FEDERAL GOVERNMENT OF NIGERIA

NATIONAL PRIMARY HEALTH CARE DEVELOPMENTAGENCY

IMPLEMENTATION GUIDELINES

FOR

PRIMARY HEALTH CARE UNDER ONE ROOF (PHCUOR)

MARCH 2018

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Foreword

Remarkable progress has been made in bringing “Primary Health Care Under One Roof” (PHCUOR) in the 36 States and FCT of the country. As at now, 33 States and the FCT have established their State Primary Health Care Boards (SPHCBs). The remaining 3 States are at advanced stages of establishing theirs.

The NPHCDA developed, printed and distributed the Management Guidelines for Primary Health Care Under One Roof (June 2016) to guide all the 36 States and the FCT. The feedback from the SPHCBs, partners and other stakeholders who have applied the management guidelines for implementation indicated there were gaps and omissions that needed to be filled to enhance the efficacy of the management guidelines to provide the required guidance for the implementation of PHCUOR at State and LGA levels.

Consequently, NPHCDA officers and representatives of SPHCBs, partners and other stakeholders undertook a comprehensive review of both the Management Guidelines and Implementation Manual for Primary Health Care Under One Roof to reflect the inputs received from SPHCBs, partners and all stakeholders on their experiences on the implementation of PHCUOR.

The outcome of the review is the Implementation Guidelines for Primary Health Care Under One Roof which clearly identify the expected roles and responsibilities of the PHC Teams at the SPHCB/LGHA (state and sub-state levels) and highlighted how to achieve a seamless implementation of PHCUOR.

While it is obvious that the 36 States and the FCT are at different stages of implementation, I am confident that these implementation guidelines will be of immense value to all states and FCT in moving the implementation of PHCUOR forward and achieving the desired health outcomes for all Nigerians through PHC.

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Acknowledgement

The Department of Primary Health Care Systems Development is very grateful to all those both within and outside the National Primary Health Care Development Agency who contributed to the review, finalization and production of these implementation guidelines.

We appreciate all individuals, partners and other stakeholders who provided technical support to the review. We are especially thankful to the Executive Director/CEO, Dr. Faisal Shuaib for his leadership role and all the members of the PHC Top Management Team for the commitment to the review process.

Our appreciation goes to the Executive Secretaries of the State Primary Health Care Boards (SPHCBs) for sharing their inputs which further enriched this document.

We are also very grateful to our partners (NGF, NHED and MNCH2) for the technical and financial support that facilitated the review process.

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Acronyms

ANC	-	Antenatal Clinic
BHCPF	-	Basic Health Care Provision Fund
CSO	-	Civil Society Organisation
CHEW	-	Community Health Extension Worker
CHIPS	-	Community Health Influencers, Promoters and Services
DHIS2	-	District Health Information Software 2
FMC	-	Facility Management Committee
FMoH	-	Federal Ministry of Health
HMIS	-	Health Management Information System
HRIS	-	Health Resource Information System
HRH	-	Human Resources for Health
ISS	-	Integrated Supportive Supervision
JCHEW	-	Junior Community Health Extension Worker
LGA	-	Local Government Area
LGHA	-	Local Government Health Authority
LGSC	-	Local Government Service Commission
M&E	-	Monitoring and Evaluation
MTEF	-	Medium Term Expenditure Framework
MSP	-	Minimum Service Package
NHIS	-	National Health Insurance Scheme
NPHCDA	-	National Primary Health Care Development Agency
NHAct	-	National Health Act
PHC	-	Primary Health Care
PHCUOR	-	Primary Health Care Under One Roof
UHC	-	Universal Health Coverage
SCM	-	Supply Chain Management
SPHCB	-	State Primary Health Care Board
SMoH	-	State Ministry of Health
SMoLG&CA	-	State Ministry of Local Government & Chieftaincy Affairs
SMoWA	-	State Ministry of Women's Affairs
TWG	-	Technical Working Group
WMHCP	-	Ward Minimum Health Care Package
WDC	-	Ward Development Committee

1 Background

Primary Health Care (PHC) is based on clearly defined principles which need to be translated into practice through the existence of structures and managerial processes. Consequently, organizational structure of primary health care determines how roles, power and responsibilities are assigned, controlled and coordinated and how information flows between different levels. While remarkable progress has been made in primary health care development in Nigeria, the system has remained weak and the health outcomes suboptimal due to multiple challenges in various aspects of the health system framework.

The unsatisfactory governance system which largely results from fragmentation has continued to undermine the delivery of primary health care in Nigeria. The existence of multiple administrative frameworks (State Ministry of Health, State Ministry of Local Government & Chieftaincy Affairs, State Ministry of Women Affairs, Local Government Service Commission and sometimes the Office of the Executive Governor) at the state level with concurrent and overlapping responsibilities for primary health care has constituted significant challenges to the delivery of high quality, efficient and equitable health services.

It is in response to the foregoing development that the National Primary Health Care Development Board in collaboration with key stakeholders introduced the "Primary Health Care Under One Roof" (PHCUOR) initiative as part of a new governance reform designed to improve primary health care implementation at state and sub-state levels. Primary Health Care Under One Roof is a policy for the integration of all PHC services under one authority (State PHC Board) to reduce fragmentation in PHC management and service delivery. This is in line with the National Health Act and Sustainable Development Goal 3 (SDG3) to achieve Universal Health Coverage (UHC)

2 Principles for Bringing "Primary Health Care Under One Roof" (PHCUOR).

Bringing "Primary Health Care under One Roof"is modeled after the by the World Health Organisation (WHO) guidelines for integrated district (LGA)-based service delivery which is based on the following key principles:

- **Integration** of all PHC services delivered under one authority (SPHCB), at a minimum consisting of health education and promotion, maternal and child health, family planning, immunization, disease control, essential drugs, nutrition and treatment of common ailments.
- **A single management body** with adequate capacity to **control services and resources** especially human and financial resources. As this is implemented, it will require repositioning of existing bodies.
- **Decentralized authority, responsibility and accountability** with an appropriate "span of control" at all levels. Roles and responsibilities at the different levels will need to be clearly defined.
- Principles of "three ones": **one management, one plan and one monitoring and evaluation (M&E) system.**
- An **integrated supportive supervisory** system managed from a single source.
- An **effective referral system** between/across the different levels of care.
- Enabling **legislation and concomitant regulations** which incorporate these key principles.

Bringing “Primary Health Care Under One Roof” is designed to unify all PHC structures and programmes at state and sub-state levels to ensure accountable and efficient service delivery within the framework of a decentralized health system. The full implementation of PHCUOR entails the repositioning of the roles and responsibilities of existing State and Local Government Areas (LGA) establishments involved in the delivery of PHC services. It also requires sustained effort and strong political will over a considerable period of time.

3 PHCUOR Pillars.

The implementation of PHCUOR at state and sub-state levels rests on nine pillars which together will result in the desired improvement in quality and increased access to health care services. The nine pillars of PHCUOR are:

- Governance and ownership
- Legislation
- Minimum Service Package (MSP)
- Repositioning
- Systems Development
- Operational Guidelines
- Human Resources
- Sustainable Funding
- Office Set-up

Benefits of Implementing PHCUOR

- Improves efficiency. The SPHCB provides oversight of all PHC activities delivered by LGAs and partners. This reduces duplication, wastage and improves efficient use of resources to achieve better health outcomes.
- Improves quality of health services. PHCUOR promotes equity and increases access to affordable high quality basic health care services to all, especially for the poor and vulnerable, at the grassroots towards the attainment of UHC.
- Enhances transparency and accountability. With clearly defined roles and responsibilities, it is easier for the Governors, LGA chairmen, Commissioners of Health and other stakeholders to know who to hold accountable at all levels for PHC service delivery.
- Increases access to more funding by enhancing eligibility for additional funding such as the Basic Health Care Provision Fund (BHCPF) and other national and international funding for PHC services.

