SPHCDA law towards rectifying its existing weaknesses. The law was awaiting the governor's assent. The State is however, yet to develop regulations for operationalizing the law, when eventually amended.

Minimum Service Package (MSP): 11%

Kaduna State is implementing special MNCH projects but is yet to adopt a costed MSP for optimal PHC resource planning and allocation in line with UHC agenda.

Repositioning: 44%

Although the Kaduna State SPHCDA law provides for the transfer of all PHC functions and structures to the SPHCDA, this is yet to be implemented as the department of PHC is still duplicated in some other MDAs.

Systems Development: 83%

Kaduna State has a costed Strategic Health Plan and an accompanying annual Operational Plan. Integrated Supportive Supervision of PHC activities are conducted on a regular basis using the specified tools. However, the SPHCDA lacks guidelines for recruitment of staff, particularly at the sub-State levels.

Operational Guidelines: 60%

Kaduna State's PHCUOR policy makes provision for HRH, M&E and accounting procedures. The SPHCDA is also capable of developing its own work plan independently of the SMOH. However, the management team is yet to be trained of the mandate of the SPHCDA using policy guidelines.

Human Resources: 13%

Although Kaduna SPHCDA has carried out a PHC staff audit, a high level HRH committee is yet to be constituted for transfer of all PHC workers to the Agency, consequently, staff providing PHC services, particularly at thee health facility level, are not yet staff of the SPHCDA. The Agency also does not have evidence of a plan to manage mal-distribution of staff neither is there documented job descriptions for health workers. Kaduna SPHCDA has no clear procedures for the recruitment of staff at the sub-State level.

Funding Sources and Structure: 40%

The SPHCDA has a dedicated budget, fund release and tracking system in place. The Agency is also capable of independently procuring health commodities for PHC service delivery. However, Kaduna State is yet to establish a strong and sustainable funding structure for PHC activities particularly as it relates to pool funding mechanisms.

Office Setup: 67%

The State Government has provided a furnished office for the SPHCDA at the State level. However, this is yet to be replicated at the sub-State level as there are no dedicated offices for the LGHAs.

The observed strengths, weaknesses and opportunity in the implementation of PHCUOR in Kaduna State are:

Strengths:

- The State has an SPHCDA backed by law.
- Ongoing amendment of SPHCDA law to correct observed deficiencies.

Weaknesses:

- There is no governing board for the Agency.
- PHC Human resources are yet to be repositioned under the SPHCDA.
- No sustainable PHC funding structure in place.

Opportunity:

- There is a strong political will.

Recommendations:

- A Governing Board should be instituted.
- The legislation amendment should provide for transfer of all staff and functions of PHC at all levels to the SPHCDA.
- National guidelines on PHCUOR should guide the PHC reforms in the State.

Kano State 57%

Background

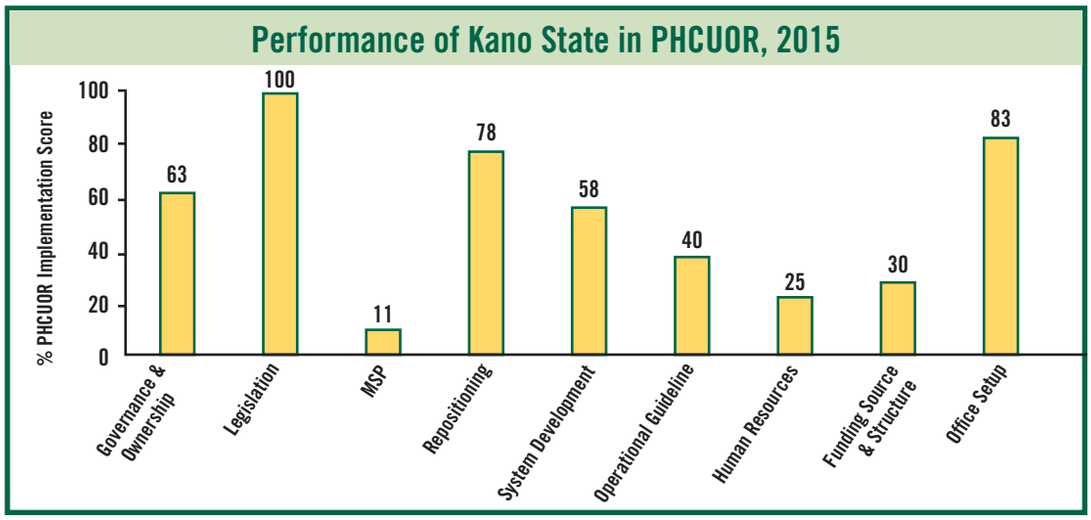
Kano State was created on May 27th 1967 and is one of the 7 States located in the North West geopolitical zone of Nigeria. It is bounded by Jigawa State to the North-East, Katsina to the North-West, Bauchi to the South-East and Kaduna to the South-West. The State has a 2015 projected population of 12,568,290 (NPC, 2006) spread across its 44 LGAs. The State has a landmass of 20,280km2 (NBS, 2010).

The State has a total of 1183 health facilities, with 1142 (96%) PHC and 39 SHC facilities. 1037 (91%) PHCs are public owned while 105 (9%) are private owned (FMOH, 2012). The State has an IMR and U5MR of 111 and 184 per 1000 respectively (MICS, 2011).

Kano SPHCMB was established in 2012 following passage of its bill State House of Assembly and assent by the State Governor.

Main Findings

The State scored 57% overall in implementation of PHCUOR, ranking 10th nationally and 3rd out of the 7 States in the North West geopolitical zone. Kano State scored best in Legislation domain (100%) and has its lowest score in MSP (11%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 63%

Kano SPHCMB has a management team, with clear lines of accountability, led by an ES who reports to the Governor through its Honourable Commissioner for Health. The State however does not have a governing board in place and there is no document clearly specifying the distinct roles of the management team from that of the governing board.

Legislation: 100%

The law establishing Kano SPHCMB has been gazetted following the passage of the bill by the State House of Assembly and assent to by the governor. Stakeholders were adequately engaged to build consensus during the process of enacting this law. The board also has regulations to operationalize this law.

Minimum Service Package (MSP): 11%

Kano State is currently implementing a special healthcare project. However, there is no evidence of a costed MSP that can aid the planning of such healthcare project in the State.

Repositioning: 78%

All PHC departments and staff in Kano State have been transferred to the SPHCMB in line with the law, after adequate engagement of all stakeholders affected by the repositioning process. However, there is no evidence of re-orientation of all PHC staff on their changing roles and responsibilities under Kano SPHCMB.

Systems Development: 58%

There is an annual costed operational plan developed from the SHDP. Operational health plans are also available at the LGA level. Although, there is an ISS tool, there is no evidence of its use for regular supervision at LGAs and health facilities. There is also no clear documented guidelines and procedures for recruitment into the SPHCMB at the State and sub-State levels.

Operational Guidelines: 40%

Kano SPHCMB uses the national manual to guide the implementation of PHCUOR in the State as it is yet to adapt this document for its use. However, the State implementation policy makes provision for HRH, M&E, accounting and other operational procedures.

Human Resources: 25%

All staff providing PHC services in the State are employees of Kano SPHCMB and there is a developed job description for all categories of staff. There is no evidence showing establishment of high level HRH committee for the transfer of PHC HR and the organogram does not show the presence of a HRH department/unit. Also, there is no evidence of a costed staff capacity building plan or mechanism to deal with mal-distribution of PHC staff.

Funding Sources and Structure: 30%

There is a dedicated budget process for the funding of Kano SPHCMB and a system to track released funds. However, funds allocated to the Board is insufficient to meet its approved work plan. Salaries, pensions and other staff benefits are not administered by Kano SPHCMB. They require external assistance for the planning and budgeting of its activities.

Office Setup: 83%

There are equipped offices designated at the State and sub-State levels, which is being utilized by Kano SPHCMB for PHC activities.

The observed strengths, weaknesses and opportunity in the implementation of PHCUOR in Kano State are:

Strengths:

- Availability of a gazetted law and regulations.
- Presence of a management team.
- Equipped offices at the State and sub-State levels.

Weaknesses:

- Absence of a governing board.
- PHC staff benefits not administered by Kano SPHCMB.
- No costed MSP to guide planning of special health project.
- No evidence of HRH committee, department or unit to address staff needs.

Opportunity:

- There is a political will for PHCUOR implementation.

Recommendations:

- Setup a governing board with adequate inclusion of stakeholders.
- Develop a costed MSP that can be used to classify PHC facilities and plan healthcare projects.
- Complete consolidation of all PHC functions under Kano SPHCMB including administering staff benefits.
- There is need to carry out regular ISS visits to LGAs and health facilities.
- Ensure adequate documentation of Kano SPHCMB activities.

Katsina State 59%

Background

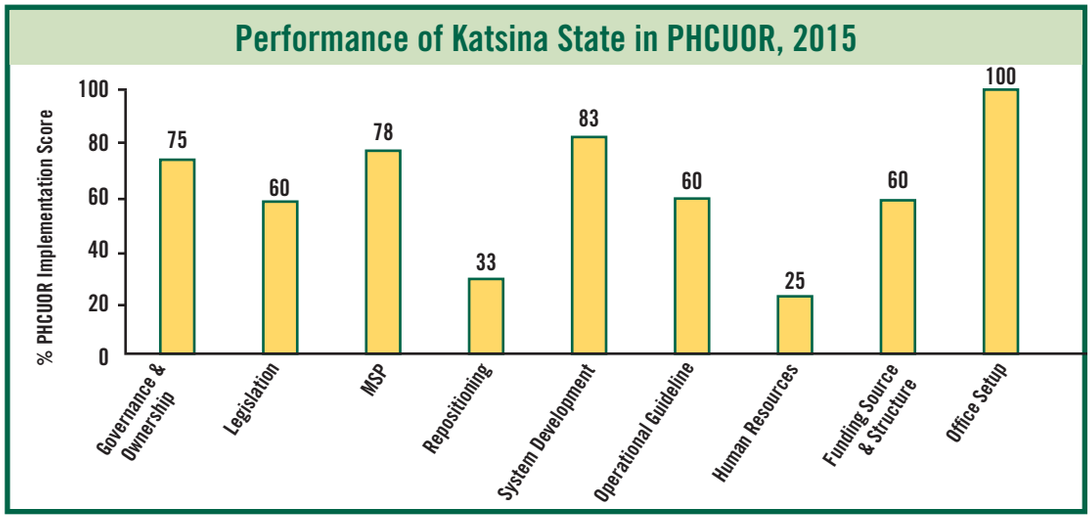
Katsina State is located in the North-West geopolitical zone of Nigeria and was created from a segment of Kaduna State in 1987. It has a land size of 23,561 km2 (NBS, 2010) and a 2015 projected population of 7,558,001 (NPC, 2006) distributed across its 34 LGAs. The State is bounded by Kano and Jigawa States to the East, Zamfara State to the West, Niger republic to the North and Kaduna State to its South.

There are 1,496 health facilities in the State out of which 1463 (98%) are PHC facilities and 32 are SHC facilities. 1418 (86%) of these PHCs are public owned while the remaining 45 are private owned (FMOH, 2012). The health indices in the State is reflected by an IMR and U5MR of 133 and 225 per 1000 respectively (MICS, 2011).

The Katsina SPHCDA was established in 2004 with the passage of its enabling law. The governing board is headed by an EC who doubles as the Chief Executive of the management team.

Main Findings

The State ranked 7th nationally and 2nd in the North West geopolitical zone having scored 59% in this assessment. The State has the highest score in Office Setup domain (100%) and the lowest in Human Resource (25%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%

Katsina SPHCDA has an appointed EC that heads both the management team and governing board and reports to the Governor through the Honourable Commissioner for Health. The law establishing Katsina SPHCDA does not clearly define the role of the management team as distinct from that of the governing board. Although the management team meets regularly, there is no evidence of publication of periodic reports like annual operational report.

Legislation: 60%

The State has had two amendments to its SPHCDA law with a third amendment currently in progress. The law is yet to be gazetted and the Agency has not drafted the regulations to operationalize this law.

Minimum Service Package (MSP): 78%

Katsina State has adopted a costed MSP which has been used to classify various health facilities. There is funding for the operationalization of the MSP which is currently been used at the health facilities which has improved efficiency and work output. However, there is no evidence of a constituted monitoring team to evaluate resource gaps in operationalizing the MSP.

Repositioning: 33%

Despite various amendments, the law establishing the Agency does not clearly transfer all PHC functions in Katsina State to the SPHCDA thus only the department of PHC at the SMOH has been collapsed into the Agency. Whereas there is a plan to reorient PHC staff on the ongoing repositioning process, there is no evidence that this activity has taken place.

Systems Development: 83%

Katsina SPHCDA has developed an annual operational plan from the SHDP which includes an ISS plan. However, the State does not conduct this ISS regularly (at least quarterly). Furthermore, guidelines for recruitment into the SPHCDA and LGHAs are yet to be developed.

Operational Guidelines: 60%

Katsina SPHCDA has carried out a staff audit and developed a database of PHC HRH in the State but these staff are not all employees of the SPHCDA. Although the Agency has also established a high level HRH committee for the transfer of PHC staff, this committee is yet to be trained on HRIS and MSP. There is no plan for managing staff mal-distribution, no developed job description for SPHCDA staff and no costed capacity building plan to address staff needs.

Human Resources: 25%

All staff providing PHC services in the State are employees of Kano SPHCMB and there is a developed job description for all categories of staff. There is no evidence showing establishment of high level HRH committee for the transfer of PHC HR and the organogram does not show the presence of a HRH department/unit. Also, there is no evidence of a costed staff capacity building plan or mechanism to deal with mal-distribution of PHC staff.

Funding Sources and Structure: 60%

At the inception of SPHCDA in Katsina State, a take-off grant was released. Subsequently, a dedicated budget process for funding the Agency was established with adequate mechanism for tracking fund release. Katsina SPHCDA is able to effectively plan and budget for it activities which includes procurement of commodities used at the various health facilities. There is no evidence of the presence of a pooled fund mechanism for PHC activities in the State and the funds released are not sufficient for the work plan of the agency. Also, the salaries and pensions of PHC staffs are not administered by Katsina SPHCDA as required by PHCUOR policy.

Office Setup: 100%

Katsina State has provided and furnished offices for the operations of the Agency at the State and sub-State levels. These offices are being adequately utilized by Katsina SPHCDA.

The observed strengths, weaknesses, opportunity and threat in the implementation of PHCUOR in Katsina State are:

Strengths:

- Availability of a management team and governing board.
- Equipped offices being utilized by the Agency for operations at State and sub-State levels.
- Costed MSP that classifies all PHC facilities and used for planning health projects.

Weaknesses:

- SPHCDA law that is not in line with PHCUOR policy.
- Incomplete repositioning of all PHC structures and functions.
- Poor HRH system and lack of staff capacity building.

Opportunity:

- The recent change in government in the State provides an opportunity to place the PHC reforms as a priority agenda for the new administration.

Threat:

- Conflicting interest from other MDAs with PHC departments, affected by the repositioning.

Recommendations:

- The law should be amended to align it with the principles of PHCUOR.
- The leadership of the management team should be separated from that of the governing board.
- Adequately engage all stakeholders that are affected by the repositioning process.
- Ensure complete consolidation of all PHC structures and functions under the SPHCDA.
- Develop job description for SPHCDA staff, a plan for managing staff mal-distribution and costed capacity building plan to address staff needs.
- Establish a pooled fund mechanism for PHC activities and improve funding for Katsina.

Kebbi State 51%

Background

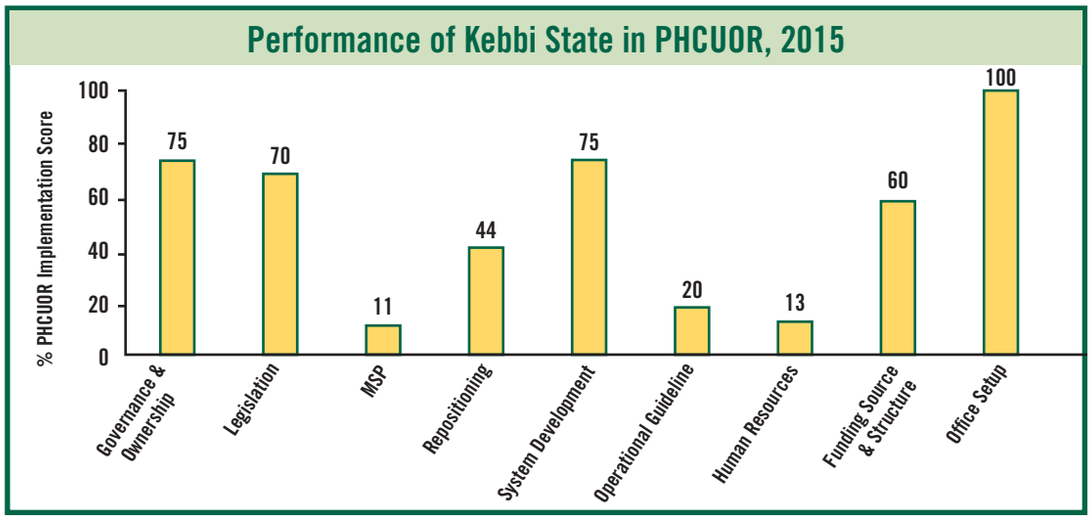
Kebbi State was created on 27th August, 1991 out of then Sokoto State and its capital city is Birnin kebbi. It is bounded by Zamfara State to the East, Republic of Benin to the West, Sokoto State to the North and Niger State to the South. The State has 4 emirate councils, 21 LGAs and 35 districts. Kebbi State has a 2015 projected population of 4,262,742 (NPC, 2006) and a total land area of 36,985Km2 (NBS, 2010).

There are 412 health facilities in the State comprising of 380 as PHC facilities and 31 SHC facilities. These PHC facilities are made up of 375 public and 5 private PHC facilities (FMOH, 2012). The State has an IMR of 127/1000 and U5MR of 212/1000 (MICS, 2011).

The SPHCDA was established in the State in 2011 following the enactment of its enabling law in 2010.

Main Findings

With an overall score of 51%, Kebbi State was ranked 12th nationally and 4th in the North West geopolitical zone of Nigeria in the implementation of PHCUOR. The State has its best performance in the Office Setup domain (100%) while its lowest score was in MSP (11%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%

The Agency has a functional Governing Board headed by an EC who doubles as the head of the management team which also has a secretary and 6 directors. The Governing Board meets quarterly while the management team meets monthly. The law does not clearly delineate the functions of the management team as distinct from that of the governing board. Also, there was no evidence of publication of periodic reports like quarterly or annual report.

Legislation: 70%

Prior to the enactment of the SPHCDA enabling law in Kebbi State, a technical committee for the drafting of the law was setup and stakeholders were engaged to build consensus on key elements. This law has been gazatted but the agency is yet to draft regulations for its operationalization.

Minimum Service Package (MSP): 11%

The State is yet to develop a costed MSP. The ongoing special health care project in the State ought to be linked to a costed MSP for the State.

Repositioning: 44%

The SPHCDA enabling law transfers all PHC functions to the Agency but only the PHC department at the SMOH has been collapsed into Kebbi SPHCDA. Although there is a plan for the reorientation of PHC staff in the State on PHCUOR, there is no evidence that this has been carried out. The agency is also yet to organize a forum to engage all stakeholders affected by the PHC reform, to discuss the changing roles and responsibilities.

Systems Development: 75%

Kebbi SPHCDA has a clear institutional structure. The Agency regularly conducts ISS visits to HFS and LGA. There are guidelines and protocols for operations at the various PHC facilities. The State has a SHDP (2014-2019) and operational health plans at the LGAs. There are no developed guidelines and policies for recruitment into the SPHCDA.

Operational Guidelines: 20%

The State is yet to adapt the national manual on PHCUOR for its use but the policy been used in Kebbi State makes provisions for HRH, M&E, accounting and other operational procedures. It was observed that the agency is not capable of developing its work plan independent of the SMOH. The management team is yet to be trained on the principles of PHCUOR policy.

Human Resources: 13%

Kebbi SPHCDA has a costed capacity building plan to address the needs of its staff. There is no evidence that the Agency has established a HRH committee, unit or department. It was observed that not all staff providing PHC services in the State are employees of the SPHCDA. The Agency is yet to develop job descriptions for the various category of staff and clear procedure for recruitment.

Funding Sources and Structure: 60%

The Agency has a dedicated annual budget and a tracking mechanism for tracking released funds. Kebbi SPHCDA can effectively plan, budget and procure commodities required for PHC services but funds released to the Agency is not sufficient to meet its approved work plan. The State is yet to adopt a pool fund mechanism for implementing PHC programmes. Salaries, Pensions and other staff benefits are administered by other agencies and not the SPHCDA as required.

Office Setup: 100%

There are designated offices for Kebbi SPHCDA in the State and sub-State level. These offices are well equipped and are being utilized by the agency.

The observed strengths, weaknesses and opportunity in the implementation of PHCUOR in Kebbi State are:

Strengths:

- There is an enabling SPHCDA law.
- Kebbi SPHCDA has designated offices at the State and sub-State levels.
- They Agency conducts regular ISS visits to health facilities and LGAs.

Weaknesses:

- Executive chairman doubles as head of the management team and governing board.
- There is no costed MSP.
- The PHC structures in the MOLG, LGSC and LGAs are yet to be collapsed into the SPHCDA.

Opportunity:

- A new governor in Kebbi State provides an opportunity to place the PHC reforms as a priority agenda for the new administration.

Recommendations:

- Amendment of the SPHCDA law to delineates the roles and headship of the management team and governing board.
- Ensure complete repositioning of PHC structures including establishment of LGHAs.
- Seek assistance to develop a costed MSP.
- Strengthen the HRH capacity of the SPHCDA.
- Develop a pool fund mechanism for PHC activities and increase funding of the SPHCDA.

Sokoto State 45%

Background

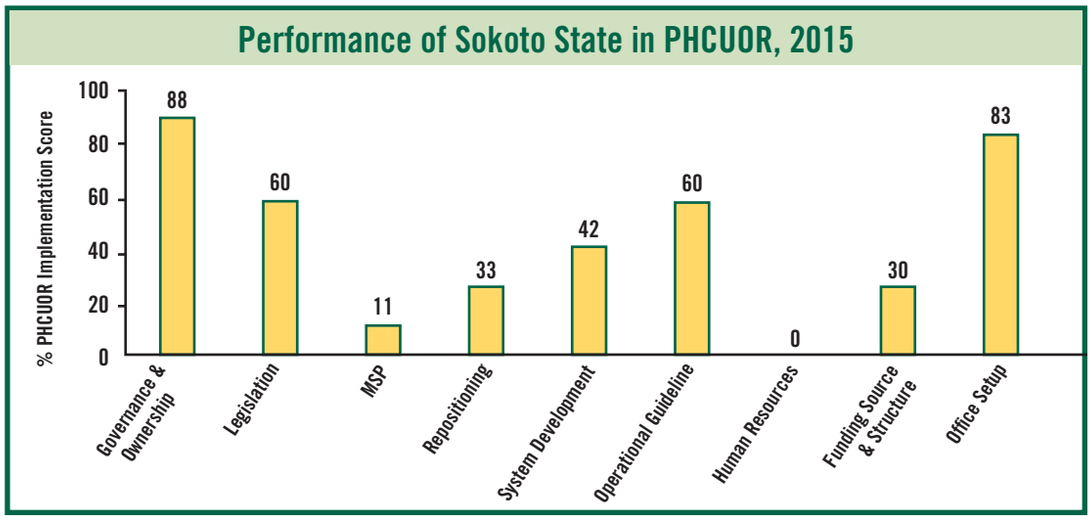
Sokoto State was created on 3rd February, 1976 and is located in the extreme northwest of Nigeria. It shares borders with State to the East, State to the West, State to the North and State to the South. The State has 23 LGAs and a 2015 projected population of 4,823,745 (NPC, 2006) spread across an area mass of 27,825km2 (NBS, 2010). Livestock production is a main agricultural activity of the State.

There are a total of 713 health facilities in Sokoto State out of which 668 (94%) are PHC facilities while 43 are SHC facilities (FMOH, 2012). All the PHC facilities public owned. The key health indices in Sokoto State shows an IMR and U5MR of 107/1000 and 178/1000 respectively (MICS, 2011).

Sokoto SPHCDA came into existence following the signing of the enabling law by the governor in May, 2010.

Main Findings

Sokoto State has an overall score of 45% ranking 16th nationally and last out of the 7 States in North West geopolitical zone of Nigeria. The State performed best in Governance & Ownership domain (88%) while their least performance was a zero score in Human Resource domain.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 88%

There is an SPHCDA in Sokoto State with an appointed ED who report to the Executive Governor through the Honorable Commissioner of Health. The management team of Sokoto SPHCDA meets at least once a month and the law clearly defines the roles of Governing Board as distinct from the management Team. Also, the Agency publishes monthly, quarterly or annual report as part of their accountability mechanism. There is currently no constituted governing board for the SPHCDA in Sokoto State.

Legislation: 60%

A technical committee drafted the SPHCDA bill that was transmitted to the State House of Assembly after engaging stakeholders to build consensus around key elements of the law. The bill has been passed and consequently assented to by the State Governor. However, this Law has not been gazetted. There was no evidence that the State has drafted regulations to operationalize the law.

Minimum Service Package (MSP): 11%

Sokoto State has not adopted an MSP for use in planning special health care projects and in the different facility types. However, Sokoto State is currently implementing a special health care project.

Repositioning: 33%

Although the SPHCDA law does not clearly transfers all functions of PHC to the SPHCDA, the PHC department in the SMOH has been collapsed into the Agency. There is a plan to re-orient all staff of the SPHCDA on the ongoing reform but this is yet to take place. There is also no evidence that that different stakeholders affected by this reformed have been adequately engaged to discuss the changing roles and responsibilities.

Systems Development: 42%

Sokoto SPHCDA has an annual operational plan developed from the SHDP but there is no evidence of operational plan at the LGAs. There is a plan for regular ISS visit to health facilities and LGAs with the available ISS tool but there is no evidence of regular implementation of the ISS plan. However, the institutional structure clearly shows lines of accountability.

Operational Guidelines: 60%

The national implementation manual on PHCUOR has been adapted for use in Sokoto State and a policy has been developed with provisions for HRH, M&E, accounting and other operational procedures. Although the SPHCDA in Sokoto State have the capacity to develop and implement its work plan independent of the SMOH, key management team members are yet to be trained on the mandate of this policy.

Human Resources: 0%

There is no evidence that the SPHCDA in Sokoto State has setup a HRH committee, unit or department for the consolidation and coordination of all PHC human resource in the State.

Funding Sources and Structure: 30%

Sokoto SPHCDA has a dedicated budget process and a mechanism to track fund release. The Agency can budget and effectively plan for its activities although the funds released to it is not sufficient to meet its work plan. Salaries, pension and other staff benefits of PHC staff in the State are not paid by Sokoto SPHCDA. The State is yet to develop joint funding mechanism for implementing PHC activities.

Office Setup: 83%

The government of Sokoto State has provided furnished offices at the State and sub-State levels for the SPHCDA. These offices are being utilized by the Agency.

The observed strengths, weaknesses and opportunity implementation of PHCUOR in Sokoto State are:

Strengths:

- Presence of an SPHCDA management team.
- Availability of furnished offices for SPHCDA at State and sub-State levels.

Weaknesses:

- The law does not clearly transfer all PHC structures and functions to the SPHCDA.
- Absence of a constituted SPHCDA governing board.
- Unavailability of a costed MSP.
- Inadequate funding of the Agency, M&E & human resource.

Opportunity:

- New government in State provides hope for full implementation of PHCUOR.

Recommendations:

- Ensure that the SPHCDA law transfers all PHC structures and functions in Sokoto State to the SPHCDA.
- Constitute a governing board with a balanced inclusion of relevant stakeholders.
- Seek support to develop a costed MSP.
- Funding of the SPHCDA should be improved.
- Strengthen the M&E, human resource and other weakened operational structure of the Agency.

Zamfara State 49%

Background

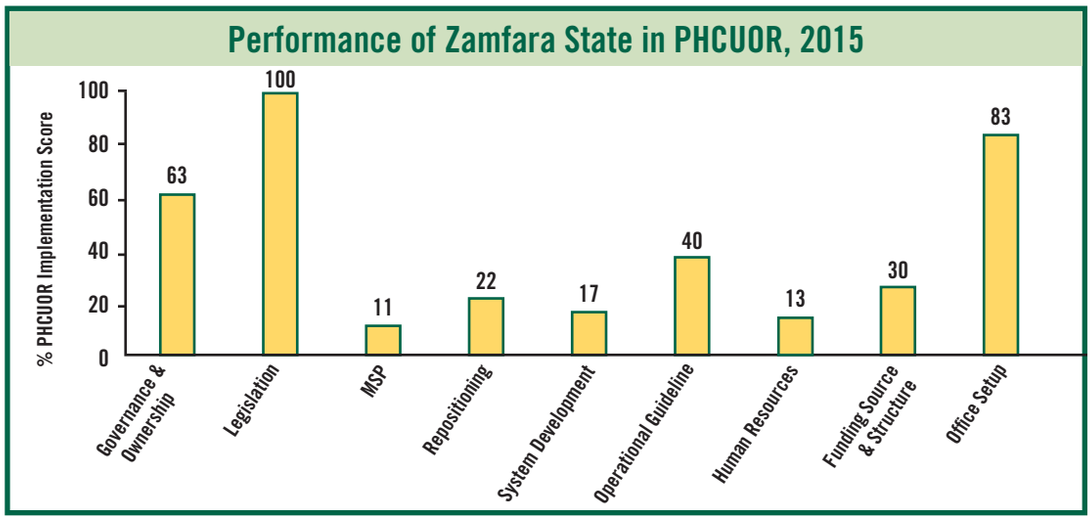
Zamfara State was created on 1st of October, 1996 from the old Sokoto State. It is one of the 11 States in the North-West geopolitical zone. The State has 14 LGAs, a 2015 projected population of 4,328,270 (NPC, 2006) and an area mass of 37,931 (NBS, 2010). Zamfara State is bounded by Katsina State on the East, Kebbi State on the West, Sokoto State on the North with Niger and Kaduna States on its Southern border.

The State has 697 health facilities out of which 677 (97%) are PHC facilities and 19 are SHC facilities. Among the PHC facilities, 664 (98%) are public PHC facilities while 13 (2%) are private PHC facilities (FMOH, 2012). Zamfara State has an IMR of 150/1000 and U5MR of 254/1000 (MICS, 2011).

Zamfara SPHCDA was established in 2010 following the enactment of the SPHCDA law.

Main Findings

Zamfara State has an overall score of 49% in the implementation of PHCUOR which places it on the 14th position nationally and 5th in the North-West geopolitical zone. The State has its best performance in Legislation (100%) and its least score in MSP (11%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 63%

There is a management team for the SPHCDA in Zamfara State headed by an ES who reports to the Governor through the Honourable Commissioner for Health. The SPHCDA law clearly distinguishes the roles of the management team and governing board. However, there is currently no constituted governing board for the SPHCDA in the State. There is no evidence that the Agency publishes periodic reports as part of their accountability mechanism.

Legislation: 100%

The SPHCDA law in the State has been gazette and regulations have been drawn up to operationalize the bill. Stakeholders were adequately engaged in the process leading to the enactment of the law.

Minimum Service Package (MSP): 11%

Zamfara State implements special health projects. However, there is no costed MSP to guide efficient planning of such programs.

Repositioning: 22%

Although the law clearly transfers all PHC functions to the Agency, there is no evidence that the PHC department at the SMOH, the MOLG, LGSC and LGA have been collapsed into the SPHCDA. There is also no plan for staff reorientation nor engagement of stakeholders on the changing roles and responsibilities as the Agency is established.

Systems Development: 17%

The institutional structure of Zamfara SPHCDA clearly shows lines of accountability but there is no evidence of a current operational plan or SHDP. Zamfara SPHCDA has specific financial management policies separate from the civil service financial regulations. There is plan plan for regular ISS visit to the LGAs and health facilities. The agency is yet to develop guidelines for recruitment into the SPHCDA at all level.

Operational Guidelines: 40%

Zamfara SPHCDA has the capacity to develop and implement its work plan independent of the SMOH. The Agency is yet to adapt the national implementation manual on PHCUOR but has developed its implementation policy with provisions for HRH, M&E Accounting and other operational procedures. The management team is yet to be trained on the mandate of the SPHCDA policy.

Human Resources: 13%

There have been PHC staff audit in Zamfara State with development of a State database. However, there is no evidence of the establishment of a HRH committee, unit or department. The State is yet to develop a job description for all category of staff and also no plan to resolve staff maldistribution. All PHC staff in Zamfara State are not employees of the SPHCDA.

Funding Sources and Structure: 30%

The SPHCDA in Zamfara State has the capacity to effectively plan for its activities including procurement of commodities and other items required at the health facilities. Funds released are adequately tracked to ensure accountability. There is no evidence that there is a dedicated budget for SPHCDA activities and funds released are not sufficient to the approved work plan. Salaries, pension and other benefits of the SPHCDA are not administered by Sokoto SPHCDA.

Office Setup: 83%

The State government has provided offices used by the SPHCDA at both the State and LGHAs. These offices are not sufficiently equipped for the activities of the agency.

The observed strengths, weaknesses, opportunity and threat in the implementation of PHCUOR in Zamfara State are:

Strengths:

- Presence of gazette law and regulation to operationalize the law.
- Presence of a management team for the Agency with an appointed ES.
- Presence of Offices for SPHCDA operations at the State and Sub-State levels.

Weaknesses:

- Absence of a constituted governing board.
- Absence of a costed MSP.
- Incomplete repositioning of PHC structures and functions.
- Absence of an adequate HRH, N&E and funding structure.

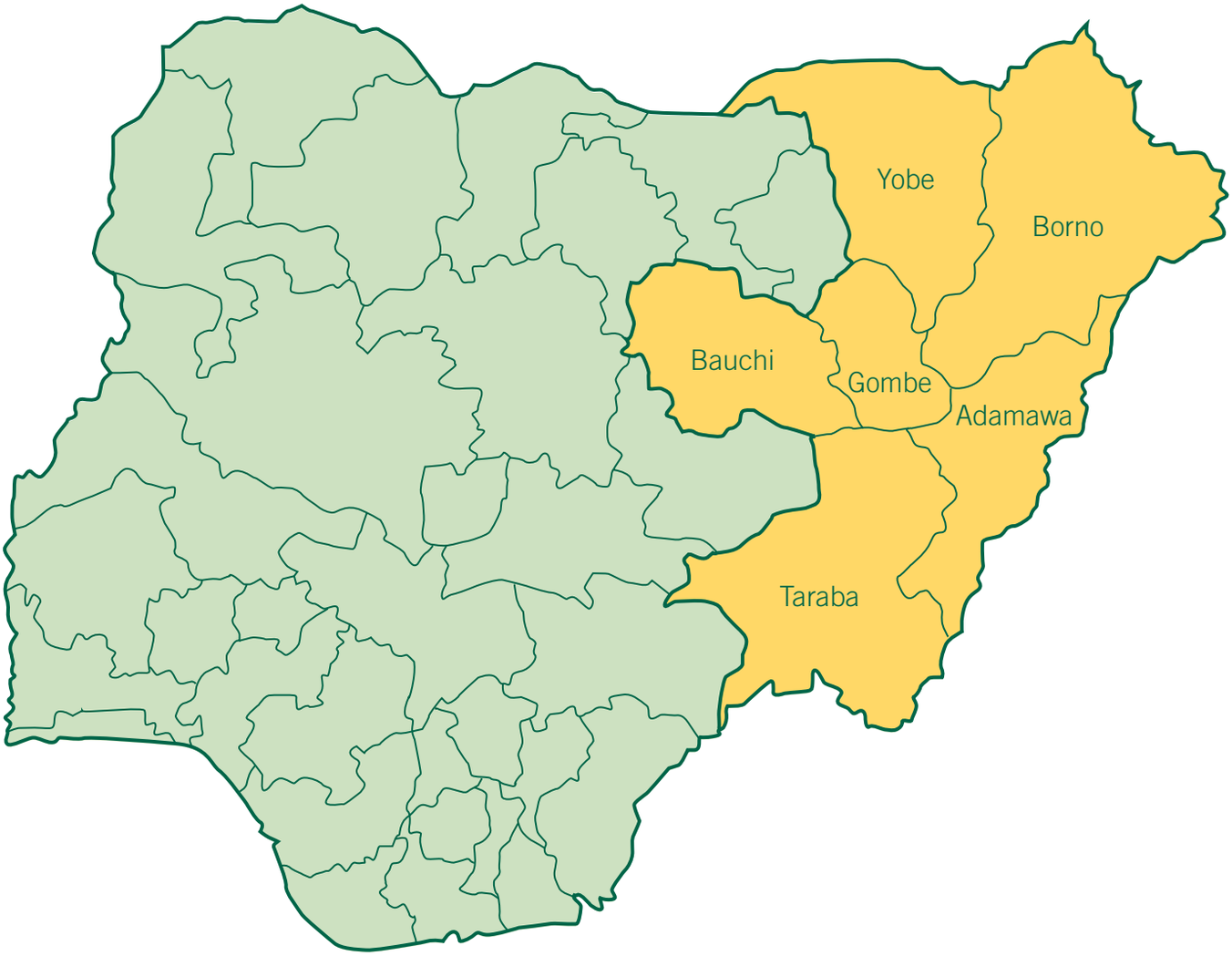
Opportunity:

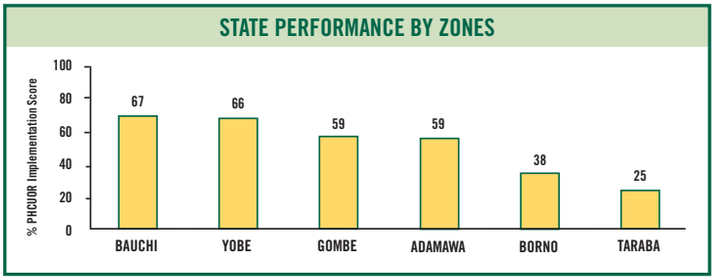
- Presence of development partners interested in PHC system strengthening.