3.1 Pillar 1: GOVERNANCE AND OWNERSHIP

3.1.1 Introduction

At the State level, a Governing Board is appointed by the Governor and it provides stewardship for setting the PHC vision, mobilizing resources and holding managers at all levels accountable. At the LGA level, the LG Advisory Committee is appointed by the Governing Board and provides stewardship in line with the state vision. The management team consists of full time employees who are responsible for the day to day operation of the State PHC Board. This structure is replicated at the sub-state levels (LGA, Ward and PHC facilities)

3.1.2 State Primary Health Care Board

The State Primary Health Care Board (SPHCB) is an administratively autonomous and self-accounting PHC entity established by law to manage PHC in the State as recommended by the 54thNational Council on Health through Resolution 29 and also backed by the National Health Act of 2014. The SPHCB consist of a governing board and a management team. The Governing Board is headed by a Chairman appointed by the Executive Governor while the management team is led by an Executive Secretary, also appointed by the Governor, who is responsible for the day to day management of the SPHCB. The State Primary Health Care Board provides a single administrative framework and managerial processes for primary health care in the state. SPHCBs are conceived to:

a. Provide stewardship and coordination ofall the activities of the LGHAs
b. Improve the allocation, distribution and ensure efficient utilization of financial and material resources.
c. Provide appropriate technical and management training for primary health care managers and various categories of health workers.
d. Set service delivery standards and provide supportive supervision for guidance and compliance
e. Monitor and evaluate programmes

Core Functions of the SPHCB.

a) Planning and Management

- Develop the overall strategic plan for improved primary health care outcomes in the State and use it to derive the State Health Annual Plan.
- Develop an evidence-based and integrated state primary health care operational plan.
- Develop a state-wide primary health care human resource management plan to ensure health care worker availability and skills at all PHC facilities and CHIPS Agents at the community level in the state at all times
- Set state targets for the entire primary health care spectrum on prevention, treatment and care services in line with national priorities such as the health sector strategic plan.
- Ensure that health system performance gaps (clinical and management/administrative) identified during supervision are addressed through appropriate capacity building and quality improvement interventions.
- Support and develop commodities and pharmaceutical supply chain management system at all levels of the PHC system.

- Ensure consolidation and timely production of quality HIS data on PHC services, and relevant reports to facilitate decision making at the state, LGA and facility levels and upward reporting to state ministry of health.
- Ensure use of evidence from HIS and other sources to evaluate the impact of various programs and services.

b) Coordination

- Provide state-wide partner coordination (including LGA and community) and alignment of PHC activities with state priorities to prevent duplication and minimize gaps in PHC service delivery and to maximize the use of available resources.
- Work with partners in other sectors (e.g. education, agriculture, and public works) on initiatives aiming to promote health.
- Support and develop patient referral care networks at all levels of the PHC system.

c) Supervision of Health Services

- Ensure delivery of community-based health services, facility-based health services, outreach services and referral linkages.
- Ensure integration of vertical programs to accomplish the overall health objectives of the state.
- Undertake technical and administrative supervision of PHC health professionals/workers.
- Carryout assessment of PHC health services, PHC providers and PHC facility performance using appropriate and defined quality assurance mechanisms.

d) Community Participation

- Monitor the performance of the Ward Development Committees (WDCs) and facility health Committees as well as other health-related community support groups.
- Ensure adequate representation of women in the Ward Development Committee (WDCs) (at least 30% of membership should be women and at least one executive position in the WDC should be occupied by women).
- Enable and encourage communities to participate in initiating, devising, implementing and monitoring decisions and plans based on their local needs, priorities, capacities and resources.

e) Financing and Resource Allocation

- Advocate for, identify and mobilize resources to address current and future gaps in PHC service delivery.
- Identify and adopt health financing mechanisms that will ensure adequate financing of PHC care programmes taking into cognizance issues of equity for the vulnerable groups.
- Ensure accountability of all stakeholders on resources, activities and results.

f) Regulation (norms and standards)

- Provide oversight in the deployment of services, resources/staff to ensure equitable distribution and to improve quality of health services within the state.
- Ensure effective dissemination, adaption and implementation of national guidelines.
- Set standards for all PHC services and establish systems for compliance.
- Ensure that all relevant health committees are in place and functioning.

g) Recommendation (Nomenclature)

The body should be named State Primary Health Care Board (SPHCB).

Governing Board (Functions and recommended membership)

Under the National Health Act, every state will need a single PHC Board whose job is to oversee and ensure the implementation of the state approach to primary health care. Each PHC Board consists of a Governing Board (which should meet at least every quarter) and a management team (full-time employees – which should meet at least once every month). This structure is repeated at lower levels.

The PHC Board's Governing Board needs a balanced inclusion of stakeholders/voices to:

- Establish a focus on the health needs of the entire population in the state.
- Ensure an integrated PHC approach that can address these needs more effectively than current fragmented approaches.
- Wield appropriate influence, power and authority to address these needs.
- Drive improvement and hold implementers accountable.

The membership of the Governing Board should comprise of the following: community representatives, health professionals, career civil servants and politicians. The Governing Board must include men and women, together with community leaders able to represent the needs of the whole population, particularly those groups who have been historically excluded.

It is imperative to note that the Governing Board should not necessarily be a body of experts and must stay away from the day to day operations of the Board. It requires one or more technical committees to provide specialist input into the board, as well as a strong management team to transform Board vision and ideas into action.

The ***mandate*** of the Governing Board of the SPHCB should be to address broad issues of policy, resource mobilization and accountability, access to PHC services, equity and quality of PHC services. The day to day running of the Board should be left for the management team.

The ***membership*** of Governing Board of the SPHCB and the LGHAs Advisory Committees needs a balanced representation of community and other members to ensure:

- Sufficient level of influence and authority needed to address the health needs of the population.
- The availability within the Governing Board of the necessary experience, expertise and commitment to advise the management team on all matters especially clinical, human resource, material and financial issues.
- The Governing Board has sufficient understanding of the political economy of the State and the capacity to engage and influence important stakeholders that control power, resources and influence.

The ***design*** of the Governing Board should reflect practical considerations, such as an appropriate duration of appointment, and realistic requirements for the meetings. The size of the Governing Board should be between 12 to 15 members.
The criteria for SPHCB Governing Board and LG Advisory Committee's membership and function should be clearly captured in the State PHCB law and regulations.

Key Issues on Board Membership

- Balance representation of all segments of the state population.
- Membership size should not be large.
- Sufficient level of influence and authority.
- Necessary expertise, experience and commitment.
- Clarity of roles between governing board, advisory committees and management teams.
- Appropriate legislation covering all above issues.

Tenure

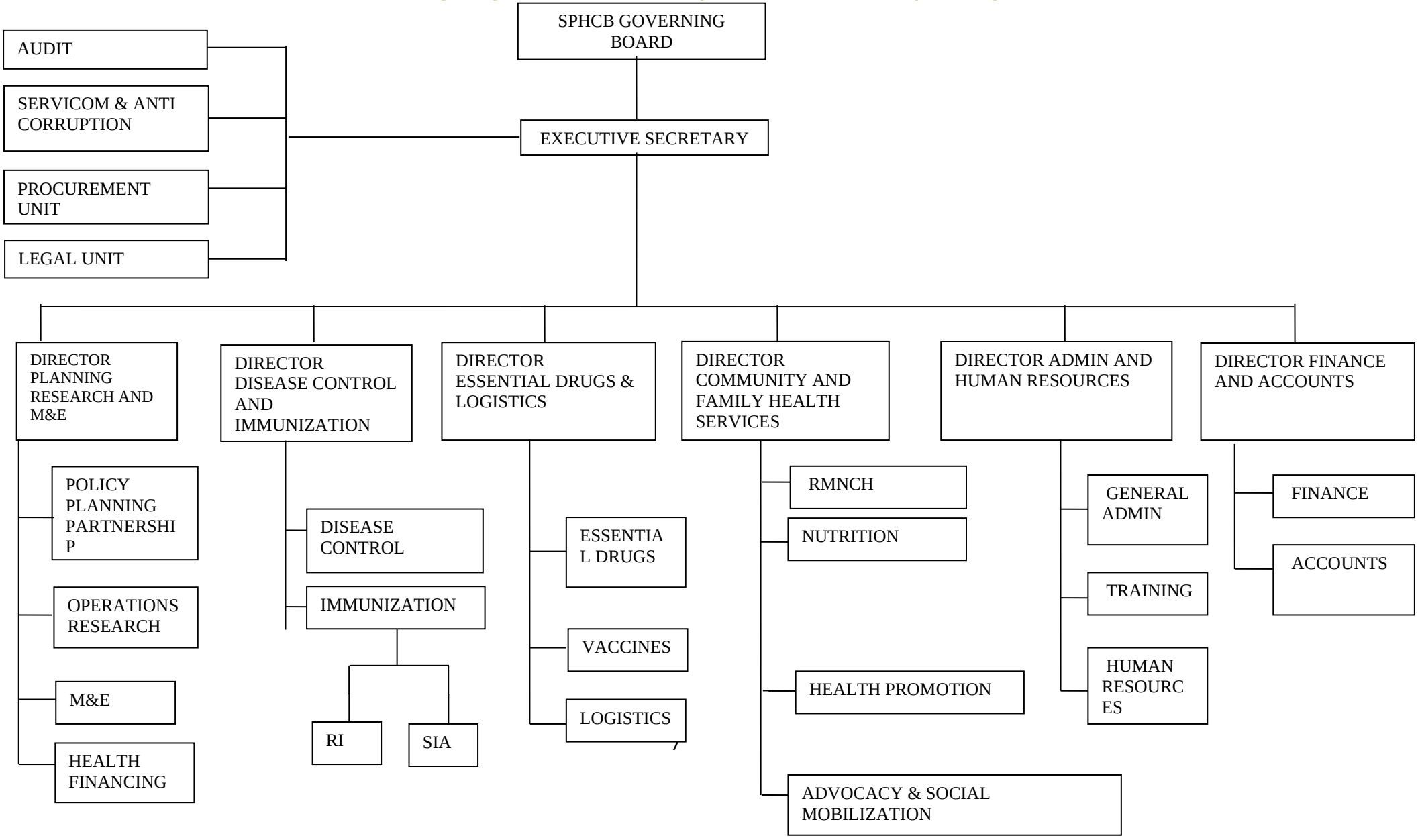
Appointed board members should hold office for a period of four years and be eligible for re-appointment for only one further term of four years which should be stipulated in the law.