Recommendations:

- Ensure complete repositioning of all PHC structures and functions as stipulated in SPHCDA law and in line with the PHCUOR policy.
- Constitute a governing board for the SPHCDA with adequate inclusion of relevant stakeholders.
- Seek assistance to develop a costed MSP.
- Strengthen the M&E, HRH, and funding structure of the SPHCDA.
- Equip SPHCDA offices at both the State and Sub-State levels.

NORTH EAST ZONE 52%





Adamawa State 45%

Background

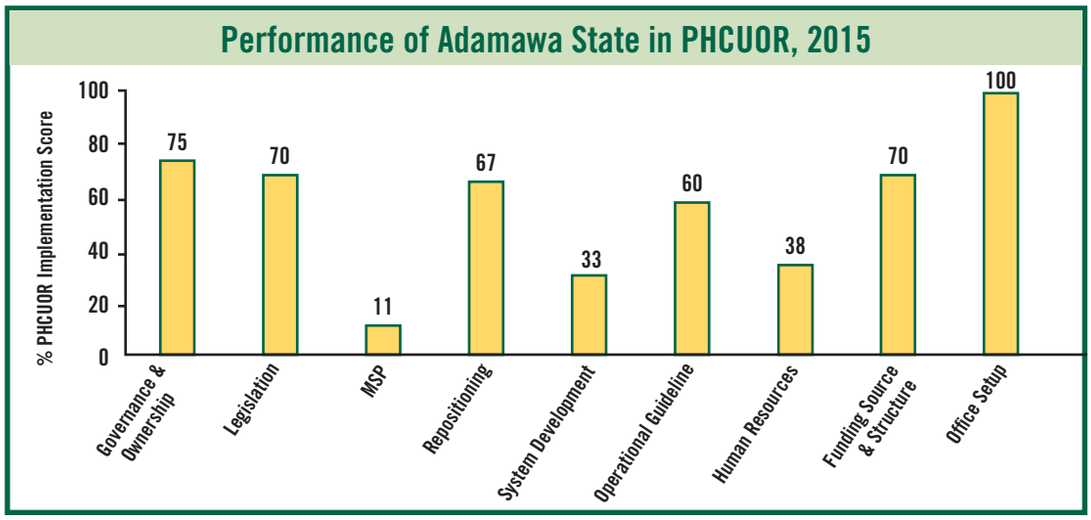
Adamawa State was created on 27th August, 1991 from the old Gongola State and has Yola as its capital city. It is one of the six States in the north east geopolitical zones of Nigeria and bordered by Borno State to the northeast, Gombe State to the west, Taraba State to the south-west. It has an eastern border with Cameroon. Adamawa State has 21 LGAs, with a 2015 projected population of 4,097,674 (NPC, 2006) and a land size of 38,700km2 (NBS, 2010).

There are 1,027 health facilities out of which 998 (97%) are primary healthcare facilities. (FMOH, 2012). The health status of the State shows that out of every 1, 000 children born in the State, 81 infants will die before their one-year birthday and 129 children will die before their five-year birthday (MICS, 2011).

Adamawa State Primary Health Care Agency (ADSPHCA) was established by Law number 10 of 30th May, 2011, signed by the State Governor on 30th July, 2011 and gazetted on 25th August, 2011. The law was amended in July, 2012. Adamawa State is one of the three States that were placed on a State of emergency on 14th May, 2013 due to the Boko Haram insurgency; this crisis has negatively affected the management of PHC facilities in the State.

Main Findings

Adamawa State has an overall score of 59% which places it 7th nationally and joint 3rd position with Gombe State in the North East geopolitical zone. The State has its best performance in Office Setup with a score of 100% and its least performance in MSP with a score of 11%.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%

The structure of the agency comprises of a governing board headed by an Executive Chairman who doubles as the head of Agency's management team and reports to the State Governor through the commissioner for health. Although the top management holds its meeting quarterly as against the stipulated monthly meetings, the agency publishes journals, reports and operational manuals. However, PHCUOR assessment shows no evidence of regular management meetings as stipulated by the national guidelines. Furthermore, the dual role of the Executive Chairman contravenes the national guidelines on PHCUOR.

Legislation: 70%

The law establishing the Agency was drafted by a technical committee in 2011 which involved stakeholders as part of the processes leading to Governor's assent. Although the law has been gazetted the Agency is yet to develop a regulation to guide its operations.

Minimum Service Package (MSP): 11%

ADSPHCA is a beneficiary of the Nigeria States Health Investment Project which is a World Bank performance based financing initiative. It is however yet to develop a costed MSP for the different types of health facility. A functional and properly costed MSP would improve efficiency and work output in the governance of PHC in the State.

Repositioning: 67%

The amended law establishing the ADSPHCA clearly transfers all PHC functions to the Agency with the PHC departments at the SMOH, MOLG and LGSC collapsed into the ADSPHCA. The departments of PHC in all the 21 LGAs have also been collapsed into the Local Primary Health Care Authority. There has neither been a forum for engaging all stakeholders to discuss the changing roles nor a plan for reorientation of the various categories of ADSPHCA staff as required. However, it is expected that the on-going repositioning process will resolve gaps in the running of the PHC in the State.

Systems Development: 33%

ADSPHCA has an annual operational plan but yet to develop its own strategic plan. The State has adopted the existing national ISS tool but there is no evidence of usage. It is noted that there are specific financial management policies separate from the State civil service financial regulations that guides PHC programs in the State. However, there are neither guidelines for recruitment into the Agency at the sub-State level nor operational plans at the LGAs.

Operational Guidelines: 60%

Adamawa State has developed a policy on PHCUOR which makes provision for HRH Management, monitoring & evaluation, accounting and other procedures. Thus the Agency is able to develop and implement PHC work plan independent of SMOH. However, there is no evidence that key personnel have been trained on the expected roles and responsibilities of the Agency.

Human Resources: 33%

In Adamawa State, all staff providing PHC services, including facility-based workers, are employees of the ADSPHCA. The Agency has developed job descriptions for health facility managers and workers but is yet to develop clear procedures for recruitment of staff. The Agency has commenced the process of staff redistribution and verification. The State is yet to establish a human resource committee for the transfer of PHC human resource.

Funding Sources and Structure: 70%

The Agency has a dedicated budget and fund-release processes for PHC with an internal control system. ADSPHCA is able to effectively plan and budget for its activities without external assistance such as planning for the procurement of commodities and other items required at the health facilities. However, allocated funds are usually not commensurate with approved plans. The Agency is yet to develop a mechanism for pooled funding for implementing PHC programmes. The LGAs make contribution to the funding of PHC activities in the State with a 15% deduction from their allocation. The salaries of health workers at the health facility level are paid by ADSPHCA, however, administration of staff pensions is done by the LGA pension board which contravene the precepts of PHCOUR.

Office Setup: 100%

There are designated offices for the operations of ADSPHCA both at the State level and the local PHC Authorities in all 17 LGAs. These offices are well furnished and are being utilized.

The observed strengths, weaknesses, opportunities and threat in the implementation of PHCUOR in Adamawa State are:

Strengths:

- SPHCDA established by law with designated office complex.
- Functional Management team and governing board in place.
- Functional sub-State structures LGHAs.
- Availability of dedicated funding mechanism.

Weaknesses:

- Dual role of the Chief Executive.
- No clear delineation between management and governing board functions.
- Lack of a costed MSP.

Opportunities:

- Availability of potential joint funding partners.
- Political will of the executive and legislative arm of government.
- New government to re-negotiate existing PHC gaps.

Threat:

- Insecurity in some parts of the State.

Recommendations:

- Separate clearly the roles of the governing board and management team. Review the existing law to attain this.
- Seek technical assistance for a functional costed MSP.
- The management team should meet more regularly to address emerging issues succinctly.
- The agency should engage and reorient staff on changing roles and responsibilities.
- Review and operationalize the existing ISS plan.
- The Adamawa State government should allocate funds commensurate with approved plan to the agency and allow the agency take over the administration of PHC staff pensions.

Bauchi State 67%

Background

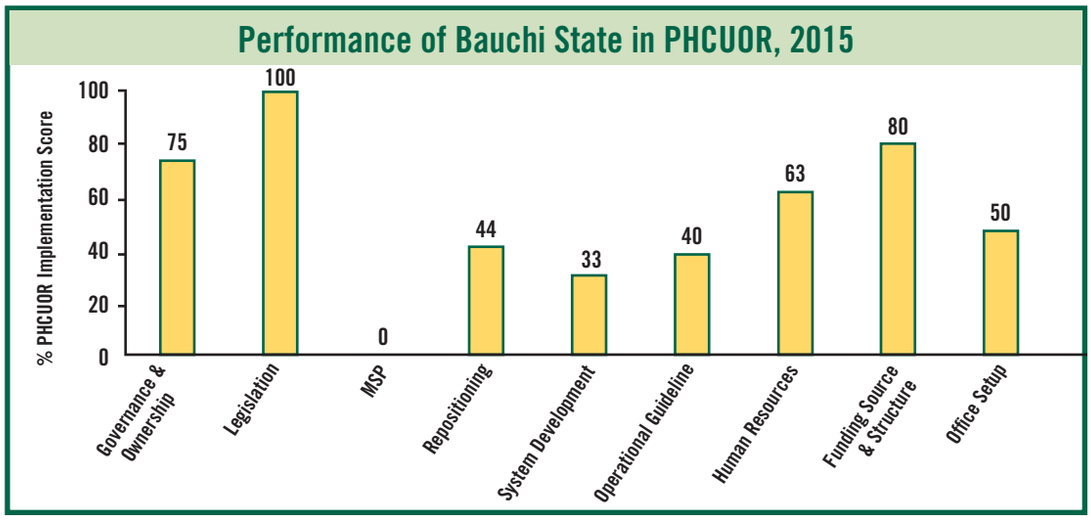
Bauchi State was created on the 3rd of February, 1976. It is located in the North-East geopolitical zone of Nigeria. Based on the 2006 National Population Census, Bauchi State has a projected 2015 population of 6,318,334 (NPC, 2006) and spans a land space of 49,119.87km2 (NBS, 2010). Bauchi State has a total of 20 LGAs. The major languages spoken in the States are Hausa, Bole and Fulfulde.

Bauchi State has a total of 1,034 health facilities out of which 1,010 (97.6%) are PHC facilities. 960 (95%) of these assessed PHC facilities are owned by the government while the remaining 50 (5%) are private PHCs (FMOH, 2012). The IMR and U5MR for the State are 140 and 236 per 1,000 respectively (MICS, 2011).

Bauchi SPHCDA was established by law that came into effect in August, 2012. The governing board is led by an EC who doubles as the head of the management team. Bauchi State is one of the States affected by the Boko Haram insurgency and this has affected PHC activities.

Main Findings

Bauchi State has an overall score of 67% in the implementation of PHCUOR thus ranking 1st in the North-east geopolitical zone and 3rd in Nigeria. The State scored 100% in Legislation while scoring 0% in Minimum Service Package.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%

Structures for Governance & Ownership such as building, organogram, governing board and management team are visible in the operation of the Bauchi SPHCDA. However, the role of the governing board is not clearly distinct from that of the management. Staff of the PHC department in the 20 LGAs have been transferred to the SPHCDA. There is no published report (whether monthly, quarterly or annual) was sighted during the assessment.

Legislation: 100%

Bauchi is one of the States in Nigeria with a law establishing its State Primary Health Care development Agency (SPHCDA). The law has also been gazetted and the regulations consistent with the laws thus enabling the SPHCDA to run with minimum interference by the State Ministry of Health or other organs of government on the State.

Minimum Service Package (MSP): 0%

No document on the Minimum Service Package (MSP) for the various facility types was sighted. The State Strategic Health Development Plan which was developed in 2009 did not make clear provision for the operation of a MSP in the health sector.

Repositioning: 44%

Although the law establishing the SPHCDA clearly provides for the transfer of all PHC functions from SMOH, SMOLG, LGSC and LGAs to the SPHCDA but there is no visible evidence that demonstrates other mechanism or forum to discuss the changing roles and responsibilities among the agencies. There is also no evidence to show that all the staff in the new agency have been properly re-orientated. Although the structure for operating PHCUOR is on ground in the State, there is no visible effort to strengthen the structure.

Systems Development: 33%

The State has a five-year health sector SHDP (2010 – 2015) from which a specific SPHCDA strategic plan may be developed. No evidence was available of the existence of an operational plan for the current year and neither is there evidence of implementation of ISS at the State and sub-State levels.

Operational Guidelines: 40%

The State adapted the implementation of the national manual on PHCUOR which made provision for HRH, M&E and Accounting procedure but there is no evidence that the manual was used during the period under review. Bauchi SPHCDA has a management team but there is no evidence to show that the team has been trained on operations of PHCUOR.

Human Resources: 63%

The State has setup a committee for the transfer of all PHC staff to the agency and letters of transfers have been disbursed. However, the transfer is still not effective as staff are still under their parent MDAs. The SPHCDA has no clear procedures for recruitment of PHC staff. Furthermore, there is no evidence of orientation or capacity building exercise carried out for staff. No costed capacity plan to address staff needs was sighted.

Funding Sources and Structure: 80%

Funding for the Bauchi SPHCDA is done through a dedicated fund for PHC by the State Government. There was release of take-off grant for the Agency at the inception of the Agency in the State and subsequently funded through its dedicated budget. The Agency has been able to plan and budget for its activities without external assistance and also able to plan for the procurement of commodities required for services across all facilities in the State. However, there is no evidence of joint funding for implementing PHC activities. Salaries of health workers at the facility level are still being paid by the LGA.

Office Setup: 50%

Bauchi SPHCDA operates from a dedicated office building at the State level and not yet at the LGA level. The office building was furnished through funds from the State government.

The observed strengths, weaknesses, opportunity and threats in the implementation of PHCUOR in Bauchi State are:

Strengths:

- There is a gazetted law and regulation establishing the SPHCDA.
- There is a physical office structure in place.
- Presence of a board and a management team.

Weaknesses:

- Lack of a costed MSP.
- Weak M&E system.
- Supporting structure for PHCUOR is however weak.

Opportunity:

- New government provides an opportunity to increase the momentum of the implementation of PHC reforms.

Threats:

- Insecurity concerns in the State.
- Incomplete transfer of PHC structures and functions to SPHCDA e.g. salary payment.

Recommendations:

- Seek assistance and provide enabling environment for the development of costed MSP for the various categories of health facilities.
- Strengthen M&E system which includes production of periodic reports, enforcing accountability system, etc.
- Strengthen HRH management to carry out staff audit and develop a capacity building plan for staff of SPHCDA.
- Setup mechanisms for pool funds for PHC activities as required by the law establishing the Agency.
- Set up LGHA and designate office for the coordination of PHC activities at the LGA level.

Borno State 38%

Background

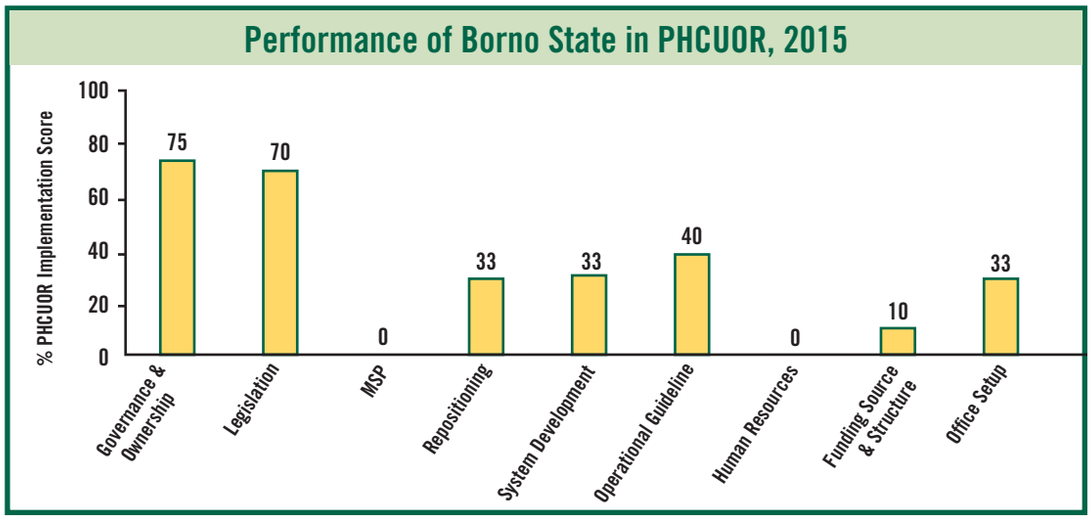
Borno State, with its capital – Maiduguri, was created in 1976 from the fragmented North Eastern States (Bauchi, Borno and Gongola) and has 27 LGAs. The State has a total land mass of 72,609 km2 (NBS, 2010) and 2015 projected population of 5,608,642 (NPC, 2006). It is bounded by Cameroun to the East, Chad to the North-East, Yobe State to the North-West, Gombe State to the South-West, Republic of Niger to the North and Adamawa State to the South.

The State has a total of 474 health facilities out of which 421 (89%) are PHC facilities. These PHC facilities are divided into 409 (97%) public and 12 (3%) private facilities. There are 52 SHC facilities in the State (FMOH, 2012). The health indices in the State shows an IMR of 116 /1000 and an U5MR rate of 192/1000 (MICS, 2011).

The implementation of PHCUOR in the State started in 2013 with the passage of the SPHCDA bill into law and its gazette on the 9th day of April 2013. Borno State is currently facing security challenges due to Boko Haram insurgency and this has affected PHC activities.

Main Findings

With an overall score of 38%, Borno State is placed 22nd nationally and ranked 5th out of the 6 States in the North Eastern Zone. Governance ad Ownership (75%) was their best performing domain, while their worst performance was in Human Resources and MSP domains with a 0% score.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%

Borno SPHCDA has a management team that meets monthly. Although there was no governing board at the time of the assessment, the law clearly delineates its role from that of the management team. There is no evidence of published periodic reports as part of accountability mechanism.

Legislation: 70%

There is a gazetted law backing the establishment and activities of SPHCDA in the State. The process of enacting this law involved consensus building among key stakeholders. Borno SPHCDA is yet to draft regulations to operationalize the law.

Minimum Service Package (MSP): 0%

The State is yet to develop and implement a costed MSP.

Repositioning: 33%

PHC department at the SMOH has been collapsed into the SPHCDA and there is a plan to reorient different categories of staff and stakeholders on their new roles and responsibilities. The repositioning process is limited by the law which is not explicit on the transfer of all PHC departments and functions to the SPHCDA particularly at the sub-State levels.

Systems Development: 33%

The institutional structure of the agency clearly shows line of accountability. Whereas Borno SPHCDA has a plan and tool for ISS, there is no evidence that ISS is been conducted. There is neither evidence of a current strategic plan nor an operational plan for the agency.