SPHCB Management Team

The management team consists of full time employees headed by the Executive Secretary who are responsible for the day to day operation of the State PHC Board. The Executive Secretary is a quasi political appointment with a four year tenure renewable only once. S/he must be a renowned health manager with a high performance track record; must be committed and of unquestionable integrity. It is noteworthy that the management team composition should follow the National PHCUOR Implementation Guidelines for uniformity and unity of purpose. The Management team should consist of:

- Executive Secretary
- Director Planning, Research and M & E
- Director Disease Control & Immunization
- Director Essential Drugs and Logistics
- Director Community and Family Health Services
- Director Administration and Human Resources
- Director Finance and Accounts

3.1.3 Organogram of State Primary Health Care Board (SPHCB)



Roles of the Management Team

- Transform the board's vision and ideas into action through coordination, supervision, monitoring and evaluation of PHC implementation.
- Responsible for the effective and efficient day to day management of the resources and implementation of plans of the SPHCB.
- Provides an efficient secretariat to convene and support the meetings of the Governing Board by circulating the agenda, keeping a record of the deliberations, producing minutes and ensuring prompt dissemination of same.
- Provides technical and managerial assistance and guidance to LGHA and PHC facilities to achieve better PHC outcomes in the state.

Reporting Line

The enabling law should take cognizance of the autonomous nature of the SPHCB. The management team under the leadership of the Executive Secretary of the SPHCB reports on policy matters and general operations of the SPHCB to the Governing Board and through the Governing Board to the Honourable Commissioner of Health. The Honourable Commissioner of Health has oversight function over all health establishments in the State.

3.1.4 The Local Government Health Authority (LGHA)

This is the body at the LGA level responsible for coordinating and providing close supervision of PHC services at the facility and community levels. It consists of an advisory committee and a management team both reporting to the Executive Secretary of the SPHCB. The Advisory Committee reports on broad policy and implementation issues while the management team reports on its day to day activities

The LGA health system in Nigeria functions under the decentralization health policy and framework which envisage:

- Full participation by the communities in the planning and implementation of health activities that respond to local needs and priorities.
- Increased accountability and transparency by making local leaders accountable to the communities they serve.
- Enhanced sensitivity and responsiveness of the local administration to the local environment by placing the planning, financing, management and control of service provision at the point where services are provided.
- Enhanced effectiveness and efficiency in the planning, monitoring and delivery of service by reducing the burden from central government officials.
- Health decentralization resulting in improved service delivery, greater coverage, improved quality, cost-effectiveness, as well as greater local control over health activities at all the levels of the LGA health system.

Local Government Health Authority Advisory Committee

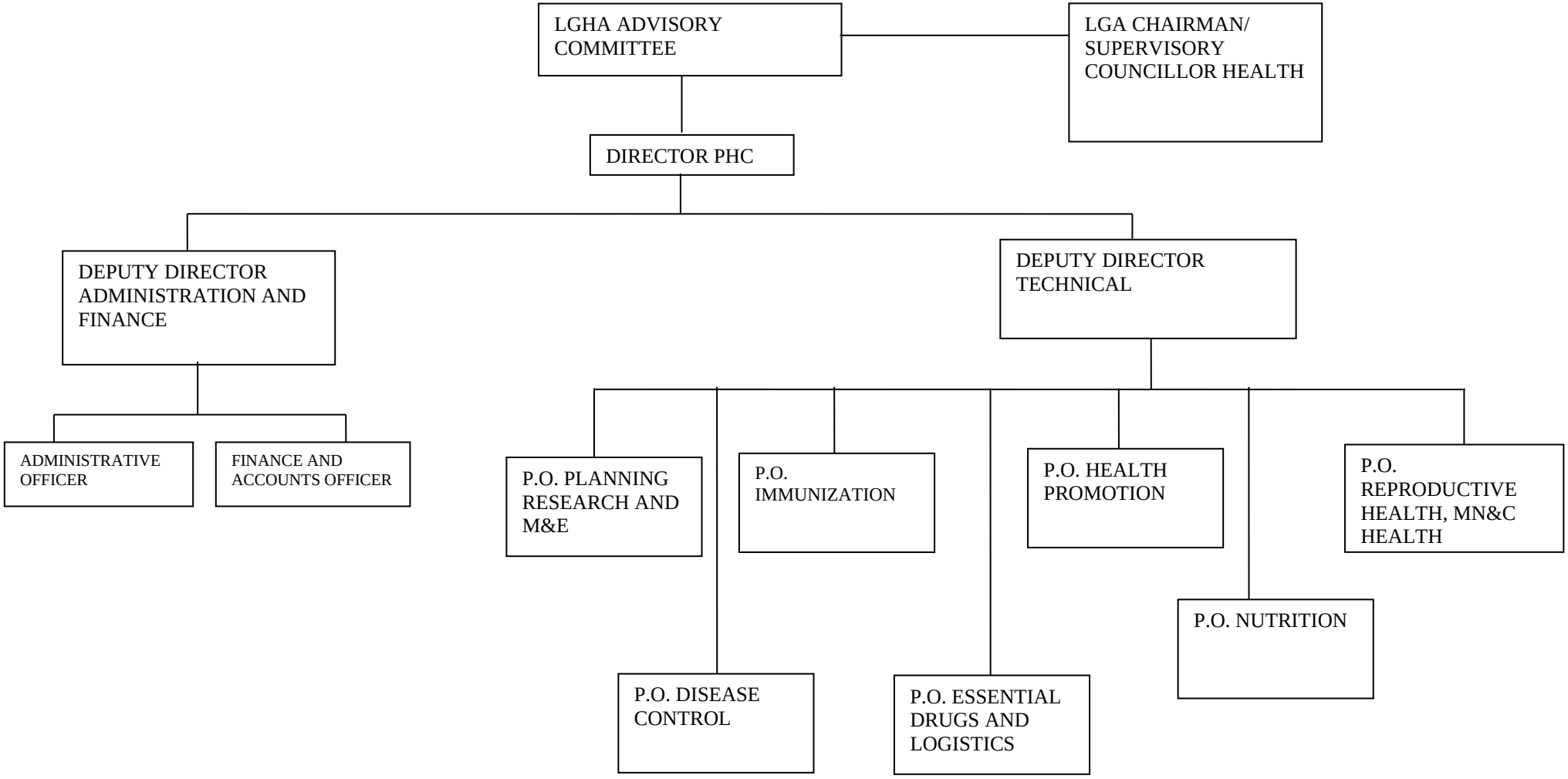
Every LGA should have an Advisory Committee whose role is to oversee and ensure the provision of PHC services in accordance with established standards, Guidelines and Procedures. The Advisory Committee needs a balanced inclusion of voices to:

- Ensure a focus on the health needs of the entire population in the LGA.
- Drive an integrated PHC approach that addresses the LGA health needs.
- Influence and take responsibility to address LGA health needs.

- Strive to improve health outcomes and be able to hold implementers to account.

The Committee should primarily advise the SPHCB and the LGHA Management Team, and should focus on broad PHC system to ensure adherence to policy, accountability, community participation/involvement, PHC financing and quality as well as access to PHC services.

3.1.5 Organogram of Local Government Health Authority (LGHA)



Composition of LGHA Advisory Committee

The LGHA Advisory Committee is a balanced representation of PHC stakeholders at the LGA and community levels.

- Hon. Chairman - Chairman
- LGA Supervisory Councillor for Health
- Directors of other departments in the LGA (Works, Agriculture, Finance, Education, Community Development, Personnel etc)
- One representative of NOA
- One representative of Traditional Council
- One representative of Religious Leaders
- Head of one referral public hospital
- One representative of private health sector
- One representative of women leaders
- One representative of health training institutions where available
- One representative of CSOs/CBOs
- Two representatives of WDC (on rotational basis)
- Director PHC - Secretary

Roles of the LGHA Advisory Committee

- Support the overall vision and mission of the LGHA
- Provide strategic direction to LGHA Management team
- Mobilize and allocate resources.
- Hold implementers to account for effective and efficient use of resources
- Develop effective working relationship with the management team and communities
- Receive and deliberate on health reports of LGA and advise LGHAMT on decisions to improve health outcomes
- Support LGHAMT on implementation of PHC in the LGA
- Identify and fund the PHC capital projects

Terms of Reference

In carrying out the above functions, the Advisory Committee shall:

- Meet quarterly.
- Record minutes of meetings.
- Adopt minutes of meetings and ensure that the Chairman and Secretary sign them.
- Comply with the quorum set for starting meetings.

The LGHA serves as the secretariat and is responsible for convening the quarterly meeting in consultation with the LGA Chairman.

The LGHA Management Team

The establishment of the LGHAMT is one of the key PHCUOR management reforms.

Composition of LGHA Management Team

The LGHAMT shall be composed of the following:

- Director PHC

- Two Deputy Directors
- Programme Officer, Planning, Research and M & E
- Programme Officer, Disease Control
- Programme Officer, Immunization
- Programme Officer, Essential Drugs and Logistics
- Programme Officer, Health Promotion
- Programme Officer, Nutrition
- Programme Officer, Reproductive, Maternal & Child Health
- Administrative Officer
- Finance and Accounts Officer

Roles and Responsibilities of LGHA Management Team

LGHAMT is responsible for the day to day management of the LGHA. The LGHA Management Team (LGHAMT) is the operational management arm of the LGHA and is under the leadership of the Director PHC. The team is responsible for overall management of LGHA resources through effective planning, implementation and coordination of PHC activities in the LGA. They will also perform the following duties:

- Ensure that health system performance gaps (clinical and management/administrative) identified during supervision are addressed through appropriate capacity building and quality improvement interventions.
- Enable and encourage community members to participate in initiating, devising, implementing and monitoring decisions and plans based on their local health needs, priorities, capacities and resources
- Provide LGA-wide partner coordination and alignment with priorities and planning to prevent duplication.
- Work with partners in other sectors (e.g. education, agriculture, infrastructure) on initiatives aiming to promote health
- Advocate for, identify and mobilize resources to address current and future gaps in health service delivery
- Provide technical and management support to WDCs and facilities to achieve better health outcomes
- Supervise the LGHA staff

Terms of Reference

In carrying out the above functions, the Advisory Committee shall:

- Meet monthly.
- Record minutes of meetings.
- Adopt minutes of meetings and ensure that the Chairman and Secretary sign them.
- Comply with the quorum set for starting meetings.
- Ensure that an account is opened for the Drug Revolving Fund (DRF).
- Keep records of all financial transactions at the LGA.
- The Director PHC shall be a compulsory signatory to the LGA DRF account.
- Reports to the SPHCB on its day to day operations and to the LGHA on broad policy, planning, implementation and PHC outcomes.

3.1.6 Key Requirements

- The State should have a PHC Board as stipulated in the NHAct.
- There should be a balanced representation of government officials, political and community stakeholders on the PHC Board at the state and sub-state levels.
- Members of the Primary Health Care Board should have a clear understanding of the benefits of bringing Primary Health Care Under One Roof.
- State health policy documents should prioritize shared PHC responsibilities with the community.
- Lines of accountability and reporting should be clearly laid out in the law and followed by the SMoH, SPHCB Governing Board and LGHA Advisory Committees and all full time staff of the SPHCB and LGHAs.

3.1.7 Implementation Steps

- **Step 1: Establishment of a Technical Committee for PHCUOR**

PHCUOR like any other health sector reform requires a multi-stakeholders buy-in and strong political will. It requires a coordinated effort that starts with the establishment of a senior technical committee, usually appointed by the Governor or Commissioner of Health and whose main responsibility is to organise the policy dialogue. The committee should include representatives of government Ministries, Departments and Agencies (e.g. SMoH, SMoLG, LGSC, SMoF, SMoJ, State Civil Service Commission, SMoWA), legislators, LGA council chairmen, council and management, partners, CBOs, professional groups, traditional and religious leaders, private health professionals that may be affected or will influence the course of things. Terms of reference for this committee should include transition activities like modalities for handing over assets including new staff to the PHC Board, resource mobilization and continuous sensitization of stakeholders. The committee's tenure should end with the establishment and take off of a management team and the governing board.

- **Step 2: Advocacy, stakeholders' engagement and consensus building around PHCUOR**

Key stakeholders need to be consulted about the plan to consolidate PHC structures in the State and decentralize roles. This process should include workshops, meetings, retreats, study tours and one-on-one dialogue to discuss the existing situation of the PHC system and to advocate for the reform options. Discussions should be frank to ensure sound reasoning towards any consensus that will be reached. The policy dialogue will involve the following key stakeholders: SMoH, SMoLG&CA, LGSC, SMoF, SMoJ, State Civil Service Commission and State Ministry of Women Affairs, legislators, LGA council chairmen, council and PHC coordinators and health managers at the facility level, development partners, community-based organizations, professional groups, traditional and religious leaders, private health professionals and any other group that is likely to wield influence.

The technical committee will drive this process but a critical mass of skilled and influential change agents with good negotiation, communication and coalition building skills are also required. Sufficient time should be allowed for the discussions to ensure consensus building and to identify home grown solutions to challenging local situations.

- **Step 3: Establishment of a technical subcommittee to draft the SPHCB bill, facilitate process of passage into law, assent by the Executive Governor and gazette.**

This subcommittee should include those technically skilled in drafting of health legislation and those with a sound knowledge of the PHCUOR policy. The ministry of justice and health committee of the state house of assembly should be consulted for their inputs and buy-in. The committee should utilize the national PHCUOR guidelines, enacted SPHCB laws from other States and must ensure alignment with the National Health Act (NHAct). The subcommittee should develop a zero draft of the SPHCB bill, receive inputs from stakeholders to build consensus and ensure that the key issues regarding funding, the composition and roles and responsibilities of the governing board, management team and other lines of authority, workforce, and service packages are covered. A final draft is then produced and transmitted to the State Executive Council for approval, and subsequent transmission to and passage by the state house of assembly, assent by the governor, gazette and dissemination for implementation.

- **Step 4: Development of SPHCB Regulations, Policy Document and Annual Work Plan.**

The technical subcommittee should develop regulations that will enhance the effective implementation of the law. Regulations provide less legal jargon of the law for managers and staff to read, understand, and follow. When setup, the SPHCB management team can then develop its policy documents including annual work plan, implementation and monitoring systems to guide its operations.

- **Step 5: Establishment of SPHCB Governing Board and Management Team**

The establishment of the Governing Board and management team is under the purview of the Governor. However, there are always vested interests which must be tactically guarded against.

It is important to lobby and ensure that the right type of people who have the requisite skills and commitment to PHCUOR implementation are appointed by the Governor as stipulated in the law. The management team should also be selected based on prior cognate experience and a track record of competence and not mere seniority. States may opt for a selection interview process to ensure the best candidates are appointed.

The Governing Board and management team are required to undergo orientation/retreat shortly after inauguration to deepen their knowledge and understanding of their new roles and relationships. Technical assistance from NPHCDA and partners would be essential.

- **Step 6: Reposition MDAs to transfer PHC responsibilities in the State to SPHCB**

Following the assent and gazette of the SPHCB law, and the establishment of the SPHCB governing board and management team, the SPHCB takes over all responsibility for PHC service delivery in the State. Because of this changed role, it is essential to reposition the SMoH, by collapsing its existing PHC department and all programmes into the SPHCB. Similarly, all PHC related functions in the State Ministry of Local Government and Local Government Service Commission should be transferred to the SPHCB. The LGA PHC department becomes the LGHA in line with the PHCUOR agenda. This requires advocacy visits/meetings with relevant

stakeholders, re-orientation, short, medium and long-term trainings, staff redistribution, system restructuring and change in attitudes for managers and staff at all levels. Systems for managing staff and assets should be developed to ensure smooth and sustained growth and development of the SPHCB.

- **Step 7: Allocate well-equipped office building at State capital and all LGAs for SPHCB and LGHAs respectively and release of take-off grant for the SPHCB**

The state government should provide an adequate, spacious and well-equipped office building for the SPHCB and LGHAs to commence their duties. Provision should be made for immediate allocation and release of take-off grant for the operations at the State and LGA levels.