Operational Guidelines: 40%

Borno SPHCDA has the capacity to develop its Operational Guidelines independent of SMOH, however it is yet to adapt the national guidelines for PHCUOR implementation in the State.

Human Resources: 0%

Borno State is yet to setup a HRH committee for the transfer and the documentation of PHC staff neither does the SPHCDA have a department for HRH management.

Funding Sources and Structure: 10%

There is a dedicated budget process and fund release for planned PHC expenditure in Borno State. However, the amount released for SPHCDA is not adequate for the activities of SPHCDA. The State is yet to establish a joint fund for implementing PHC activities in line with PHCUOR national policy.

Office Setup: 33%

The State government has provided an equipped office for SPHCDA activities in the State but it is yet to be replicated at the sub-State levels.

The observed strengths, weaknesses, opportunities and threat in the implementation of PHCUOR in Borno State are:

Strengths:

- Management team in place.
- SPHCDA law gazetted.
- Equipped office at the State level.

Weaknesses:

- No costed MSP.
- Governing board yet to be constituted.
- Non-existence of operational plans and regulations.

Opportunities:

- Strong political will.
- The current interest towards re-building health systems in the State by development partners.

Threat:

- The insurgency in the State.

Recommendations:

- The State should setup a governing board with balanced inclusion of stakeholders.
- Effective coordination of partners towards post insurgency rebuilding of PHC system.
- Establishment of joint funding mechanism with contributions from the State, LGAs and development partners for PHC activities.
- Development of regulations to operationalize PHCUOR in line with national policy.

Gombe State 59%

Background

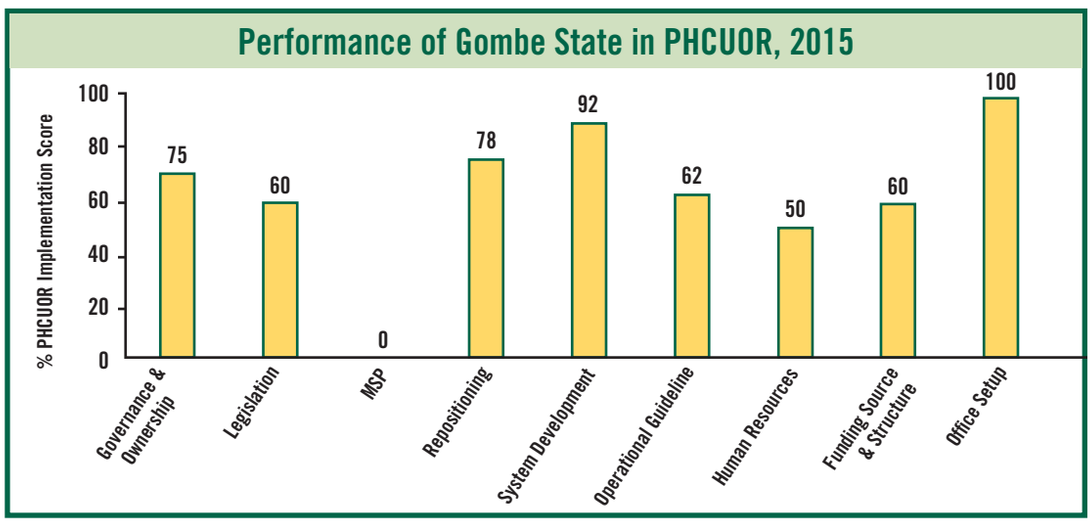
Gombe State is located in the North East geopolitical zone of Nigeria with its capital city as Gombe. Created in 1996, the State shares boundaries with Borno State to the East; Bauchi State to the West; Yobe State to the North; Adamawa and Taraba States to the South. It has an estimated landmass of 17,100 km2 (NBS, 2010) and a 2015 projected population size of 3,125,370 from 2006 census (NPC, 2006). Gombe State is made up of 11 LGAs.

There are a total of 531 HF in the State. Among these, 508(96%) are PHC facilities. 447 (88%) PHC facilities are public owed, while 61 (12%) are private facilities (FMOH, 2012). In 2011, Gombe State had an IMR of 117/1000 live births and U5MR of 196/1000 live births (MICS, 2011).

Gombe SPHCDA was established in 2013 following the enactment of an enabling law in 2011.

Main Findings

Overall, Gombe State scored 59%, ranking 7th nationwide and 3rd position in the North East zone. Gombe State scored 100% in Office Setup while scoring zero in the MSP domain.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 75%

Although the Gombe SPHCDA was established with a governing board distinct from the management team, the governing board stood dissolved as at the time of this assessment. The Management team on the other hand is chaired by the ES and holds top management meetings at least once a month. The ES does not report to the Governor through the Honorable Commissioner of Health neither does the Agency publish periodic reports on its activities.

Legislation: 60%

The law establishing Gombe SPHCDA was generated following 1) a series of high-level advocacy, 2) consultative meeting with major stakeholders, and 3) establishing a technical committee to draft the bill. The law was signed by the governor in 2011 however, the regulations for operationalizing the bill is yet to be drafted.

Minimum Service Package (MSP): 0%

Gombe State has not yet adopted a costed MSP for different facility types which ensures appropriate financial and organizational planning for equitable PHC implementation.

Repositioning: 78%

The law establishing Gombe SPHCDA clearly transfers all PHC functions as well as collapses the department of PHC at the SMOH, MOLG, LGSC and LGA into the Agency. While this is a key objective in implementing PHCUOR policy, it also means shifting roles and responsibilities across all agencies. The State has not yet re-oriented personnel and managers on their new roles and responsibilities in relation to PHCUOR.

Systems Development: 92%

Gombe State has developed a Strategic Health Plan, an annual work plan, and ISS plan and tools. The ISS tools are currently used to supervise PHC activities at the LGA and health facilities but the supervisory visits are not consistent. The institutional structure of the Gombe SPHCDA clearly shows lines of accountability with guidelines and protocols for operations and staff recruitment.

Operational Guidelines: 60%

The State has in place an Operational Guidelines for the implementation of PHCUOR. The policy document makes provision for HRH, monitoring and evaluation, accounting and other procedures. In addition, the SPHCDA has the capacity to develop and implement its work plan independent of the SMOH, but is yet to train key personnel and managers on its guidelines.

Human Resources: 50%

A PHC staff audit was conducted and a HRH database was developed in July 2015, however there are no implementation plans for managing mal-distribution of staff and their needs. The staff providing PHC services especially at the sub-State level are full employees of the Agency with job descriptions.

Funding Sources and Structure: 60%

The State released a takeoff grant for the SPHCDA and the Agency has a dedicated budget process for funding planned PHC activities, as well as a mechanism for tracking the funds released. Additionally, SPHCDA effectively plans for procurement of commodities and other items needed at the health facility for effective health care delivery without external assistance. However, there are funding gaps between resources required, amount approved and timing of releases. Currently, the LGA's contributions towards PHC activities are deducted from source, but there is no mechanism for joint funding from different sources for implementing PHC activities. Furthermore, the Agency does not pay health workers' salaries benefits and pension as stipulated in the PHCUOR policy.

Office Setup: 100%

Gombe State government has provided office accommodation for SPHCDA activities at both State and LGA levels. The offices are fully furnished and equipped with computers and internet facilities.

The observed Strengths, weaknesses, opportunity and threat in the implementation of PHCUOR in Gombe State are:

Strengths:

- The existence of an SPHCDA backed by law.
- The SPHCDA law makes provision for transferring all PHC functions as well as collapsing of parallel departments of PHC into the Agency.
- Availability of designated offices for SPHCDA at State and sub-State levels.

Weaknesses:

- Flawed line of accountability as the ES does not report to the Governor through the Honourable Commissioner for Health.
- Unavailability of costed MSP for different facility types.
- No implementation plans for managing mal-distribution of PHC staff.

Opportunity:

- Continuity in State government provides opportunity for sustained improvement in PHC implementation.

Threat:

- Security challenges.

Recommendations:

- Streamline the reporting structure to ensure the ES reports to the Governor through the Honourable Commissioner for Health of Health.
- Adopt and draft a costed MSP for different facility types.
- Implement a plan to communicate and re-orient stakeholders, key personnel and officers on PHCUOR reforms.
- Develop clear strategies for managing mal-distribution of staff in the State.
- Establish a pool fund for PHC inclusive of contributions from the LGAs, State and federal governments, donors and possibly private sector.

Taraba State 25%

Background

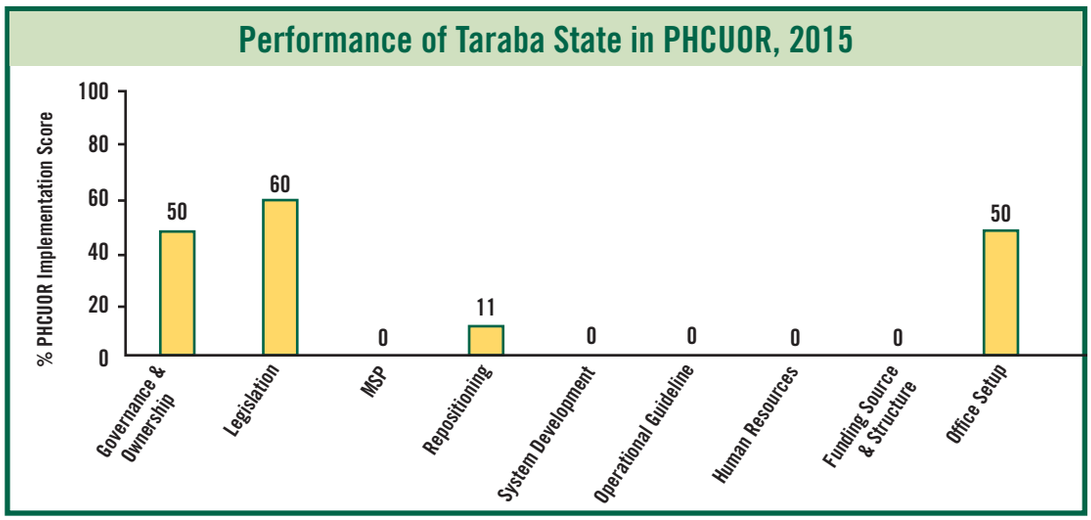
Taraba State was created out of the former Gongola States on 27th August, 1991 with its capital city – Jalingo. It has a land mass of 56,282km2 (NBS, 2010). Taraba State is bounded by Adamawa State to the North East, East and South by the Republic of Cameroon, to the North West by Plateau State and West by Nasarawa and Benue States, and Bauchi and Gombe States to its North. The State has a 2015 projected population of 2,949,612 (NPC, 2006) spread across 16 LGAs.

There are a total of 1,045 health facilities in the State. Out of which 1030 (99%) are PHC facilities and 14 are SHC facilities. 895 (87%) are public owned PHC facilities while the remaining 135 (13%) are private PHC providers (FMOH, 2012). The health indices in the State show an IMR of 71/1000 and an U5MR of 111/1000 respectively (MICS, 2011).

The Taraba SPHCDA was established through the enactment of an enabling law.

Main Findings

The overall average score of Taraba State in PHCUOR implementation is 25% thus ranking the State 28th nationally and 6th in the North East geopolitical zone of Nigeria. The State performed best in the Legislation domain (60%) and least in the domains of MSP, System Development, Operational Guidelines, Human resource and Funding, sources and structure with a zero score.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 50%
Taraba SPHCDA has a management team headed by an ES who reports to the Governor of the State through the Honourable Commissioner for Health. Although the SPHCDA law specifies the roles of a governing board as distinct from that of the management team, there is no evidence of a constituted governing board. There is no evidence of periodic management meetings and periodic publications as part of accountability mechanism.

Legislation: 60%
Having established a technical committee that drafted the bill, there was stakeholder engagement to review and build consensus around the key elements of the bill. The bill has been passed by the State House of Assembly and assented to by the State Governor. However, the Law has not been gazetted and regulations for operationalizing the Law is yet to be developed.

Minimum Service Package (MSP): 0%
Taraba State is yet to develop a costed MSP that can be classified into the different health facilities.

Repositioning: 11%
Although the law establishing the Taraba SPHCDA transfers all PHC functions to the Agency, this provision of the law is yet to be implemented. There is no evidence of stakeholders engagement to discuss changing roles and responsibilities following the establishment of SPHCDA in the State.

Systems Development: 0%
Standard guidelines and policies for PHCUOR operations are yet to be established in Taraba State.

Operational Guidelines: 0%
The national guidelines for PHCUOR implementation in Taraba State is yet to be adapted.

Human Resources: 0%
The PHC HRH structure in Taraba State is still fragmented.

Funding Sources and Structure: 0%
There is no integrated PHC funding structure in Taraba State.

Office Setup: 50%
There are designated offices for use at the State levels but Taraba State is yet to replicate at the sub-State levels.

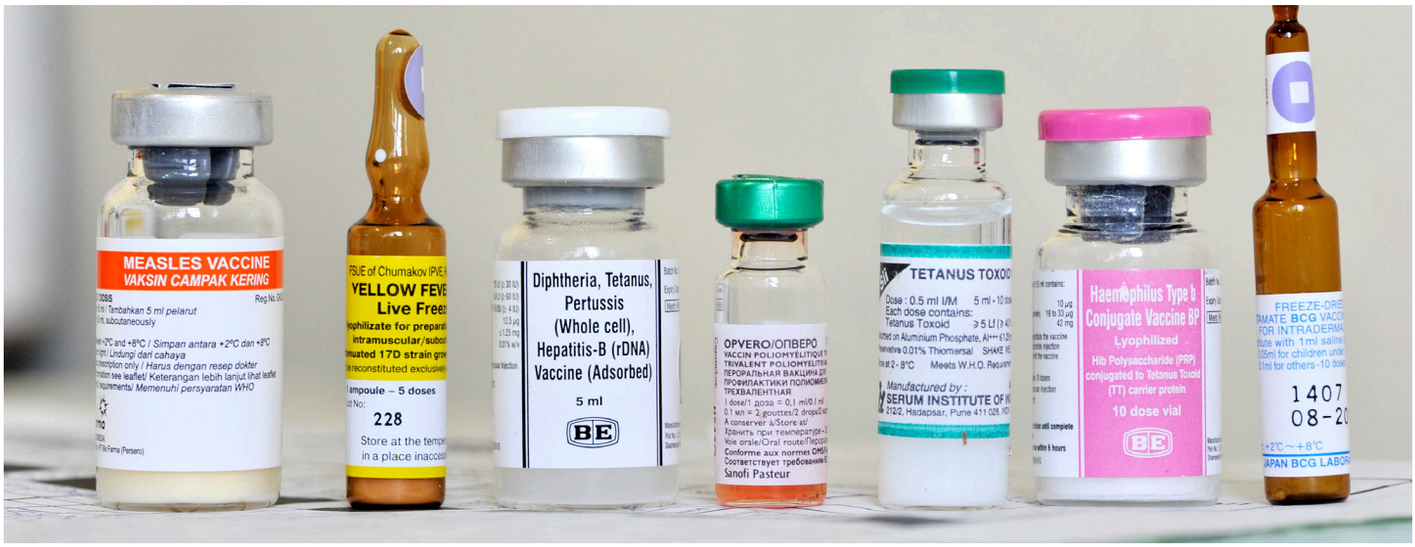
The observed strengths, weaknesses and opportunity in the implementation of PHCUOR in Taraba State are:

Strengths:
- The SPHCDA is backed by law and a management team in place.
- Strong political will.Presence of an office at the State and LGA levels.

Weaknesses:
- Lack of a constituted governing board.
- Lack of a PHC HRH structure.
- Lack of a costed MSP.

Opportunity:
- Presence of partners.

Recommendations:
- Constitute a governing board for the Agency.
- Seek support to develop a costed MSP.
- Establish and designate offices for LGHAs.



Yobe State 66%

Background

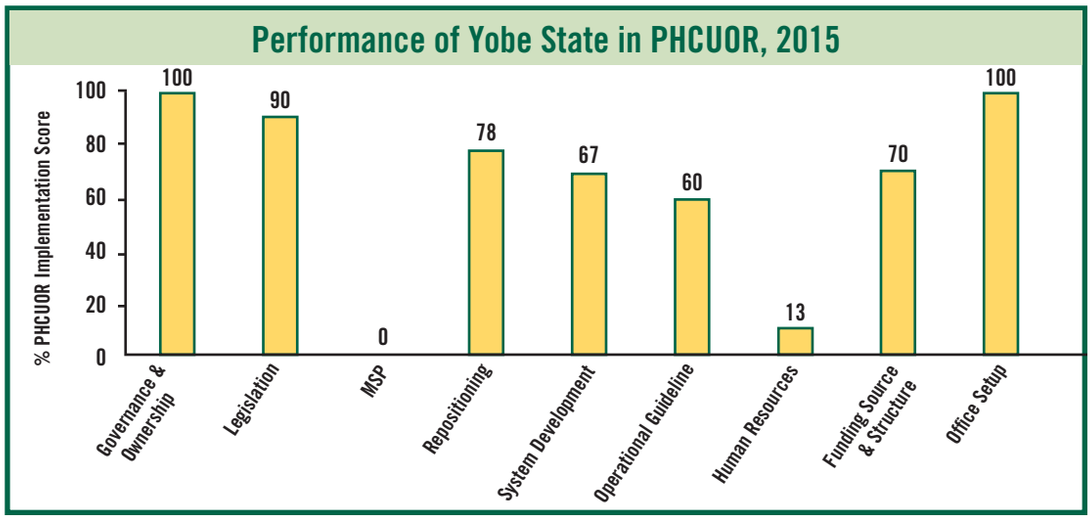
Yobe State, created out of Borno State on August 27, 1991 with 17 LGAs, has its capital city as Damaturu. The State is located in the North East geopolitical zone of Nigeria. It has a land mass of 46,609 Km2 (NBS, 2010) sharing boundaries with Borno to the East; Bauchi and Jigawa to the West; Niger Republic to the North; and Gombe and Borno to the South. The State has a projected 2015 population of 3, 179,376 (NPC, 2006). IMR and U5MR (per 1000 live births) in the State are 142 and 240 respectively.

A total of 517 health facilities are located in the State, 486 (94%) of which are PHC facilities, 30 (6%) are Secondary facilities, while 1tertiary health facility exists in the State. All PHC facilities are public owned facilities.

Yobe SPHCMB was established in 2010 following the enactment of an enabling law. Yobe State is one of the North East States challenged with the Boko Haram insurgency.

Main Findings

Yobe State scored 66% in this assessment, ranking 4th nationally and 2nd in the North east Zone. The State has the highest score of 100% in Office Setup and Governance & Ownership while the lowest score was a zero score in MSP.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 100%

The Board has a 17-member Governing Board and Director-General string the affair of the board. The Governing Board meets quarterly while the management team meets monthly. The Board has a well layout organogram specifying the management structure. The roles of the governing Board and the management team are distinctly defined in the enabling laws.