- **Step 8: Establishment of Local Government Health Authority Management Team and Advisory Committee.**

The Governing Board and Management Team of the SPHCB should establish Management Teams and Advisory Committees for all the LGHAs. The key principles for establishing the LGHA are single lines of accountability between this level and the SPHCB, well-established accountability lines upwards from LGHA to SPHCB and creation of LGHA structures.

- **Step 9: Build Capacity of Governing Board and Management Team of SPHCB and LGHAs.**

SPHCB board members should undergo capacity building on governance and general oversight in policy formulation and direction. The new management team should also be trained on PHCUOR policy, guidelines and roles. A structured management capacity building programme needs to be developed and implemented. The PHCUOR Implementation Guidelines and the National Guidelines for Development of Primary Health Care in Nigeria (PHC Green Book) are readily available resources apart from several other resource materials that focus on specific capacity in management systems in a decentralized setting. SPHCBs can seek training expertise from the NPHCDA, partners and other states with well-established SPHCBs. Study tours to these states are encouraged.

- **Step 10: Orient and Reorient Stakeholders and SPHCB/LGHA Staff on PHCUOR Policy, New Roles and Responsibilities**

As proposed PHCUOR reform begins to produce a unified and decentralized PHC system, more attention should be shifted to improving PHC service delivery. This attention should focus on the orientation and reorientation of key policy makers and managers from the SMoH, SMoLG, SPHCB and LGHA staff, members of state house of assembly and other PHCUOR 'champions' to deepen their understanding and practice of the PHC law and regulations. This should include regular brain storming sessions, retreats, and workshops crafted in the operations of the agency to reduce distraction. Support to facilitate the sessions will be an essential exercise but the frequency will depend on need. The SPHCB Law, Regulations and other policy documents can be used to guide discussions and the orientation exercise.

- **Step 11: Adoption and Utilization of the WMHCP approach**

A key technical step is for the new SPHCB management team to focus on improving PHC services. The Ward Minimum Health Care Package (WMHCP) approach is

appropriate step towards achieving this and guidelines for its implementation are available as resource materials from the NPHDCA and the NHAct.

3.1.8 Key Success Factors

These include the following:

- *Engage stakeholders*

This involves sustained stakeholders' sensitization, orientation and capacity building by the PHCUR champions. This is required to achieve the proposed changes and ensure effective transition and sustainable implementation of PHCUOR.

- *Involve women and other non-health actors*

Specific notes in documents and selection/appointment criteria should emphasize the need for the involvement of women and non-health actors at all levels

- *Effective leadership and management support*

PHC Board, LGHA and community/facility level committees need effective leadership and management support to ensure members are well informed and able to make good decisions.

3.1.9 Key Indicators for Success

The following are the key indicators for success to measure if governance and ownership Pillar is in place:

- Consensus is built among stakeholders after at least two consecutive meetings prior to taking steps on the implementation of PHCUOR.
- Technical committee established to facilitate the PHCUOR process that focuses on Minimum Service Package (MSP).
- Legislation on key elements of the reform process, including new roles and responsibilities for state health institutions, ministries and parastatals in place.
- Regulations that define how the law will be implemented are developed on key elements to operationalize the SPHCB.
- SPHCB governing board and management team are in place.
- LGHAs are established to manage PHC services.
- State ministry of health, state hospitals management board, state ministry of local government and local government service commission are repositioned to function in line with their new roles and responsibilities.
- Guidelines are developed for the effective functioning of the new institutions including a capacity building programme for managers.
- Sustainable sources of funding are secured.
- Human and material resources are mobilized to strengthen PHCUOR.

3.1.10 Conclusion

The essence of the introduction of PHCUOR policy is to engender reforms, introduce efficiency and effectiveness in the management of integrated PHC services under one authority to achieve better PHC results. It must be recognized that its implementation requires both technical and governance solutions as well as full implementation of requirements of the nine (9) pillars working in synergy. It is expected that all actors key into this initiative.

The achievements recorded will depend on an excellent understanding of the political economy of each State. Wide consultation, advocacy and engagement remain very important approaches to putting the right pressure for desired outcome.

3.2 Pillar 2: LEGISLATION

3.2.1 Introduction

Legislation provides the framework on which everything else depends. Without legislation, managers in the public sector have no framework to guide them in the performance of their duties and no legal footing to backstop their actions. Legislation provides for clear delineation between roles and responsibilities of the policy makers (the politicians) and the implementers (managers in the public sector). Legislation avoids the blurring of boundaries between these two groups and thus should reduce interference in the functioning of the two groups and delivery of PHC services. There is a need for both legislation and regulations.

An appropriate act of the State House of Assembly provides a long term enabling environment for the implementation of PHCOUR. The legislation, which is initiated as a Bill needs to pass through the whole legislative process, including but not limited to being presented to and passed by the State House of Assembly. While in the assembly, it will be subjected to public hearing by the Health Committee of the State House of Assembly. Once it is passed by the house, the bill becomes a “Law”, which then goes to the Governor for assent. A Law comes into effect only after being signed by the Governor. Each step allows for alterations to the draft Bill and bottlenecks (as with the National Health Bill) can be taken care of where possible.

Regulations, on the other hand, are more specific and map out the details and actions required to realize the promise that is the enabling language of a Bill/Law. Regulations are usually signed off by the Commissioner of Health or Governor, dependent on a state's laws and don't need to go through the House of Assembly. This shortened process usually means that it is easier to amend Regulations as and when changes occur. In a sense, Regulations are more responsive to changing conditions. Regulations must be aligned with the State Law and any State Law needs to be harmonized with a relevant federal Law. Where there is no relevant federal Law, state legislation and regulations should be aligned with national policy. Regulations are more technical documents developed to fulfill the vision contained in the resulting Law.

Furthermore, it is important for budget implications to be worked out. This requires realistic estimates of both savings and increased costs. It is critical that politicians understand the budget implications of what is being proposed. A solid financial analysis is therefore critical and can further be used to engage relevant ministries, other policy makers and development partners for the realignment of resources.

Political, religious and traditional leaders, professional associations in the health sector and communities need to be consulted in the development of a Bill addressing health. A Bill should reflect the aspirations of the people of the state. One of the benefits of these consultations is to ensure that the key aspects of the bill are not watered down or removed because of inadequate understanding or other motives.

Consultations also ensure wide ownership of the final product. All of these will enhance implementation. It is also essential to note that consultation is an ongoing

process that continues even after a Bill has been passed and becomes a Law with the PHC Board established.

3.2.2 Key Requirements

- Technical committee for PHCUOR implementation should have representatives from the State Ministry of Justice.
- Wide Stakeholder consultation
- Bill should cover key issues like
    - Governing structure – State PHC Board, LG Health Authority, Ward Development Committee, clarity on reporting lines.
    - Funding mechanisms and financial autonomy of the Board
    - Delineation of roles and responsibilities between SMoH, State PHC Board and other relevant state level MDAs.
    - Movement of PHC programmes to the Board
    - Transfer of PHC facilities to the Board
    - Minimum Service Package
    - Clear provision for movement of PHC staff, salaries and emoluments to the Board
    - Human resources management and control.
- The bill, once passed by the House of Assembly should be assented to by the Governor and gazette.
- Regulations should be developed in line with the law.

3.2.3 Implementation Steps

- **Step1:Consult thoroughly and be realistic about time lines**

To develop effective legislation, all stakeholders should be adequately consulted, understand the proposed changes and have ownership of the process and product. This requires time and should not be rushed.

- **Step 2: Build strong consensus among all stakeholders**

Build strong consensus among all stakeholders including government structures, for example, the SMoH, SMoLG&CA, LGSC, SMoF, SMoJ, State Civil Service Commission, State Ministry of Women Affairs, state legislators, LGA chairmen and councils, partners, community-based organizations, professional groups, traditional and religious leaders and private health professionals.

- **Step 3: Involvement of LGA chairmen and PHC coordinators and teams**

It is critical that local government politicians and health service providers are included in the discussions to build the necessary consensus for the envisaged changes. Representatives from local government need to be included in the technical committee. As some of the expected changes will affect how local government personnel and finances are managed, it is key that they are part and parcel of the planned changes.

- **Step 4: Develop the Bill and Regulations**

This is necessary to support the establishment of a SPHCB and relevant lower level health structures and to address transitional measures, for example staffing, financing and structures/services, minimum service package, movement of PHC staff and programmes from the State Ministry of Health and the LGAs to the Board. This

is a critical area and states will need to draw on both legal and health policy expertise in these areas. Health and legal experts should be both from within and outside the state.

- **Step 5**: **Strengthen advocacy for Bringing "PHC under One Roof".**

For the initiative to move forward and the PHC system to be unified and decentralized, many stakeholders need to be informed and involved in the discussion and development of reforms, to enable them understand the advantages, the challenges and the pitfalls. These stakeholders include politicians from federal to LGA levels, health workers and health managers at all levels, traditional and religious leaders and the community at large. In addition, the process requires strong, skilled and influential leadership at all levels, as well as considerable advocacy, communication and coalition building at the state and community levels to achieve the critical mass of change agents required for this transformation. Thus, a carefully-planned advocacy campaign needs to be developed and implemented.

It is important that all stakeholders understand the implications, the challenges and the benefits of the proposed changes. There will be those who are reluctant to change for a variety of reasons. However, through structured workshops and retreats, study tours and an ongoing advocacy and information campaign, most of these concerns can be addressed.

- **Step 6**: **Championing the Bill through the legislative process**

It is strongly recommended that the technical committee for PHCUOR implementation should shepherd and monitor the Bill through the legislative process to its assent by the Governor. This is to ensure that the draft bills are not substantively altered in the process. The technical committee membership should be of the rank of permanent secretaries or equivalent to advise politicians of the implications of any substantial alteration in the original bill.

- **Step 7: Gazette**

The State Ministry of Justice should ensure that the law is in gazette.

- **Step 8: Dissemination of the Law**

It is very important that the law and all components of the PHCUOR is widely disseminated amongst all relevant stakeholders to secure their buy-in.

3.2.4 Key Success Factors

- Build strong consensus among all stakeholders based on the political economy of the State
- Carry along the legal person from State House of Assembly from the word go who is privy to the details of the bill and can defend it.
- Ensure that the State Ministry of Justice drives the drafting of the bill.
- Ensure wide dissemination of the Bill.
- Honourable Commissioner should give the State Governor updates on PHCUOR implementation
- Ensure that the technical committee on PHCUOR implementation is constituted by the State Executive Council.

3.2.5 Key Indicators for Success

- Bill covers key issues like governance, repositioning, transfer of PHC facilities, funding mechanism, MSP and human resources for health.
- Developed/amended bill is submitted to the State House of Assembly.
- Law assented to by the Governor and gazette.
- Regulations developed and assented to by the Governor or Commissioner of Health as relevant under state law.
- Stakeholders aware of and satisfied with the PHC Board, sub-state structures and management arrangements.

3.2.6 Reviewing the Law (Legislative Process)

If the law does not meet the above requirements, there will be a need to review (update or repeal and replace) the law.
Steps to law review

- Set up a law review committee: Members of this committee should as much as possible include members of the initial high-level technical committee on PHCUOR implementation.
- Follow steps highlighted above for developing the PHCUOR law.

3.2.7 Conclusion

There is a need for both legislation and regulations. While legislation enables and provides the long-term vision, regulations map out the details and actions required to realize the vision and can be changed to address the operational needs as they arise. It is important that the law explicitly covers key aspects of PHCUOR implementation such as repositioning, funding mechanisms and MSP. This will enable seamless implementation. Finally, there is a need for wide consultation on the development and passage of the PHCUOR Bill and extensive dissemination of the law to all relevant stakeholders.

3.3 Pillar 3: MINIMUM SERVICE PACKAGE (MSP)

3.3.1 Introduction

The concept of a Minimum Service Package (or Essential Health Package/Basic Health Care Package) grew out of the 1993 World Development Report (WDR), a World Bank report that focused on health in developing countries. The overall conclusion from this and other studies was that public health expenditures in developing countries were often not directed toward the most cost-effective programmes. Substantial amounts of public funds were being spent on services which resulted in little gain for the population in terms of life expectancy or quality of life. The report argued that the most effective use of public money, in which the greatest amount of population health can be obtained per dollar spent, is when Ministries of Health ensures that their resources are allocated in a manner that ensures most cost-effective public health and clinical services that are accessible to all. Other services, outside this Minimum or Essential package of services would be left to be financed through other funding mechanisms.

No country in the world has the resources to meet all the health needs of its people and Nigeria is not an exception. The Nigerian Government has also adopted the Minimum Service Package (MSP) concept to address the basic health needs of majority of Nigerians. The concept of an essential package of care is therefore rooted in the NHAct to guarantee a basic package of public health and clinical interventions that are:

- cost effective,
- socially and economically accessible especially to the poor and
- deal with the priority disease burdens of the Nigerian population.

The MSP concept is also in line with current FMoH thrust on PHC revitalisation policy for delivering PHC services to achieve UHC.

3.3.2 What is Minimum Service Package (MSP)

MSP is a guaranteed minimum priority set of health care interventions or services that is provided at primary and/or secondary facilities daily and always through government financing mechanisms with the aim of concentrating scarce government resources on interventions which will provide the best 'value for money' gains. It is expected to improve efficiency, equity, political empowerment and accountability.

3.3.3 Ward Minimum Health Care Package (WMHCP)

The Ward Minimum Health Care Package is a broader package that includes all health interventions or services that address the priority health and health related problems in a political ward resulting in substantial health gains and at low cost.

3.3.4 Objectives of MSP Development Process

The main objective of developing a State MSP is to ensure increase in coverage and quality of health services and to increase access to health services in all parts of a state. The specific objectives of developing an MSP are:

- Define and agree on a minimum service package for preventive, promotive, curative and rehabilitative health services/interventions that each type of facility should provide in a State.
- To cost the package.

- Develop a realistic/affordable implementation plan to deliver the MSP.
- Strengthen the State PHC Board as the major government delivery platform for MSP for PHC services to achieve improved PHC outcomes.

3.3.5 Benefits of MSP

- Improves standardisation of facility typology in relation to clinical services it should provide.
- A vehicle for rapid attainment of universal health coverage – addresses 90% of maternal mortality & morbidity and U5 mortality conditions.
- Promotes equity in access to services.
- It is a tool to improve coordination among States, partners, NPHCDA, SDGs, NHIS etc
- Improves efficiency and effectiveness in service delivery.
- It is a constitutional requirement (NHAct sections 11 &13) in relation to Basic Minimum Health Care Provision Fund & Certificate of Standards for Basic Minimum Package of Health Services to guarantee a minimum package of health interventions for majority of Nigerians.

3.3.6 Challenges

There are key challenges that States need to keep in mind while developing their MSP.

- Poor understanding and inadequate planning to develop and implement MSP.
- Political pressure. Facility typology, service distribution, procurement have strong political dimensions and many leaders and health managers may resist attempts to classify and distribute health facilities rationally. This must be handled in a sensitive manner.
- Paucity of good data. Costing requires many assumptions in relation to the level of service utilisation, coverage population and so on. Poor service utilisation data will result in very inaccurate quantification and costing of service packages. Utilisation data taken over a long period of time or survey data may reduce the error.
- MSP implementation guidelines, costing tools and other reference documents produced by NPHCDA and other development partners are not widely disseminated and used by health managers. Information from relevant background documents must be used to enhance implementation capacity.
- Low capacity to plan and a poor implementation culture limits integration of MSP into state health plans & budget. MSP is part of a state's annual, MTEF and longer-term plans and must be integrated into these plans.
- Inadequate allocation of resources (financial, human, infrastructure, medicines and supplies) to implement MSP. With dwindling government resources, all efforts to ensure the development of affordable packages cannot be overemphasised.
- Weak stakeholders' coordination towards implementation of MSP.

3.3.7 Key Requirements

The key requirements for implementation of MSP are in two categories:

- The development of PHC intervention packages and
- The costing of PHC intervention packages.

Requirements for the development of intervention packages are:

- Classification of facilities (**Facilities Typology**) based on the services they provide.
- Standardize a **list of health interventions/services** to address common health problems for each type of facility.
- Standardize **treatment** for each clinical intervention using Standard Treatment Guidelines.
- Standardize **resources required** for the treatment to align with the standard treatment and type of facility. Resources for standardisation include:
  - Number and skills mix of staff
  - Infrastructure
  - Equipment
  - Drugs, lab and medical supplies
  - Utility services

Requirements to determine the cost of a package:

- Quantification of drugs & consumables
- Quantification of equipment
- Number and type of Infrastructure including utility services
- Human resources (payroll)
- Compute the assumptions
  - Catchment Population
  - Disease prevalence in catchment population
  - Service utilization (demand): %admissions, average prescriptions/patient, EmOC, FP etc.

3.3.8 Implementation Steps.

The design and implementation of a State MSP is a complex and lengthy process that will affect many of the key elements of the State and LGA health systems. International experience would suggest that successful implementation will require a number of elements. There should be a recognition that the design of an MSP is not a one-off exercise but something that will need to be incorporated into the State and sub-state structures such as PHC Boards and LGHA planning processes for future adjustments.