Legislation: 90%

While the Yobe SPHCMB was inaugurated in 2010, it's enabling law was enacted in 2012. The process of legislation included the constitution of a technical committee for the drafting of the law. Consensus was built among the major stakeholders on the bill establishing the Board. There is no evidence indicating that the enabling law has been gazetted.

Minimum Service Package (MSP): 0%

The State is yet to develop a costed MSP to guide efficient and equitable investments in its PHC system.

Repositioning: 78%

The law establishing the Board clearly transfers all functions of all PHC from the SMOH, MOLG, LGSC and LGA to the SPHCMB, with the exception of staff training fund which still remains with the LGSC. The law also defines clearly the new roles of the SMOH and MOLG. The departments of the PHC at the SMOH, MOLG, LGSC and PHC at the LGA have been collapsed into the Board. However, there is no evidence of plan for re-orientation of different categories of PHC staff of.

Systems Development: 67%

The State has developed a Strategic Health Plan as part of its Midterm State Strategic Plan and there is an annual operation plan for the current year. The State has an integrated supportive plan but there is no evidence of recent ISS visit. There are no guidelines for recruitment into the SPHCMB at the Sub-State levels. The institutional structure of the Board clearly shows line of accountability and there are guidelines and protocols for operations at different levels.

Operational Guidelines: 60%

The State policy on PHCUOR makes provision for human resources, monitoring and evaluation, accounting and other procedures. The SPHCMB has the capacity to develop and independently execute its work plan. However, key staff are yet to be trained on the Board's mandate using the guidelines.

Human Resources: 13%

Yobe SPHCMB has a department for human resources headed by a Director. The Board has a data base for the staff and the PHC staff audit has been done. However, orientation has not been organized on human resource information system and MSP for the human resources committee members. All the PHC staff in the State are yet to be fully integrated into the Board. The Board is yet to develop implementation plan on how to resolve the mal-distribution of PHC staff. Also there is no evidence that procedures for recruitment of staff for sub State structures have been put in place.

Funding Sources and Structure: 70%

The Board has an annual budget funded by the State government even though the amounts released by the government are not commensurate with its plan. The SPHCMB has an internal mechanism for tracking released funds. The LGAs' financial contribution to the Board for the management of PHC services are deducted from source. The Board is responsible for the salaries of the health workers at the health facility level. However, the State has not developed mechanism for joint funding for implementation PHC programmes and services.

Office Setup: 100%

The Yobe SPHCMB has a furnished office complex located on Gusau Road Damaturu. The State has also designated offices for the operation of the LGHAs in all LGAs level.

The observed strengths, weaknesses, opportunity and threat in the implementation of PHCUOR in Yobe State are:

Strengths:

- Availability of an enabling law establishing the SPHCMB.
- Functional management team in place.
- Agency has structures and systems at both State and LGA levels.

Weaknesses:

- Not adopting the MSP for different health facility types.
- Lack of implementation plan for managing mal-distribution of staff.
- The existence of a PHC department in the SMOH parallel to the SPHCDA.
- Training funds of staff still with the LGSC.

Opportunity:

- Partners and organizations can be leveraged for progression in PHCUOR implementation in the State.

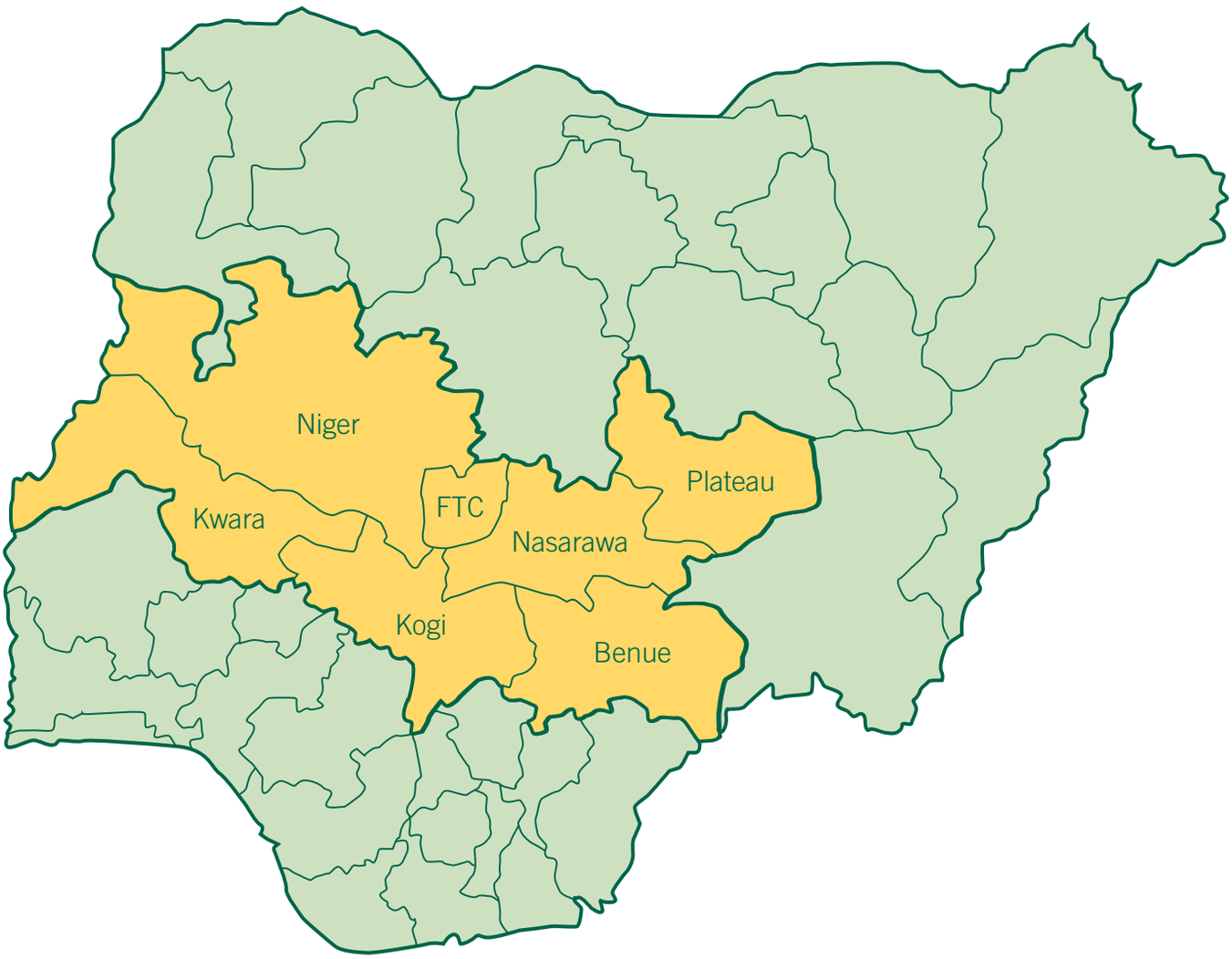
Threat:

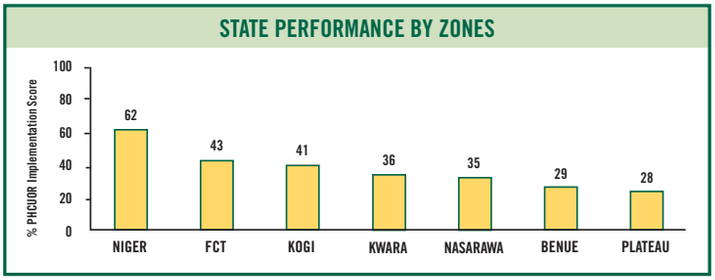
- Security challenges in the Yobe State.

Recommendations:

- Adopt a costed MSP for different facility types to ensure effective and efficient service delivery.
- Develop an implementation plan for the re-orientation and capacity building of SMOH, MOLG, LGSC and LGA personnel to their new roles and responsibilities in relation to the Board.
- Organize trainings for the HR Committee members on HR Information Systems and MSP.
- Develop strategies for managing issues related to mal-distribution of staff to ensure equity in service delivery.
- Establish a Pool-Funding mechanism for implementing PHC programmes and services.

NORTH CENTRAL ZONE 39%





Benue State 29%

Background

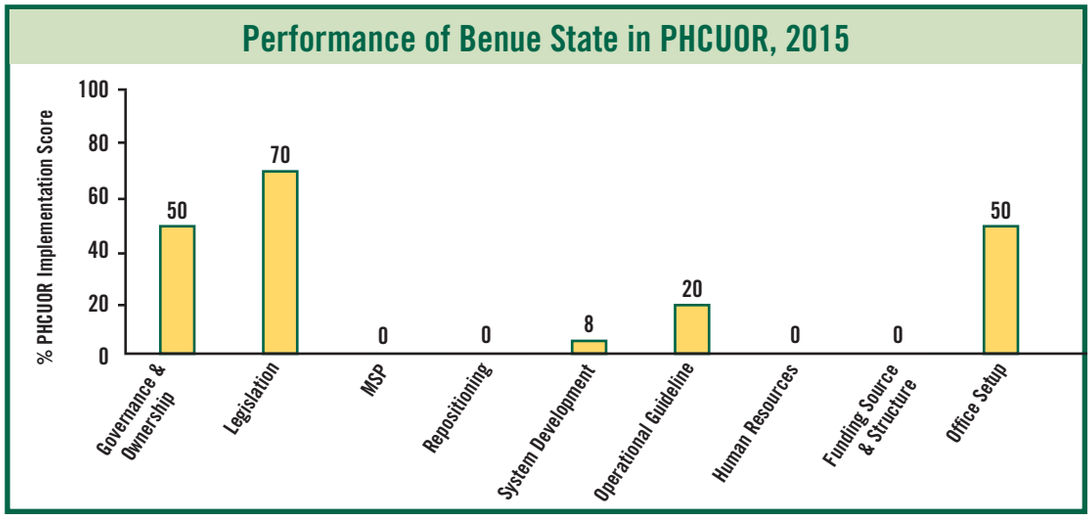
Benue State created on February 3rd 1976, with its capital city - Makurdi, is located in the North Central geo-political zone of Nigeria. It is bounded by Taraba to the East, Kogi and Enugu States to the West, Nassarawa to the North, Cross-River and Ebonyi to the South. The State has a projected total population of 5,505,156 (NPC, 2006) in 2015, spread across its 23 LGAs and a landmass of 30,800km2 (NBS, 2010).

The State has a total of 1206 health facilities out of which 1111 (92%) are PHC facilities. The PHC institutions consist of 771 (69%) public and 340 (31%) private facilities (FMOH, 2012). Benue State has an IMR of 97 per 1000 and U5MR of 158 per 1000 (MICS, 2011).

The PHCUOR implementation in Benue State commenced in 2012 following the passage of the SPHCDA bill by the State House of Assembly and subsequent assent by the State Governor.

Main Findings

With an overall score of 29%, Benue State is ranked 26th nationally and 6th out of the 7 States in the North Central Zone. Legislation (70%) was their best performing domain while they scored 0% in Funding Sources & Structure, Repositioning, Human Resources and MSP.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 50%
The State has a physical structure in place and an organogram. There is an acting ES heading the management team who reports to the Governor through the Honourable Commissioner for Health. Benue SPHCDA does not have a governing board in place and there is no document clearly specifying the distinct roles of the management team from the governing board.

Legislation: 70%
The bill for the establishment of SPHCDA in Benue State has been assented to by the Governor following passage by the State House of Assembly. The law has been gazetted but the State is yet to draft regulations to operationalize the law.

Minimum Service Package (MSP): 0%
The State has not developed a costed MSP to guide implementation of PHC programs.

Repositioning: 0%
Despite the establishment of SPHCDA in Benue State, there is no evidence of repositioning in line with the PHCUOR policy.

Systems Development: 8%
Although the institutional structure of Benue SPHCDA clearly shows lines of accountability, the Agency is yet to develop a strategic plan and operational plans at both State and LGA level. There is neither proof of ISS implementation nor clear guidelines and procedures for recruitment of staff of SPHCDA.

Operational Guidelines: 20%
The State policy document makes provision for human resources, monitoring and evaluation, accounting and other procedures to follow. However, there is no evidence of adaptation of the national implementation manual of PHCUOR in the State.

Human Resources: 0%
The SPHCDA in Benue State is yet to have a HRH department neither is there evidence of a plan in place to transfer of PHC staff.

Funding Sources and Structure: 0%
There is no dedicated funding for SPHCDA operations.

Office Setup: 50%
Benue SPHCDA has an inadequately equipped office at the State but LGHA offices are yet to be designated.

The observed strengths, weaknesses, opportunity and threat in the implementation of PHCUOR in Benue State are:

Strengths:
- The existence of Benue SPHCDA is backed by law.
- The SPHCDA has a management team.

Weaknesses:
- There is no governing board.
- Consolidation of all PHC staff and functions under the SPHCDA is yet to commence.
- Absence of a costed MSP to guide PHC programme.
- Lack of regulation and Operational Guidelines for PHCUOR implementation.

Opportunity:
- A new government in place to invigorate PHC reforms.

Threat:
- Non conformity with the PHCUOR guidelines.

Recommendations:
- Put a process in place that will urgently address the failing PHCUOR implementation.
- Set up a governing board with balanced inclusion of relevant stakeholders.
- The State should get a costed MSP for its PHC operation.
- All PHC functions and departments should be completely collapsed into Benue SPHCDA.

Federal Capital Territory 43%

Background

The Federal Capital Territory (FCT) is located in the North Central geopolitical zone of Nigeria and hosts Abuja, the capital of Nigeria. It was created in 1976 from parts of Nasarawa, Niger and Kogi States. The territory is made up of 6 Area Councils and 96 wards. It has an estimated landmass of 7,607km2 (NBS, 2010) and a 2015 projected population size of 3,128,382 (NPC, 2006). FCT shares territorial boundaries with Nasarawa State on the East and South, on the West and North with Niger State, Kaduna State to the Northeast, and Kogi State to the Southwest.

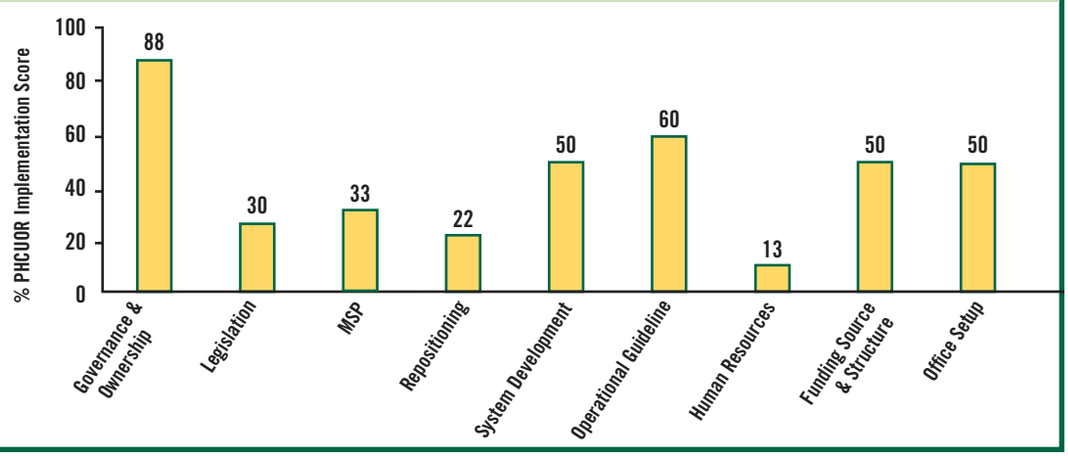
There are a total of 656 health facilities in FCT. Among these are 559 PHC facilities and 90 SHC facilities. Of the 559 PHC facilities, 179 (32%) are public and 380 (68%) are privately owned (FMOH, 2012). FCT has an IMR and U5MR of 92 and 148 deaths per 1,000 live births (MICS, 2011).

FCT PHCB commenced operations on September 26, 2010 following approval by the FCT Executive Committee and appointment of an ES. However, the bill establishing the board is yet to be signed into Law. FCT is governed by the FCTA under the leadership of a Minister appointed by the President. Its bill is passed by the National Assembly.

Main Findings

Overall, FCT scored 43% on PHCUOR implementation thus ranking 18th nationally and 2nd out of 7 States in the North Central zone. FCT performed best in Governance & Ownership domain (88%) and its least score in Human Resource domain (13%).

Performance of Federal Capital Territory in PHCUOR, 2015



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 88%

FCT PHCB has a governing board and a management team on the other hand oversees the day-to day running of the Board. FCT has no Honourable Commissioner for Health thus the ES reports to the FCT Minister through the FCT secretary of health. The FCT PHCB holds top management meetings at least once a month. Additionally, there is no evidence that the FCT PHCB publishes periodic reports as part of accountability mechanism.

Legislation: 30%

A technical committee was constituted for drafting the FCT PHCB bill and it is yet to complete this process for onward transmission to the National Assembly. The provisions of this bill was initially included in the national health bill before its sudden removal. This was recognized with the assent of the national health act and this explains why FCT PHCB is just in the process of drafting its bill.

Minimum Service Package (MSP): 33%

FCT PHCB is one of the few agencies/board that has adopted a MSP. While health facilities have been classified according to the MSP, the MSP has not been costed nor implemented at the health facility level. Furthermore, special health care projects implemented and linked to the MSP are not costed.

Repositioning: 22%

The unavailability of a law has limited the repositioning process as only the PHC activities at the FCTA has been collapsed into the FCT PHCB while other agencies still retain their PHC service implementation. In addition, personnel in the different categories of the FCT PHCB are yet to be oriented on their new roles and responsibilities as the board is being fully established.

Systems Development: 50%

The FCT PHCB has developed and budgeted for a 5 years Strategic Health Plan (2012-2016) and an annual operational plan for its PHC activities. Although the Integrated Supportive Supervisory (ISS) implementation plan developed by the Board is still rudimentary, the ISS tool is currently in use to supervise PHC activities at the LGA and health facilities level but not conducted consistently. Institutional structure of FCT PHCB also shows clear lines of accountability, but there are no guidelines and protocols for recruitment. In addition, there are no operational health plans at the Area Council level.

Operational Guidelines: 60%

There is an Operational Guidelines in use for the implementation of PHCUOR in FCT. The policy guideline makes provision for HRH, M&E and accounting. Although the FCT PHCB has the capacity to develop and implement their work plan independent of the FCTA health department, the management team has not been trained on the mandate of FCT PHCB using the policy guideline.

Human Resources: 13%

FCT PHCB conducted staff audit in 2012 and subsequently updated the database in 2013. However, staff providing PHC services especially at the health facility level are not employees of the board. Furthermore, there are no clearly defined job description and recruitment process for the staff. The board is yet to develop a costed capacity building plan to address staff needs.

Funding Sources and Structure: 50%

At the commencement of FCT PHCB operations in 2010, a takeoff fund was provided and an internal audit system was developed to track release of funds. Presently, an annual dedicated budget for FCT PHCB expenditure exists but the allocated funds for FCT PHCB activities are not commensurate with the approved planned budget for PHC expenditure. Additionally, there is a provision in the draft bill made for joint funding for implementing PHC activities in line with the MSP, but this bill is yet to become law.