- **Step 1:** Set up MSP development and coordination committee that includes technical and political stakeholders from State and LGAs.

- **Step 2:** There should be a body that acts as the MSP Secretariat and provides administrative and technical support to both the high level coordinating body and the several sub-committees.
- **Step 3:** Use NPHCDA guidelines to classify PHC facilities.
- **Step 4:** Develop service delivery standards for each facility type.

- **Step 5:** Cost MSP for each type of facility and sum up costs for all facilities in state.
- **Step6:** Develop an investment plan & mobilise resources for state-wide implementation.
- **Step 7:** Supportive supervision, regular performance review and M&E to track health outcomes.
- **Step 8:** Capacity building of health team.
- **Step 9:** Sensitisation and mobilisation of policy makers, health team and consumers on the benefits of MSP.

3.3.9 MSP Tools

MSP tools have been developed to simplify the costing process and they include the following:

- A costing model. This is used to compute the cost per facility
- A planning tool. This is used to calculate the costs of the State as a whole (based on the number of existing and new facilities planned for the State)
- The HR planner tool. This is designed to calculate the number and cadre of staff required and the budgets per facility.

Computer software packages are also being developed to enhance costing

3.3.10 Key Success Factors

To develop MSP, the following factors are required:

- Create a MSP committee to oversee the process. This committee should be broad based and comprise of people who have political influence, health managers who are technically sound in service delivery. It should also include SMoH, state budget and economic planning team, state health insurance agency, state hospitals management board, a representative from Governor's office, State PHC Board, private sector, development partners and CSOs.
- Develop MSP policy. The policy should define the minimum services based on category of facility, classify the facility, cost the services, develop State MSP medium term expenditure framework and allocate resources accordingly.
- Don't neglect the sub-state structures. In many cases, the focus is on State level offices and its requirements while the sub-state level (LGHA) is neglected. It is vital that both levels are addressed in the selection of office space and the requirements needed to operationalize these offices as clearly stated
- Build Capacity: Train the SPHCB governing board and management team as well as the MSP committee on the MSP policy and the use of the tools. This training is a continuous process and should be cascaded down to the facility and community levels to include the Community Health Influencers, Promoters and Services (CHIPS) Agents
- Carry out supportive supervision and performance review. It is important to maintain focus on results achieved from the MSP. Regular joint performance review of activities and progress on PHC service delivery indicators using DHIS2, survey report etc. should be carried out to assess PHC performance.

3.3.11 Key Indicators for Success

- Health facilities classified in line with NPHCDA guidelines.
- State Minimum Service Package developed in line NPHCDA guidelines
- Minimum Service Package costed.
- State MSP investment plan developed in line with MTEF.
- MSP investment plan implemented as part of MTEF.
- State MSP resource gaps regularly evaluated.
- State annual health plan including MSP activities is implemented.
- Health service delivery performance outcomes regularly reviewed to track progress and to inform policy.

3.3.12 Conclusion

MSP implementation is an important strategy towards the provision of high quality health services to enhance the achievement of UHC and build on the support of NPHCDA and development partners to ensure the use of simple & robust MSP costing models. The MSP provides a basic package of clinical care at PHC, hospital levels and a component of a state-wide investment plan and require a high political buy-in to mobilise resources for implementation. The State PHC Boards are veritable platforms for implementing MSP to foster accountability for results, regular monitoring with a focus on service delivery outcomes to enhance achievement of desired health outcomes.

3.4 Pillar 4: REPOSITIONING

3.4.1 Introduction

Following the assent and gazette of the State Primary Health Care Board (SPHCB) Law, the SPHCB is established and repositioned to take over all responsibilities for Primary Health Care (PHC) programmes and implementation in the State. As a result of this new role, it is imperative to reposition the State Ministry of Health (SMoH) by collapsing its existing PHC department and all PHC programmes into the SPHCB. Similarly, all PHC related functions in the State Ministry of Local Government and Local Government Service Commission should be transferred to the SPHCB. The LGA PHC department becomes the Local Government Health Authority (LGHA) in line with the PHCUOR agenda. Repositioning requires advocacy, tact, diplomacy, system restructuring, staff redistribution, re-orientation on their new roles and responsibilities as well as capacity building at all levels. The four key areas for repositioning are:

- Leadership and Management
- Human Resource for Health
- Financial Resources
- Primary Health Care programmes in SMoH and PHC facilities in the LGAs

The lack of clarity on movement of Primary Health Care programmes from the State Ministry of Health to the State PHC Boards and their new roles led to a stakeholders' consensus building meeting of Honourable Commissioners of Health and Executive Secretaries of State PHC Boards with the following resolutions:

Movement of PHC Programmes- Maternal and Child Health, Reproductive Health, Nutrition, Immunization, HIV/AIDS, TB, Malaria, Guinea Worm, Onchocerciasis, other Vector Control programmes should be moved to the State PHC Board to promote integration and effective service delivery while non-communicable diseases and Epidemiological units remain under the SMoH.

Roles of the State Ministry of Health - The SMoH, without prejudice to the functions of the State PHC Board, is responsible for policy formulation, setting standards, resource mobilization, partner coordination and oversight of all health activities in the state to enhance quality assurance and accountability.

Timelines **–** The technical committee should facilitate the smooth implementation of the repositioning and restructuring of the SMoH and transfer of the PHC programmes listed above to the State PHC Board with clearly defined terms of reference (ToR) and timelines.

3.4.2 Challenges

- **Involvement of all stakeholders**

Just as choices about governance needs to engage a wide range of stakeholders, stakeholders' involvement is essential in implementing the new structures, as defined in the Law and Regulations, and repositioning staff to operate the new structures effectively. It is especially critical that health workers on the ground, their professional bodies and local management structures are involved in the re-orientation. The process needs to cascade from state to LGA levels, as well as to

facility and community levels. It is key that the State Ministry of Local Government and Chieftaincy Affairs (SMoLG&CA) and any other state level body that has previously been involved in health care delivery be involved. Repositioning involves hard decisions, but failure to ensure that all health workers and community members understand and support repositioning can lead to poorly implemented systems, misunderstandings, resistance to change, and, ultimately, failure to improve services and of “Bringing PHC under One Roof”.

- **Funding**

Re-orientation workshops and capacity building programmes for managers are expensive but necessary. It is important that the required workshops and capacity building programmes are budgeted for in planning the repositioning process and sources of funding are sought from both government and external funders, for example, development partners.

- **Nature of capacity building programmes**

Many capacity building programmes for managers are theoretical in nature and remove the managers from their sites of work, where they are needed most. Capacity building therefore, needs to be done on-the-job wherever possible. New management skills, coaching and mentoring are all key elements in the design of a capacity building programme.

- **Resistance to change**

Transformation, by its very nature, prompts resistance to change amongst many. Fear of the unknown, fear of losing what one has and fear of an uncertain future are critical issues that facilitators in reorientation programmes need to be aware of and work with. It is important that the process of managing change, developing new systems and re-orientation allows time and space to deal with these issues.

3.4.3 Key Requirements

For effective operationalization of the PHCUOR, the technical committee is required for a successful repositioning of the SMoH and LGA PHC departments through:

- Involvement and orientation of stakeholders.
- Identification and agreement on new roles and responsibilities for the SMoH, health department in Ministry of Local Government and Local Government Service Commission as distinct from the State PHC Board’s role.
- Orientation of the managers (both SMoH and SPHCB), committees and key staff in the new structures.
- Development and implementation of capacity building plan for managers to undertake their new tasks diligently.

3.4.4 Implementation Steps

- **Step 1: Re-orientate, advocate and gain the commitment of key stakeholders on repositioning**

In order to reposition the SMoH and LGA PHC Departments, it is important to continuously engage and re-orientate policy makers, health managers and communities to gain their commitment/buy-in.

- **Step 2: Repositioning of SMoH, State Hospitals Management Board and other structures for their new functions and roles**

Passage and enactment of the Bill/Act, development of Regulations and creation of new structures with different arrangements, particularly for finance, human resource management and service provision, will require changes in and understanding of the roles and responsibilities of existing and new bodies and should be addressed sensitively at each stage and in each situation. It is critical to understand this and create the space and time for the bodies to adapt to new situations. All bodies, both old and new, will require responsive support throughout the repositioning process.

- **Step 3: Support for the repositioning process at LGA level**

After passage and enactment of the Bill/Act and the development of Regulations, it is important that existing LGA PHC departments support the restructuring process. The management of human resources (HR), finance and service delivery will all change. The process will be far smoother if the LGAs have been part of the process from the beginning, their concerns are understood and they are allowed to play a full part in the repositioning activities.