Office Setup: 50%

There is a fully equipped office with furniture; computers and internet access for the operation of FCT PHCB but none has been provided at the various Area Councils.

The observed strengths, weaknesses, opportunities and threat in the implementation of PHCUOR in FCT are:

Strengths:

- Presence of a technical team drafting the PHCB bill.
- A management team headed by an ES.
- The FCT PHCB annual operational plan and 2012-2016 strategic health plan.

Weaknesses:

- NPHCB without a legal backing.
- A dissolved governing board.
- Absence of LGHA equivalent at the various Area Councils.

Opportunities:

- FCT PHCB is located in the Country's capital city with close proximity to decision makers.
- A hub of partners located in FCT willing to support PHC strengthening.

Threat:

- FCT PHCB bill prolonged navigation through the house of Assembly.

Recommendations:

- Urgent enactment of FCT PHCB law.
- Re-constitution of a governing board with balanced inclusion of relevant stakeholders.
- Costing of the MSP and ensure utilization at service delivery points.
- Adequate stakeholder engagement and staff orientation on the principles of PHCUOR.
- Complete repositioning of all PHC departments and staff to the FCT PHCB.
- Ensure the implementation of joint funding for PHC activities as seen in the draft bill and improve funding for PHC activities in FCT.
- Establish and equip FCT Area Council Health Authorities (ACHA).

Kogi State 41%

Background

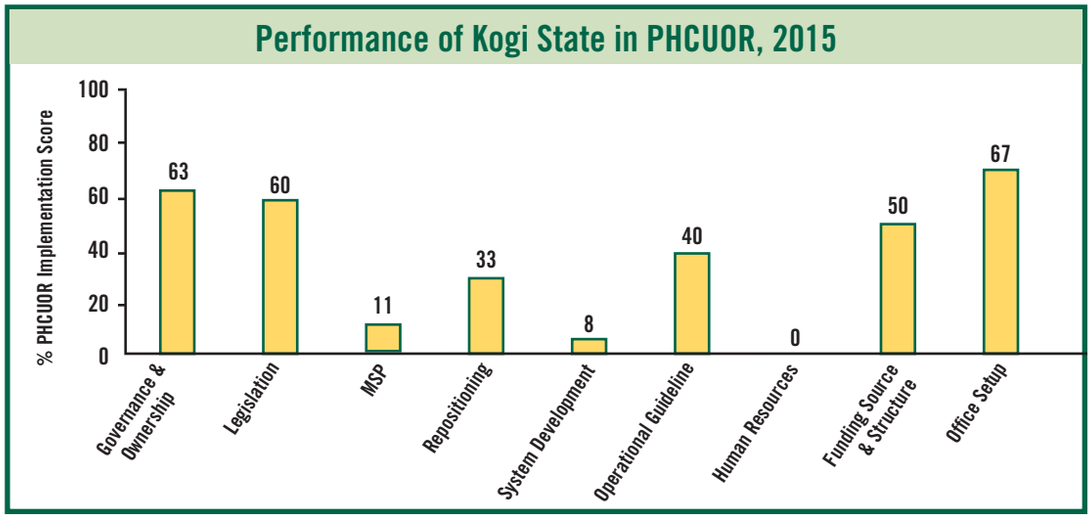
Kogi State, popularly known as the Confluence State is located at the North central region of Nigeria with Lokoja as its capital city. The State was created on 27th August, 1991 from parts of Benue and Kwara States. Kogi State has 21 LGAs with a 2015 projected population of 4,277,682 (NPC, 2006) with a landmass of 27,747km2(NBS, 2010).

The State has a total of 1,077 health facilities out of which, 868 (81%) are PHC facilities and 28 are SHC facilities. There are 823 95% public and 45 () private PHC facilities (FMOH, 2012). The key health indices in Kogi State shows an IMR of 82 per 1000 and U5MR of 132 per 1000 (MICS, 2011).

The Kogi SPHCDA was established on 12th April, 2012 following passage of its law.

Main Findings

Kogi State has an overall score of 41% on PHCUOR implementation progress thus ranking 20th nationally and 3rd in the North Central geopolitical zone. Office Setup is their best performing domain with 67% while Human Resource was their worst performing domain with a zero score.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 63%

Kogi SPHCDA has a management team headed by an ED who reports to the Governor through the Honourable Commissioner for Health. There is a clear institutional structure with evidence to show that the top management team meets regularly. The governing board is yet to be constituted and the law does not clearly define the roles of the management team as distinct from that of the governing board. Also, there is no available evidence of periodic report as part of accountability mechanism.

Legislation: 60%

The process that led to the enactment of the Law involved the drafting of a bill, engagement with stakeholders to build consensus on key elements, transmission to the State House of Assembly and its subsequent signing into Law by the executive governor following passage by the State House of Assembly. The law is yet to be gazetted and regulations for operationalizing this law is yet to be drafted.

Minimum Service Package (MSP): 11%

Kogi State is currently implementing a special health care project but has no costed MSP that classifies the various PHC facilities in the State.

Repositioning: 33%

While the SPHCDA law clearly transfers all PHC structures and functions to Kogi SPHCDA, only the PHC department at SMOH has been collapsed into the SPHCDA. There is also no evidence to show that key stakeholders affected by this reform have been oriented on the principles of PHCUOR.

Systems Development: 8%

Although the institutional structure of the SPHCDA, as reflected on their organogram, clearly show lines of accountability, there was neither an evidence of a current SHDP nor an annual operational plan for the SPHCDA at the State and LGA level. Kogi SPHCDA does not carry out regular ISS visits to the LGA and health facilities. Also, there are no documented protocols and procedures for PHC activities at health service delivery points.

Operational Guidelines: 40%

Kogi SPHCDA has the capacity to develop and implement its work plan independent of the SMOH. The State policy document on implementation of PHCUOR makes provision for M&E, HRH, accounting and other operational procedures however, the management team has not been trained on the mandate of this policy.

Human Resources: 0%

Kogi SPHCDA is yet to establish a HRH committee, unit or department to address transfer, document and address the needs of all PHC staff in the State.

Funding Sources and Structure: 50%

The State government released a take-off grant for the Agency at its inception and has now established a dedicated budget for its activities. Fund released are adequately tracked to ensure accountability although funds released are not commensurate with approved work plan. The Agency is capable to effectively plan and budget for its activities without external assistance which includes procurement of commodities and other items required at the health facilities. There is no joint funding mechanism for implementing PHC activities while salaries, pensions and other benefits of PHC staff are administered by the LGAs.

Office Setup: 67%

The State government has designated an equipped office for the operations of Kogi SPHCDA located at the State capital. This is yet to be replicated at the various LGAs.

The observed strengths, weaknesses, opportunity and threat in the implementation of PHCUOR in Kogi State are:

Strengths:

- Enacted SPHCDA law.
- Presence of a management team.
- Well-equipped office at the State level.

Weaknesses:

- Lack of a constituted governing board.
- Absence of a costed MSP.
- Weak M&E and HRH structure.
- Incomplete repositioning of PHC structures and functions.

Opportunity:

- Proximity to the FCT which houses the NPHCDA and lots of development partners.

Threat:

- Uncertainty of the future Political space due to forth coming elections.

Recommendations:

- Amendment of the SPHCDA law to align it the provisions of PHCUOR policy.
- Constitution of a governing board with an adequate inclusion of relevant stakeholders.
- Seek assistance to develop a costed MSP.
- All PHC structures and functions should be consolidated under the SPHCDA.
- Strengthen the M&E and HRH capacity of the SPHCDA.
- Setup and equip LGHAs in all LGAs of the State.

Kwara State 36%

Background

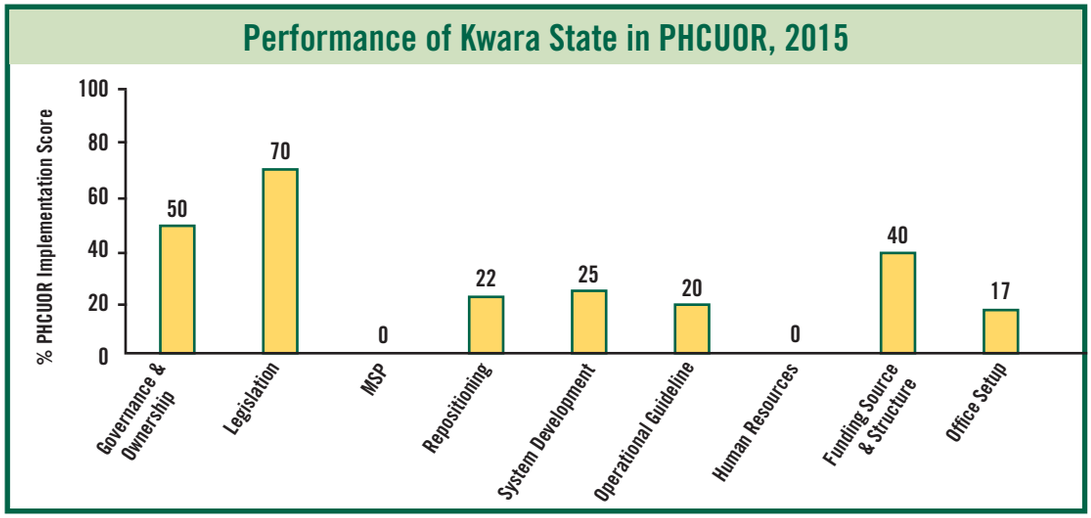
Kwara State with its capital city – Ilorin was created in 1967 and is among the 7 States in the North Central geopolitical zone of Nigeria. It has a total land mass of 35,705km2 (NBS, 2010) and a 2015 projected population of 3,003,625 (NPC, 2006). There are 16 LGAs in Kwara State and bounded to the East by Kogi State, to the West by the Republic of Benin, to the North by Niger State with Oyo, Osun and Ekiti States on its Southern border. The three main ethnic groups in Kwara State are Yoruba, Nupe and Baruba.

Kwara State has a total of 740 health facilities with 575 (78%) PHC and 164 SHC facilities. The PHC facilities are further divided to 512 (89%) public and 63 (11%) private PHC facilities (FMOH, 2012). The IMR in the State is 70/1000 while the U5MR is 110/1000 (MICS, 2011).

The State has an established SPHCDA backed by enabling law.

Main Findings

With an overall score of 36% in this assessment, Kwara State occupies the 23rd position nationally and the 4th position in the North Central geopolitical zone. Legislation domain (70%) was their best performing domain while scoring zero in MSP and Human Resource domains.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 50%

The agency had a governing board headed by Chairman who doubled as the head of the management team and reported directly to the executive governor. At the time of this assessment, the governing board stood dissolved and the Director of PHC & Disease Control is responsible for the day-to-day running of the agency, in an acting capacity. There was no evidence of periodic published report thus making it difficult to know the progress of the institution over time.

Legislation: 70%

The Kwara SPHCDA establishment is backed by law. Although the law has been gazetted, Regulations and policy documents necessary for the operationalization of the law establishing the agency are yet to be developed.

Minimum Service Package (MSP): 0%

The agency does not have a costed MSP that classifies the different facility types in the State.

Repositioning: 22%

The law establishing the Agency transfers all PHC structures and functions at all levels, to the SPHCDA however, this has only been implemented with the SMOH. PHC staff are yet to be re-oriented on the reform processes.

Systems Development: 27%

The institutional structure of the SPHCDA clearly shows lines of accountability. PHC operational plans are not available at the State and LGA levels. Protocols for PHC services exist at health facilities. Although there is an ISS tool available, there is no evidence of ISS being conducted by the Agency.

Operational Guidelines: 20%

Although the Agency has the capacity to develop and implement its work plan independent of the SMOH, guidelines for its operations are yet to be developed.

Human Resources: 0%

PHC staff in Kwara State are not employees of the SPHCDA as salaries, pensions and other benefits are not being administered by the SPHCDA.

Funding Sources and Structure: 40%

Kwara SPHCDA has dedicated budget and fund release processes for planned PHC expenditures as well a system to track released funds. Whereas the Agency is able to budget for its activities without external assistance, it is unable to procure commodities required at health facilities for effective service delivery. The State does not operate a Pool Fund system for implementing PHC programmes.

Office Setup: 17%

There is a designated office building for Kwara SPHCDA which is currently under renovation consequently, the Agency still shares office complex with the SMOH. There are no designated offices at the LGAs.

The observed strengths, weaknesses and opportunity in the implementation of PHCUOR in Kwara State are:

Strengths:

- TThe SPHCDA is legally established.
- Dedicated budget for SPHCDA.

Weaknesses:

- Weak management structure not in conformity with national policy.
- No guidelines or regulations developed for SPHCDA operations.
- Unavailability of a costed MSP.

Opportunity:

- Technical guidance available for PHC system strengthening.

Recommendations:

- Amend the SPHCDA law to align the establishment and functions of the governing board and management team with national PHCUOR guidelines.
- Develop Operational Guidelines for the SPHCDA.
- Ensure total transfer of PHC structures and functions at all levels in the State to the SPHCDA.
- Develop costed MSP for the State.

Nasarawa State 35%

Background

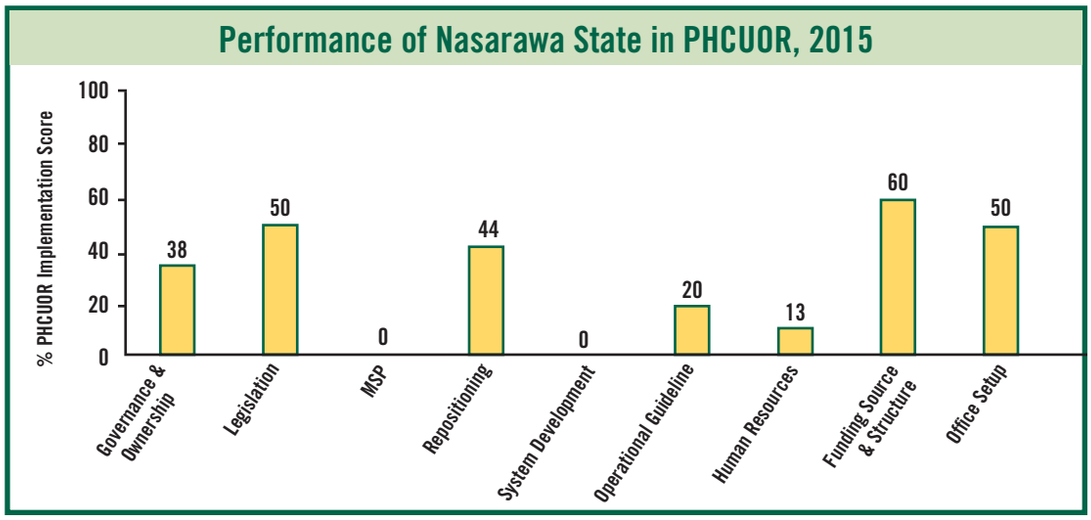
Nasarawa State was created on October 1st 1996 and has its capital as Lafia. It is one of seven States in the North Central Zone. The State's 13 LGAs have an aggregate 2015 population of 2,431,151 (NPC, 2006) distributed over a total landmass of 28,735 Km2 (NBS, 2010). Nasarawa is bounded to East by Plateau & Taraba States; to the West by the FCT; to the North by Kaduna State and to the south by Kogi and Benue States.

The State's IMR and U5MR are 109 and 182 per thousand live births respectively (MICS, 2011). The State has a total of 909 health facilities 874 (96%) of which are PHC facilities. 609 (70%) PHC facilities are public owned while the remaining 265 (30%) are private providers (FMOH, 2012).

Nasarawa SPHCDA was established in June 2009 following assent of its enabling law by the State governor.

Main Findings

Nasarawa overall score of 35% in this assessment places it on the 24th position nationwide while ranking 5th in the North Central geopolitical zone. The State scored best in the Funding Sources & Structure domain (60%) while having zero-score in both MSP and System Development domains.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 38%

The Nasarawa SPHCDA law provides for the governing board and a management team both headed by Executive Chairman/ Chief Executive contrary to provisions of the national guidelines. Furthermore, a governing board is yet to be appointed while the Executive Chairman does not report to the Governor through the Honourable Commissioner for Health. Additionally, the Agency is yet to develop a document that specifies the roles of the management team distinct from the governing board.

Legislation: 50%

Even though Nasarawa SPHCDA is established with the backing of law, regulations for its operations are yet to be developed. Further, some aspects of the law conflicts with the national policy on PHCUOR.

Minimum Service Package (MSP): 0%

Nasarawa is yet to adapt a costed MSP, which is an economic blueprint for organizing the health sector to optimize service delivery.

Repositioning: 44%

The SPHCDA law does not provide for the transfer of all PHC staff to the Agency. Although the PHC department in the SMOH has been collapsed into the SPHCDA, the departments of PHC at the LGA level still remain operationally independent of the Agency.

Systems Development: 0%

There is presently no evidence of a PHC strategic or operational plans for the SPHCDA at both State and LGA levels neither are there guidelines and procedures for recruitment into the sub-State structures.

Operational Guidelines: 20%

Although the Nasarawa SPHCDA has the capacity to develop its own work plan independent of the SPHCDA, the State policy on PHCUOR make provision for HR, M&E, Accounting and other procedures.

Human Resources: 13%

All PHC staff in Nasarawa are now employees of the Agency. However, the State has no implementation plan for managing issues relating to mal-distribution of staff. Similarly, job description for facility managers and workers are yet to be developed. There are no clear procedures for staff recruitment for sub-State structures in place neither is there evidence of existence of costed capacity building plan to address staff needs.

Funding Sources and Structure: 60%

The Nasarawa SPHCDA has dedicated budget and fund release processes for planned PHC expenditure as well as a system to track funds released. The Agency began payment of salaries of health workers at facility level in June 2015 but is yet to start administering staff benefits and pension. A process for developing joint funding mechanism for implementing PHC programmes has commenced in Nasarawa State with contributions from the LGAs now being deducted at source.

Office Setup: 50%

Although the State Government has provided an equipped building to serve as the Agency's office at the capital city of Lafia, the sub-State level the State is yet to designate offices for the take- off of the LGHAs.

The observed strengths, weaknesses and opportunity to implementing PHCUOR in Nasarawa State are:

Strengths:

- SPHCDA establishment backed by law.
- Dedicated budget and fund release system with contributions of LGAs deducted at source.

Weaknesses:

- The non-delineation of roles of the management board as distinct from the management team.
- Absence of a Governing Board.
- Non-inclusion of LGA structures in the PHC reform process.

Opportunity:

- The health sector reform coalition available to provide support for the reform.

Recommendations:

- Develop the regulations to guide SPHCDA operations.
- Strengthen governance structure by appointing a board and delineating the role of its chairman from that of the Chief Executive.
- Establish LGHA as the sub-State arm of the SPHCDA.

Niger State 62%

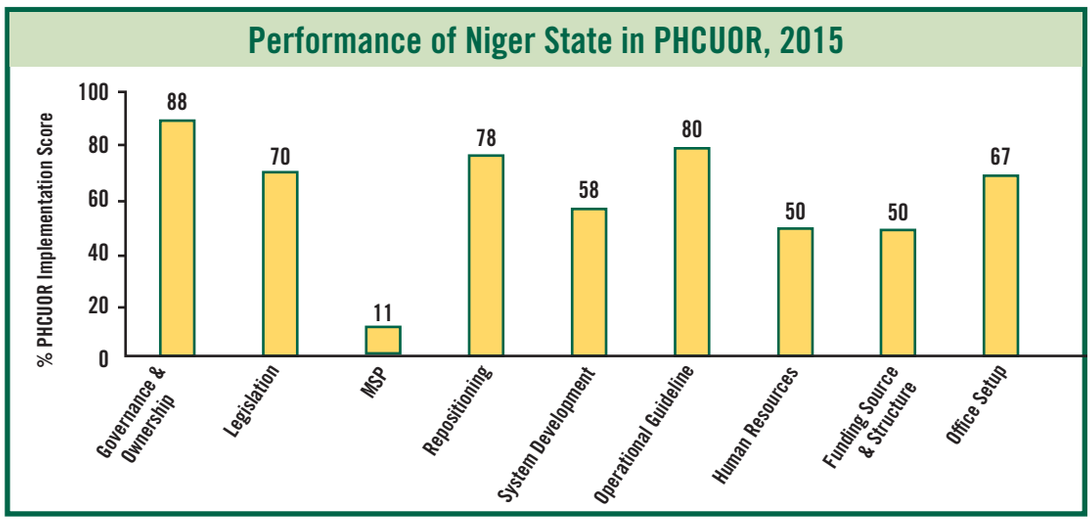
Background

Niger State was created on the 3rd of February 1976 out of the then North Western Nigeria. It is situated in the North Central geo political zone of Nigeria and its Capital city is Minna. The State has a land mass of 68,925km2 (NBS, 2010) and a 2015 projected population of 5,337,149 (NPC, 2006), spread across its 25 LGAs. It shares borders with Kaduna State and FCT to the East, Republic of Benin to the West, Kebbi and Zamfara States to the North with Kwara and Kogi States on its Southern border.

There are 1,335 health facilities in Niger State, out of which 1322 (99%) are PHC facilities. 1095 (83%) of these PHC facilities are public owned while the remaining 227 (17%) are private owned (FMOH, 2012). The health indices of the State show an IMR of 78/1000 and an U5MR of 123/1000 (MICS, 2011).
Niger SPHCDA was introduced in 2009, following assent to the law establishing the Agency headed by an Executive Director.

Main Findings

With an overall score of 61%, Niger State ranked 6th nationally and 1st in the North Central geopolitical zone of Nigeria. The State has its best performance in Governance & Ownership domain (88%) and its least performance in MSP domain (11%).



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 88%

There is an established management team and governing council for SPHCDA in Niger State with the law establishing the Agency clearly specifying their distinct roles. There is evidence to show that the management team meets at least once a month but none to show that they publish periodic reports as part of their accountability mechanism.

Legislation: 70%

The SPHCDA in the State has a legal backing. The law has been gazetted but regulations to operationalize this law is yet to be developed.

Minimum Service Package (MSP): 11%

The State has no costed MSP. However, the State conducts free MCH and Immunization services.

Repositioning: 78%

With the establishment of the Agency in Niger State, there was adequate stakeholder engagement to discuss changing roles and responsibilities. Although the law establishing the Agency clearly transfers all PHC structures and functions to the SPHCDA, the PHC department at the LGAs are yet to be repositioned as LGHAs. There is no evidence that the planned re-orientation of different categories of SPHCDA staff has taken place.

Systems Development: 58%

Niger SPHCDA has developed an annual operational plan from the SHDP but is yet to develop its specific financial management policy separate from that of the civil service. There is a clear institutional structure and developed guidelines for recruitment into the Agency. Although there is an ISS plan and tool, there is no evidence that the Agency conduct regular ISS visits to the LGAs and health facilities.

Operational Guidelines: 80%

Although the Agency is yet to adapt the national implementation manual, its policy for PHCUOR implementation makes provision for M&E, HRH, Accounting and other operational procedures. The management team has been trained on the provision of this policy and the SPHCDA has the capacity to develop its work plan independent of SMOH.

Human Resources: 50%

The Agency had setup a high level HRH committee for the documentation and transfer of all PHC staff to the SPHCDA but they are yet to trained on HRIS and MSP. All staff providing PHC services in Niger State are employees of the agency and job description have been developed for all category of Staff. There is a costed capacity building plan to address staff needs but no evidence of an implementation plan to address staff maldistribution issues. There is also no evidence of recent staff audit and development of a PHC HRH database.

Funding Sources and Structure: 50%

The Agency has a dedicated budget line and a mechanism to track fund released for PHC activities. Although the Agency administers staff pension and other fringe benefits, they do not pay the salary of all PHC staff in Niger State. There is council approval for Basket funding of the activities of the Niger SPHCDA but it is yet to be operationalized because the LGAs haven't complied to the legislation that provides for 15% remittance.

Office Setup: 67%

There is a dedicated building with offices for Niger SPHCDA at the State Capital. It is well furnished and being utilized by the Agency. However, this is yet to be replicated at the various LGAs.

The observed strengths, weaknesses, opportunities and threat in the implementation of PHCUOR in Niger State are:

Strengths:

- Niger State has a gazetted SPHCDA law.
- There is a management team and governing council for the SPHCDA.
- The Council approval of a pool funding of the Agency.

Weaknesses:

- Absence of a drafted regulation for the operationalization of the law.
- Unavailability of a costed MSP.
- Incomplete repositioning of PHC structures especially at the LGA level.

Opportunities:

- Strong political will.
- Presence of many development partners interested in PHC system strengthening.

Threat:

- Opposition by the LGAs to comply with pool funding mechanism as enshrined in the law.

Recommendations:

- Improve funding for PHC activities and carry out LGA stakeholder engagement to comply with council approved pool funding and 15% remittance as enshrined in law.
- Seek support to develop a costed MSP.
- Ensure complete repositioning of all PHC structures and functions including establishment of LGHAs.
- Develop regulations to operationalize the law, ensure regular ISS visits, staff audit and documentation.
- Encourage documentation of SPHCDA activities and publication of periodic reports as part of accountability.

Plateau State 28%

Background

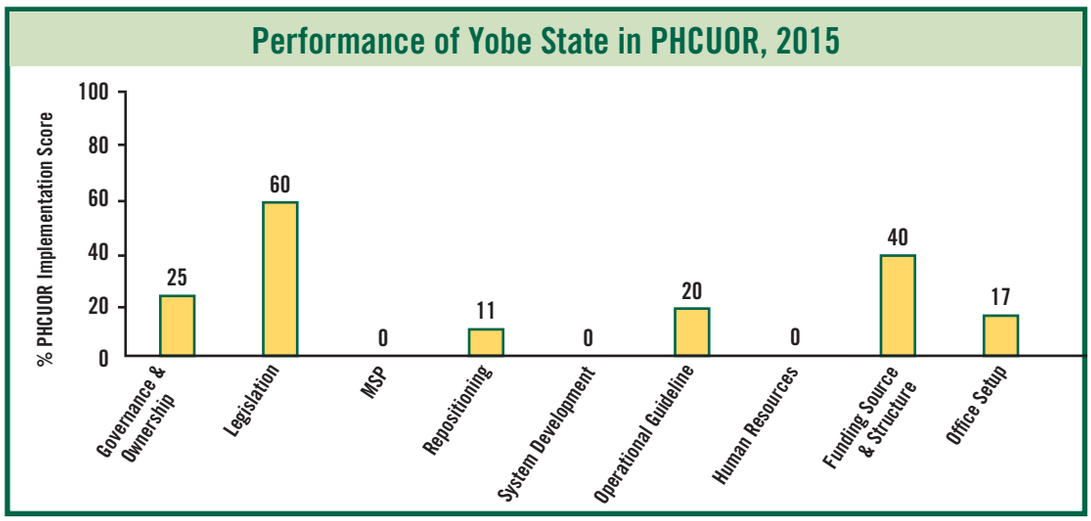
Plateau State, with its capital city as Jos, was created on 3rd February, 1976 from the previous Benue-Plateau State. It is located in North Central geopolitical zone of Nigeria. Bounded by Taraba State on the East; Kaduna and Nasarawa to the West; Bauchi States to the North while Nasarawa and Taraba again occupy the Southern border. Plateau State has a total land size of 27,147 km2 (NBS, 2010). The total population of Plateau State is 4,040,035 (NPC, 2006) and it comprises of 17 LGAs.

Plateau State has 883 health facilities out of which 833 (94%) are PHC facilities, 49 (5.5%) are secondary facilities with one tertiary facilities. 729 (87%) of the PHC facilities are public while 104 (12%) are private. The health status of the State shows an IMR of 103 per 1000 and an U5MR of 171 per 1000 (MICS, 2011).

Plateau SPHCDA came into existence in 2015 with the enactment of the enabling law.

Main Findings

With an overall score of 28%, Plateau State was placed on the 27th position nationally. The State is the least performing in the North Central zone of Nigeria with their highest score on the Legislation domain (60%) and their lowest score (0%) on the MSP, System Development and Human Resources.



Detailed analysis of the results by domains is presented below.

Governance & Ownership: 25%

There is an appointed ES of the Agency also chairs the governing board by law. The ES reports to the Governor through the commissioner of health. There are key officials of the management team and the Agency is yet to have an organogram. There is no evidence of regular management meetings nor indication of publication of periodic reports. The law establishing the Agency does not clearly specify the role of the governing board as distinct from that of the management team.

Legislation: 60%

The law establishing the SPHCDA has been signed into law by the governor following passage of the bill by the State house of assembly. Prior to this time, the State had setup a technical committee that drafted the bill, engaged stakeholders to review and build consensus on key components before transmitting it to the Plateau State house of assembly. The SPHCDA law is yet to be gazetted and there is no evidence that a regulation has been drawn up from the PSPHCB law as stipulated.

Minimum Service Package (MSP): 0%

Plateau State is yet to adopt a costed MSP for the different types of health facility in the State to guide efficient investment in PHC.

Repositioning: 11%

The law establishing the Agency does not transfer all PHC functions as the SPHCDA has powers only to recruit, promote, post, transfer, train and discipline staff on grade level 07 and above. The only appreciable repositioning process that has taken place is the collapse of the PHC department at the State ministry of health into the Agency. There is no evidence to show that the SPHCDA has organized a forum to engage stakeholders and reorient staff on the changing roles and responsibilities.

Systems Development: 0%

There is no evidence of a strategic or operational plan in the Agency, neither were there laid down guidelines for recruitment of staff at all levels in line with the principles of PHCUOR.

Operational Guidelines: 20%

Although Plateau SPHCDA has the capacity to develop and implement its work plan independent of the SMOH, Operational Guidelines are yet to be developed.

Human Resources: 0%

Plateau State is yet to establish a human resource committee that will look at the documentation and transfer of PHC human resource in that State and also ensure that all staffs providing PHC services in the State are employees of the SPHCDA.

Funding Sources and Structure: 40%

At the inception of SPHCDA, the government approved a take-off grant but this was not released. However, there is now a dedicated budget process and funds are released for planned PHC expenditure with a system in place to track released funds. The Agency is able to effectively plan and budget for its activities without external assistance and one of these activities is the planning for the procurement of commodities and other items required at the health facilities for effective health care delivery. There was no evidence to show that Plateau State has developed a mechanism for Pool Funding for PHC. It was further observed that the fund usually allocated to the board is not commensurate with its approved plans. The SPHCDA does not administer staff salaries, pensions and other benefits contrary to PHCUOR policy stipulations.

Office Setup: 17%

Plateau SPHCDA does not have a building of its own but uses a cubical room as its office. Plateau State has identified and designated an office for the operations of the Agency at the State level but not at the LGA level. These offices are not adequately furnished to meet the operational needs of the board.

The observed strength, weaknesses and opportunity in the implementation of PHCUOR in Plateau State are:

Strength:

- Existence of the SPHCDA backed by law.

Weaknesses:

- Law inconsistent with PHCUOR guideline particularly in terms of the management structure and repositioning process.
- Unavailability of Operational Guidelines for the Agency.
- Lack of a costed MSP.

Opportunity:

- New government in place to drive PHCUOR with renewed vigour.

Recommendations:

- SPHCDA law should be amended to clearly transfer all PHC departments and functions in the State to the PSPHCB.
- An equipped office should be provided for the Agency at the State and sub-State levels.
- Regulations and Operational Guidelines should be developed for the SPHCDA.
- Adequate funds should be made available to the board in line with its approved operational plan and a pooled funding mechanism, with LGA's contributions deducted from source, should be explored.

2 YEAR IMPLEMENTAION WORK PLAN

Narrative Report of Primary Health Care Under One Roof (PHCUOR) Scorecard

2 Year Implementation Work Plan for PHCUOR

ACTIVITY	INPUT	OUTPUT	RESPONSIBLE	KEY PERFORMANCE INDICATORS (KPI)	YEAR ONE				YEAR TWO			
					1ST QUARTER	2NF QUARTER	3RD QUARTER	4TH QUARTER	1ST QUARTER	2NF QUARTER	3RD QUARTER	4TH QUARTER
Convene broad stakeholder meeting to build concensus on PHCUOR implementation	National PHCUOR policy	Concensus reached on PHCUOR implementation	Governor	Minutes of stakeholder meeting								
Establish inter-ministerial technical committee on PHCUOR implementation	National PHCUOR policy and National PHCUOR guidelines	Technical committee established	Governor	Technical report and workplan for PHCUOR implementation								
Draft SPHCDA bill	National PHCUOR policy and National PHCUOR guidelines	Draft SPHCDA bill available	Sub-committee on drafting of bill	Draft SPHCDA bill available								
Establish a sub-committee on human resource repositioning	National PHCUOR policy and National PHCUOR guidelines	PHC Human Resource database and Staff audit report	Technical Committee on PHCUOR implementation	Minutes of Sub-committee meetings								
Establish a sub-committee on PHC financing	National PHCUOR policy and National PHCUOR guidelines	PHC financial management policy and funding plan	Technical Committee on PHCUOR implementation	Minutes of Sub-committee meetings								
Convene stakeholder meeting to build concensus around key elements of the draft SPHCDA bill	Draft SPHCDA bill and National PHCUOR guidelines	Reviewed draft SPHCDA bill available	Technical Committee on PHCUOR implementation	Reviewed draft SPHCDA bill available								
Transmit draft SPHCDA bill to the Governor to approve as an executive bill	Reviewed draft SPHCDA bill	SPCHDA bill approved by Governor	Commissioner for Health	Executive SPHCDA bill available								
Transmit executive SPHCDA bill to the State House of Assembly for its passage	executive SPHCDA bill	Executive bill passed by the State House of Assembly	Governor/State House of Assembly	Passed SPHCDA bill available								
Draft regulations in line with SPHCDA law for approval by Commissioner for Health or Governor	SPHCDA law	Approved SPHCDA regulations	Technical Committee on PHCUOR implementation and Commissioner for Health	Approved SPHCDA regulations available								
Assent of the bill by the Governor and gazetting of the SPHCDA law and regulations	Passed SPHCDA bill and regulations	SPHCDA law enacted and gazetted	Governor	Gazetted SPHCDA law and regulations								
Set up SPHCDA with a governing board and management team	SPHCDA law and National PHCUOR guidelines	Governing board and management team established	Governor	Appointment letters								
Set up Local Government Health Authorities (LGHAs)	SPHCDA law and National PHCUOR guidelines	LGHAs established	Governor	Functional LGHAs available								
Release take off grant for the SPHCDA	National PHCUOR guidelines	SPHCDA take-off grant	Governor	Take-off grant available								
Allocate well equipped offices/building for the SPHCDA and LGHAs at state and sub-state levels	National PHCUOR guidelines	Equipped offices for SPHCDA and LGHAs	Governor	Equipped offices available								
Develop long term Strategic plan and annual operational plan	State Health Plan and PHCUOR policy	Strategic plan and annual operational plan	SPHCDA	Strategic plan and annual operational plan available								
Collapse the PHC departments at the MDAs and LGA into the SPHCDA and LGHAs respectively	SPHCDA law	All PHC departments collapsed into SPHCDA	SPHCDA	Consolidated PHC structures under SPHCDA alone								
Transfer all PHC staff to the SPHCDA and LGHAs including payment of salaries, pensions and other benefits to SPHCDA	PHC Human Resource database and Staff audit report	Harmonised human resource under SPHCDA	SPHCDA	All PHC Staff paid by SPHCDA								
Transfer all PHC projects and programs to the SPHCDA and LGHAs	SPHCDA law	All PHC projects manned by SPHCDA and LGHA	SPHCDA	Strategic plan and annual operational plan available								
Convene stakeholder meeting to discuss changing roles and responsibilities	SPHCDA law and National PHCUOR guidelines	PHC stakeholders aware of roles and responsibilities	SPHCDA	Minutes of stakeholder meeting								
Develop a recruitment/redistribution plan and job descriptions for PHC staff	PHCUOR implementation manual & training manual	Recruitment plan, redistribution plan and job description for all Staff	SPHCDA	Job description manual available								
Conduct orientation and capacity building for all PHC staff	PHCUOR implementation manual & training manual	All SPHCDA staff aware and capable of carrying out their roles and responsibility	SPHCDA	Report & minutes of training of all PHC staff.								
Develop costed Minimum Service Package (MSP) for PHC service delivery	National Miniimum Service Package	Developed costed Minimum Service Package (MSP) for PHC service delivery	SPHCDA	Costed minimum service package available								
Commence integrated PHC management including integrated supportive supervision (ISS)	Operational plan	supportive supervision of to strengthen integrated PHC management	SPHCDA	Number of integrated supportive supervision conducted								

ANNEX 1

State Performance Ranking

NATIONAL RATING

S/N	State	Average State performance	Position
1	Jigawa	80	1st
2	Rivers	73	2nd
3	Bauchi	67	3rd
4	Ondo	66	4th
5	Yobe	66	4th
6	Niger	62	6th
7	Adamawa	59	7th
8	Gombe	59	7th
9	Katsina	59	7th
10	Kano	57	10th
11	Ekiti	55	11th
12	Kebbi	51	12th
13	Lagos	50	13th
14	Zamfara	49	14th
15	Kaduna	46	15th
16	Sokoto	45	16th
17	Ogun	44	17th
18	Abia	43	18th
19	FCT	43	18th
20	Kogi	41	20th
21	Delta	40	21st
22	Borno	38	22nd
23	Kwara	36	23rd
24	Nasarawa	35	24th
25	Anambra	35	24th
26	Benue	29	26th
27	Plateau	28	27th
28	Taraba	25	28th
29	Cross River	15	29th
30	Edo	13	30th
31	Enugu	10	31st
32	Imo	8	32nd
33	Osun	8	32nd
34	Oyo	8	32nd
35	Bayelsa	5	35th
36	Akwa Ibom	0	37th
37	Ebonyi	0	37th

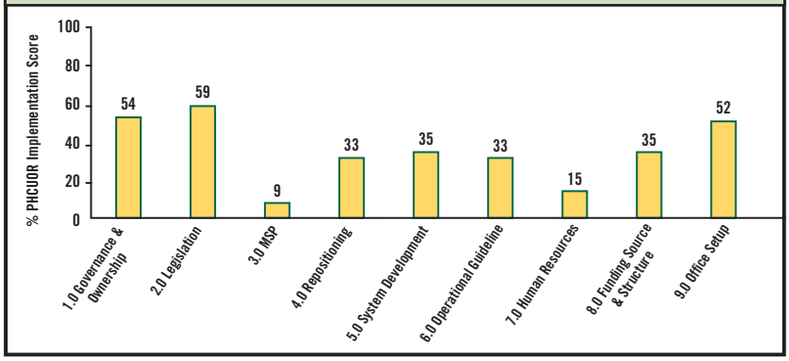
ZONAL RATING

Zone	States	Average State performance	Position
NORTH WEST	Jigawa	80	1st
	Katsina	59	2nd
	Kano	57	3rd
	Kebbi	51	4th
	Zamfara	49	5th
	Kaduna	46	6th
	Sokoto	45	7th
NORTH EAST	Bauchi	67	1st
	Yobe	66	2nd
	Gombe	59	3rd
	Adamawa	59	3rd
	Borno	38	5th
	Taraba	25	6th
NORTH CENTRAL	Niger	62	1st
	FCT	43	2nd
	Kogi	41	3rd
	Kwara	36	4th
	Nasarawa	35	5th
	Benue	29	6th
	Plateau	28	7th
SOUTH WEST	Ondo	66	1st
	Ekiti	55	2nd
	Lagos	50	3rd
	Ogun	44	4th
	Oyo	8	6th
	Osun	8	6th
SOUTH SOUTH	Rivers	73	1st
	Delta	40	2nd
	Cross River	15	3rd
	Edo	13	4th
	Bayelsa	5	5th
	Akwa Ibom	0	6th
SOUTH EAST	Abia	43	1st
	Anambra	35	2nd
	Enugu	10	3rd
	Imo	8	4th
	Ebonyi	0	5th

PERFORMANCE BY DOMAIN

Domain	National Average
1.0 Governance & Onwership	54
2.0 Legislation	59
3.0 MSP	9
4.0 Repositioning	33
5.0 System development	35
6.0 Operational guideline	33
7.0 Human resources	15
8.0 Funding source & structure	35
9.0 Office setup	52

NATIONAL AVERAGE FOR DOMAINS



ANNEX 2

Scorecard III Assessment Tool (Quantitative)

State:				
ORGANIZATION:				DATE:
S/N	1.0 GOVERNANCE AND OWNERSHIP	YES	NO	NOTES
1.1	Is there a physical structure (building) called the SPHCDA/B or its equivalent?			Sight it and take pictures
1.2	Is there an organogram for the SPHCDA/B?			Sight and obtain copy
1.3	Is there an appointed head of the SPHCDA/B? Name Official designation (ES, ED, EC?)			
1.4	If "Yes" to Q1.3 above, does the head of the SPHCDA/B report to the Executive Governor through the Hon. Commissioner of Health?			
1.5	Does the State Primary Health Care Agency have key officers			
1.6	Does the SPHCDA/B hold top management meetings at least once a month?			Sight and obtain copy of minutes
1.7	Is there a SPHCDA/B Governing Board?			
1.8	Is there a document specifying the role of the Governing Board as distinct from the role of the Management Team (SPHCDA/B)?			Sight and obtain copy
1.9	Does the SPHCDA/B publish monthly, quarterly or annual reports as part of accountability mechanisms?			Sight and obtain copy
	Total			
	Percentage Score = (Total Yes/total Number of Questions*100)			
S/N	2.0 LEGISLATION	YES	NO	NOTES
2.1	Has the State established a technical committee for the drafting of the Bill to establish the SPHCDA/B?			Obtain copy of team composition
2.2	If "Yes" to Q 2.1 above, has the technical committee been engaging with stakeholders to build consensus on the key elements of the Bill?			Sight and obtain minutes of meeting / report
2.3	Has your State drafted a PHC Bill to establish the SPHCDA/B?			Sight and obtain copy
2.4	Has the Bill reached the State House of Assembly from the Executive Arm of Government?			
2.5	Has a PHC Bill been passed by the State House of Assembly?			
2.6	Has the Governor assented to the PHC Bill passed by the Legislature?			Sight and obtain copy of the law
2.7	Has your State drafted Regulations for operationalizing the Bill when passed into Law?			Sight and obtain copy of the regulations
2.8	Has the Regulation been signed by the Governor or Commissioner as the case may be?			
2.9	Has the PHC Law establishing the SPHCDA/B and Regulations been gazetted?			Sight & obtain copy of gazetted law & regulations
2.10	Are the regulations consistent with the law establishing the SPHCDA/B?			
	Total			
	Percentage Score = (Total Yes/total Number of Questions*100)			
S/N	3.0 MINIMUM SERVICE PACKAGE (MSP)	YES	NO	NOTES
3.1	Has your State adopted a Minimum Service Package for different facility types?			Sight & obtain copy of State MSP
3.2	Has the SPHCDA classified the health facilities in the State based on the MSP?			
3.3	Is the MSP available and being used at the health facility level?			
3.4	Have resources been mobilized for implementing the MSP?			

ANNEX 2

Scorecard III Assessment Tool (Quantitative)

S/N	3.0 MINIMUM SERVICE PACKAGE (MSP)	YES	NO	NOTES
3.5	Has the MSP been costed?			Confirm in copy of MSP
3.6	Is there funding for operationalizing the MSP for effective and efficient delivery of services?			
3.7	Does your State monitoring team regularly (at least yearly) evaluate the resource gaps for implementing the MSP?			Sight & obtain copy of report or other available evidence
3.8	Do you think the MSP has improved efficiency/work output in the PHC facilities?			
3.9	Is the State implementing any special health care project such as free MCH services, Conditional Cash Transfer for MCH services etc?			Sight & obtain copy of concept note, implementation report or any other evidence
3.10	Is the delivery of the special health care project linked with the costed MSP?			
	Total			
	Percentage Score = (Total Yes/total Number of Questions*100)			
S/N	4.0 REPOSITIONING	YES	NO	NOTES
4.1	Does the Law establishing the SPHCDA/B clearly transfer all PHC functions from the SMOH, MOLG, LGSC and LGA to the SPHCDA/B?			Sight & obtain copy of report or other available evidence
4.3	Has there been any forum for engaging with different stakeholders (SMOH, MOLG, LGSC, LGA, Devt Partners, CSOs, Professional bodies, Media etc) to discuss the changing roles and responsibilities as the SPHCDA/B is established?			Sight and obtain minutes of meeting / report. Verify at the LGA
4.4	Has the department of PHC at the SMOH been collapsed into the SPHCDA/B?			Sight new organogram
4.5	Has the department of PHC at the MOLG been collapsed into the SPHCDA/B?			Sight new organogram. Verify at the LGA
4.6	Has the department of PHC at the LGSC been collapsed into the SPHCDA/B?			Sight new organogram. Verify at the LGA
4.7	Has the department of PHC in the Local Governments been collapsed into the SPHCDA/B as part of the Local Government Health Authority?			Sight new organogram. Verify at the LGA
4.8	Is there a plan for the re-orientation of different categories of SPHCDA/B staff?			Sight & obtain copy of plan
4.9	Using the plan, has any re-orientation activity taken place for SPHCDA staff?			Sight & obtain copy of report
4.10	Do you think the on-going repositioning process has resolved a gap in the running of the PHC system in your State?			
	Total			
	Percentage Score = (Total Yes/total Number of Questions*100)			
S/N	5.0 SYSTEMS DEVELOPMENT	YES	NO	NOTES
5.1	Has the SPHCDA/B developed a Strategic Health Plan (usually for 3-5 years)?			Sight & obtain copy
5.2	Does the SPHCDA/B have bi annual Operational Plan for the current year?			Sight & obtain copy
5.3	Does the SPHCDA/B have other specific financial management policies separate from the State Civil Service financial regulations to guide its programme activities?			
5.4	Does the SPHCDA/B have an Integrated Supportive Supervision plan?			Sight & obtain copy
5.5	Is the SPHCDA/B's Integrated Supportive Supervision plan being implemented?			Sight & obtain copy of last 3 reports
5.6	Is there an Integrated Supportive Supervision tool?			Sight & obtain copy
5.7	If "YES", is it used during Integrated Supportive Supervisory visits to LGAs and health facilities?			Sight & obtain copy of report of previous ISS visit & check for data analysis
5.8	Does the State consistently conduct Integrated Supportive Supervision visits on a quarterly basis?			Sight & obtain copy of last 3 reports

ANNEX 2

Scorecard III Assessment Tool (Quantitative)

S/N	5.0 SYSTEMS DEVELOPMENT	YES	NO	NOTES
5.9	Are there guidelines and procedures for recruitment into the SPHCDA/B and sub-State level structures?			See any documented evidence
5.10	Does the institutional structure of the SPHCDA clearly show lines of accountability?			See Organogram
5.11	Are there guidelines and protocols for operations at different levels e.g. Standing Orders in PHC facilities; Programme Guidelines (Immunization, Reproductive Health, MCH etc)?			Sight & obtain copy. Verify at a HF in the LGA
5.12	Is there an Operational Health Plan in the LGAs?			Sight & obtain copy. Verify at a HF in the LGA
	Total			
	Percentage Score = (Total Yes/total Number of Questions*100)			
S/N	6.0 OPERATIONAL GUIDELINES	YES	NO	NOTES
6.1	Has the State adapted the Implementation Manual on PHCUOR?			Sight & obtain copy
6.2	Is the implementation manual in use?			
6.3	Does the State policy on PHCUOR make provision for HR, M&E, Accounting and other procedures to follow?			
6.4	Does the SPHCDA/B have the capacity to develop and implement its work plan independent of the SMOH?			
6.5	Have key personnel (management team) been trained on the mandate of the SPHCDA using the policy guidelines?			Sight and obtain copy of training report or attendance list
	Total			
	Percentage Score = (Total Yes/total Number of Questions*100)			
S/N	7.0 HUMAN RESOURCES	YES	NO	NOTES
7.1	Has your State established a high level Human Resource Committee for documentation and transfer of PHC human resources?			See list of committee members
7.3	Has the PHC staff audit, development of database and other related activities been carried out?			Sight and obtain copy
7.5	Has an orientation been organized on Human Resource Information System and MSP for the HR Committee members?			Sight & obtain copy of report
7.6	Are all the staff providing PHC services especially at the health facility level, employees of the SPHCDA/B?			Verify at a HF in the LGA
7.7	Is there an implementation plan for managing issues related to mal-distribution of staff?			Sight and obtain copy of plan, Note actions taken
7.8	Has your State developed Job Descriptions for health facility managers and workers?			Sight & obtain copy
7.9	Are there clear procedures for recruitment of staff for sub-State structures (Zonal and LGA levels)?			Sight & obtain copy
7.10	Is there a costed capacity building plan to address staff needs?			Sight & obtain copy
	Total			
	Percentage Score = (Total Yes/total Number of Questions*100)			
S/N	8.0 FUNDING SOURCES & STRUCTURE	YES	NO	NOTES
8.1	Did your State release a take-off grant for the SPHCDA/B?			
8.2	Is there an established SPHCDA/B dedicated budget process and fund release for planned PHC expenditure?			
8.3	Is there a system that tracks funds released to the SPHCDA/B?			

ANNEX 2

Scorecard III Assessment Tool (Quantitative)

S/N	8.0 FUNDING SOURCES & STRUCTURE	YES	NO	NOTES
8.4	Has the SPHCDB/A developed mechanisms for joint (Basket or Pool) funding for implementing PHC programmes and services in line with the MSP?			Sight & obtain copy of guiding document
8.5	Is the SPHCDA/B able to effectively plan and budget for its activities without external assistance?			
8.6	Is the SPHCA/B able to plan for procurement of commodities and other items required at the health facility for effective service delivery?			
8.7	Are the funds allocated to the SPHCDA/B commensurate with its approved plan?			
8.8	Does the LGA make financial contribution?			
8.9	Is the financial contribution by the LGA deducted from source?			Verify at a HF in the LGA
8.10	Are the salaries of health workers at the facility level paid by the SPHCDA/B?			
8.11	Does the SPHCDA/B administer staff benefits and pension?			
	Total			
	Percentage Score = (Total Yes/total Number of Questions*100)			
S/N	9.0 Office Set-up	YES	NO	NOTES
9.1	Has your State identified and designated a specific office for the operations of the SPHCDA/B at the State level?			
9.2	If "Yes" to Q9.1 above, is the office being used by the SPHCDA/B?			
9.3	Has your State identified and designated specific offices for the operations of the LGHAs at the LGA level?			Verify at the LGA
9.4	If "Yes" to Q9.3 above, are these offices being used by the LGHAs?			Verify at the LGA
9.5	Is the office complex of the SPHCDA/B furnished with office equipment and installations such as furniture, internet, computers and access?			
9.6	Was/Is there a costed start-up plan for the take-off of the management team of the SPHCDB/A?			Sight document
	Total			
	Percentage Score = (Total Yes/total Number of Questions*100)			

Name of Interviewer 1: _____ Phone no: _____

Signature : _____ Date: _____

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

Plot 681 /682 Port Harcourt Crescent, off Gimbiya Street,
Area 11, Garki, Abuja.

PHCUOR IMPLEMENTATION QUESTIONAIRE

Instructions:

1. *These qualitative questions should be answered by respondents prior to the day of assessment.*
2. *Respondents should include, but are not limited to: the executive secretary or chairman of SPHCDA/B and the management team members.*
3. *Respondents in states without SPHCDA/B would include the commissioner for health or permanent secretary, director PHC, director PRS, state immunization officer and other directors in the state ministry of health.*
4. *Response should be type-written and two copies handed over to the interviewer on the day of assessment.*

Questions:

1. *What are the names, phone numbers and corresponding designations of respondents (Answer in a tabular format as indicated below)?*

S/n	Name	Designation	Phone number	Signature

2. *Which year did you introduce your state's SPHCDA/B (or its alternative)?*
3. *How was SPHCDA/B introduced in your state?*
4. *What name do you call your state's SPHCDA/B (write in full)?*
5. *What are the names of the current state's SPHCDA executive director and Board chairman? (if none, why?)*
6. *What is the coordinating platform that is driving the implementation of PHCUOR in your state, who leads it, who is in it and how often do they meet?*
7. *Outline the PHC strengthening processes or activities that have taken place since the last PHCUOR assessment in mid-2012.*
8. *List the partners or organisations in your state that support PHC strengthening processes/activities or PHUOUR implementation (Answer in a tabular format as indicated below).*

S/n	Partner or organisation	Programs	Impact on PHC or PHCUOR

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

Plot 681 /682 Port Harcourt Crescent, off Gimbiya Street,
Area 11, Garki, Abuja.

Interview Protocol

Pre-Interview Preparation

1. The National Primary Health Care Development Agency (NPHCDA) will send out a notice of the national scorecard3 assessment with a copy of the questionnaire and list of required documents to the SPHCDA/Bs or SMOH ahead of time to enable them to assemble their team, prepare responses to the questionnaire and provide documents required to be obtained as evidence to "yes" answers in the assessment tool.
2. ZTO will liaise with respondents to finalise the time and venue of assessment (must hold between 28th August and 5th September, 2015).
3. Assessment and interview at the state level will last for about one hour.
4. Assessment and interview at the state level with verification at the LGAs and health facilities will not last more than three days and will be carried out between 28th August and 5th September, 2015.
5. Interviewer should be prepared to make photocopies of documents sighted.
6. Interviewer should have (print) the attendance sheet, list of required documents, interview protocol, two copies of the questionnaire and two copies of the assessment just to guide the respondents (**ALL DOCUMENTS IN FLASH DRIVE**)
7. Interviewer should have a notebook, pen, flash drive (USB) and recorder (if available).

Proposed Respondents

Respondents should be a team of the SPHCDA/B that include, but are **not limited** to, the executive secretary or chairman of SPHCDA/B and the management team members. Respondents in states without SPHCDA/B should **include** the commissioner for health or permanent secretary, director PHC, director PRS, state immunization officer and other directors in the state ministry of health. Endeavor to get these stakeholders under one roof to administer the assessment tool.

Interview Process

1. Introduce the assessment tool to the respondents and obtain consent to both administer the assessment tool and record discussions.
2. Ensure that an attendance list with name, phone number, designation and signature of the respondents is obtained using the attendance sheet provided.
3. Verify that copies of the evidence documents to the "yes" answers are available (list of documents already sent to states prior to the day of assessment).
4. Documents for evidence can be in a hard copy or soft copy format.
5. Verify that two type-written (hand written allowed) copies of responses to the questionnaire are available (copy of questionnaire already sent to states prior to the day of assessment).
6. Administer the assessment tool and obtain evidence for any "yes" answer that requires a supporting document while taking pictures of relevant structures and buildings.
7. For documents in soft copy format,
    a. Obtain the soft copy using a flash drive provided and send with other documents.

b. A printout of the first page of all documents in soft copy format must be obtained.

8. Ask if there are any questions in the assessment tool that need to be reworded or they had difficulties understanding or answering; review those questions.
9. Obtain two type-written copies of responses to the questionnaire and seek clarification where necessary.
10. Conclude by requesting further contacts to verify answers and thanking the respondents.

LGA validation

1. Assessment and interviews will be held at the state level, followed by the LGA level validation at the LGA secretariat.
2. Three LGAs will be selected from each state, representing each of the senatorial zones. One LGA will be randomly selected from each of the three senatorial zones.
3. Questions to be verified at the LGA level are 4.1, 4.2, 4.3, 4.5, 4.6, 4.7, 4.13, 4.14, 5.11, 5.12, 7.6, 8.10, 9.3 & 9.4.
4. Confirm answers to questions 5.11, 7.6 & 8.10 at randomly selected health facilities in the LGAs visited.

Post Interview Task

1. Write a report on notes and recordings taken during the assessment and discussions.
2. Ensure that you have two copies of all documents (make a second copy where necessary). A copy will be sent to the address below while the ZTO keeps the other copy as backup.
3. Expected documents from State ZTO:
    a. Filled assessment tool
    b. Type-written responses to the questionnaire
    c. Type-written report on recordings and notes taken
    d. Evidence of "yes" response in hard copy format
    e. Printouts of first page of documents in soft copy format
    f. Flash-drive (USB) containing soft copy format of evidence for "yes" answers.

    NB: All documents in flash-drive must have their front page printed in hard copy format.

4. Enclose all documents and flash-drive in a secured envelop and send via speed post to:

    Deputy Director & Head PPP&PC
    PRS Department,
    National Primary Health Care Development Agency,
    Plot 681/682 Port Harcourt crescent,
    Area11, Garki, Abuja, FCT.

Please ensure all documents **reach** the NPHCDA Headquarters by 11th September, 2015.

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Health Reform Foundation of Nigeria

IVAC Evidence ➤ Policy ➤ Access

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