- **Step 4**: **Orientation and team building of staff and community members for their new roles**

With the changing environment and the movement of staff, it is vital that all staff are oriented with respect to new structural arrangements and the roles and responsibilities of the different bodies. LGA and PHC health personnel and community members, especially ward development and facility health committees, will be key in each of these processes. The Bill/Law and the Regulations there under must be used to guide discussions and change.

- **Step 5: Capacity building of managers in the new structures**

It is also critical to build the capacity of new managers in the system. A structured management capacity building programme needs to be developed. There are several models currently operating in Nigeria. It is proposed to use an on-the-job coaching and mentoring approach with minimal time away from work. All capacity building programmes should be tailored to state specific circumstances that can be adjusted according to the budget available and can be linked to a certificated programme through a tertiary institution. Time on the programme could be structured in the following ways:

- time for participants to share challenges, successes and to discuss solutions
- input from facilitators and experts tailored to the specific local context – this might be on human resources, health management information systems, drug supply or other areas.
- technical support, facilitation and mentoring for team projects, innovations and assignments, providing direct improvements to services on the ground.

3.4.5 Key Success Factors

- Reach agreement on core roles and responsibilities and the commitment of the SMoH leadership.
- Engage stakeholders to address anticipated resistance to change.

- Build capacity (leaders, managers & service providers) for new roles in practical and relevant manner.
- Include a budget for capacity building to reposition policy makers, health managers and service providers into SPHCB budget.

3.4.6 Key Indicators for Success

- Roles and responsibilities of Governing Board, Management Team and sub-state structures established.
- Capacity building programmes for managers functioning.
- Key stakeholders involved.
- Capacity building on repositioning and other programmes budgeted for and funded.

3.4.7 Conclusion

Repositioning strongly relies on other pillars of PHCUOR, and therefore requires the commitment of stakeholders, policy makers and health managers to ensure its full implementation.

3.5 Pillar 5: SYSTEMS DEVELOPMENT

3.5.1 Introduction

The State Primary Health Care Board (SPHCB) is tasked with the responsibility for organizing and managing its resources (human, financial and material) for effective and efficient PHC services. There is, therefore, the need to establish comprehensive and robust systems for quality health outcomes. Governance and management systems need to reflect the needs of stakeholders and to be implemented in pursuant to legislation. To achieve this, the SPHCB should develop a strategic and costed annual operational plan, knowledge management system, human resource policy, and implement and monitor its activities. All these will be hinged on the development of sound management systems. Therefore, PHC management systems should function in an integrated manner for efficient and effective PHC service delivery.

3.5.2 Challenges

There are three key challenges that states need to keep in mind as they move forward in “Bringing PHC under One Roof”.

- **Appointment of inappropriate people**

There is clearly a danger in the creation of new structures with new posts. Powerful people will want to install their favourites. It is critical that a fair and transparent process is followed. Job descriptions of the key posts need to be drawn up. The technical committee needs to ensure that an open, transparent, fair selection process is adopted and followed. Key role players, especially the Governor and the Commissioner of Health, need to be regularly informed of progress. This is important for the state and sub-state governing boards and management teams. Inappropriate appointments or unpopular appointments will diminish the credibility of the new state and sub-state structures and thus the success of the transformation.

- **Lack of clear distinction between governing body and management team**

There is the need to clearly define the role of politicians and administrators. This is played out in the respective roles and functions of the governing boards and the management teams. For many years, this distinction has not been clear and has led to inappropriate interference in the functioning and management of the health services. Often this has had disastrous effects. Thus, the new Law and Regulations must clarify the roles and responsibilities of the politicians, the state and sub-state governing bodies and related management structures. For example, the Law/Regulations should specify that the Governor is responsible for approving the appointment of the governing board and the Executive Secretary or equivalent of the SPHCB and ensure that LGA chairmen are represented on the advisory committees of LGHAs. The Governing Board and has the overall responsibility for policy development and approval and oversight of the SPHCB and LGHAs management teams. However, governing boards and advisory committees are not entitled to become involved in the day-to-day management of the SPHCB or LGHAs. That is entrusted to the Management Teams at state and sub-state levels. To address these challenges, governing board, advisory committees and management teams should have orientations on roles clarifications as well as regular retreats.

- **Gender imbalances in the governing boards**

Health services are provided to mothers and children who make up the bulk of the patients. However, governing boards often have a history of inadequate representation from women. This is an issue that needs to be addressed in the new Bill/Law and Regulations there under and must be considered by the technical committee in assembling names for the Governing Board to submit to the Governor for approval.

3.5.3 Key Requirements

- Planning, implementation and performance review system.
- Organization and management of Primary Health Care system should be in line with the principles of the 'three ones' - One management, One plan and One monitoring and evaluation system with decentralized authority, responsibility and accountability and integration of services across all levels.
- The PHC Board should develop a strategic health plan, business plan and costed annual operational plans in line with the overall State Strategic Health Plan.
- LGHAs, Wards and facilities should develop costed annual operational plans.
- Development of a plan, by the PHC Board, for quarterly review of the PHC services and systems.
- The PHC Board should develop and implement a single PHC management body with adequate capacity to control services such as financial, human resources including comprehensive job descriptions, administrative system, essential drugs and commodities supply chain and Health Management Information System (HMIS).
- Development and implementation of quality assurance and integrated supportive supervision systems.
- There should be a high level technical committee comprising of state representatives (not lower than the level of a Permanent Secretary) of the following with very clear terms of reference to address the issue of systems development:
  - Office of the Head of Civil Service
  - Zonal Director NPHCDA
  - Ministry of Local Government & Chieftaincy Affairs
  - Local Government Service Commission
  - Ministry of Health
  - Ministry of Finance
  - Ministry of Justice
  - Ministry of Budget and Planning
  - Development partners
  - CSOs
  - A representative of the State Hospitals Management Board

3.5.4 Implementation Steps

To achieve an effective and efficient PHC system, the following steps are required:

- **Step 1: The technical committee drives the process of establishing the SPHCB in order to ensure its proper take off**

The committee, which is appointed by the Governor, should oversee the process. It is key that the appointment of the members of the governing bodies and the management teams at state and sub-state levels follow a fair and transparent process, which is in consonance with the law establishing the SPHCB and the political economy of the state. In addition, the technical committee needs to communicate progress regularly to all stakeholders, notably the Governor, Commissioners of Health and Local Government and Chieftaincy Affairs.

- **Step 2**: **Establish the SPHCB and management team to manage the new system**

An essential requirement for effective integration is that existing PHC staff, including staff currently employed by the LGA, LGSC and/or SMoH will all come under the management of the SPHCB following a comprehensive human resource for health audit and requirements. Payment of staff will be through the SPHCB. Recruitment and equitable distribution of staff will be the responsibility of the SPHCB. Similarly, finances will fall under the SPHCB. This will entail consolidating health funds that currently fall under LGAs, the SMoH, the SMoLG and any other bodies. At this stage, with managerial control over finances and human resources, the SPHCB will be empowered to manage and provide health services. Usually, the health services provided will fall in line with the MSP adapted from federal level guidelines.

- **Step 3: Establishment of LG health authorities**

The Local Government Health Authorities (LGHAs) are the operational arms at the sub-state level. The key principles for establishing these sub-state structures are:

- Single lines of accountability between each level and the authority above.
- Well-established accountability lines upwards at every level for finance, staff and service delivery.
- Creation of structures of an appropriate size with borders that are coterminous with current political borders.
- Creation of structures with sufficient but not excessive spans of control.

3.5.5 Key Success Factors

- Identify priority systems e.g. planning, implementation, finance, human resources to be the focus.
- Adopt and adapt from state & national policies.
- Ensure wide participation & sustained engagement of relevant PHC stakeholders.
- Continuous orientation and capacity building.
- Regular joint reviews of systems performance.

3.5.6 Key Indicators for Success

- Governing board and management team fully functional at all levels.
- PHC system established in line with the principle of ''three ones''.

- Decentralized authority for management of resources and integrated approach to the provision of PHC services.
- Plan to develop prioritized management systems is followed to ensure the establishment of such systems at all levels Clear lines of accountability and communication established in the system.

3.5.7 Conclusion

Systems Development is very vital in the implementation of PHCUOR and should be critically carried out to ensure the identification and inclusion of priority systems such as planning and implementation, finance and human resources for health. The PHC system should be in line with the principle of 'three ones' (One management, One plan and One monitoring and evaluation system) and integration of all PHC services delivered under a decentralized authority. The SPHCB management systems should adopt and adapt the existing State and National policies, systems and guidelines while ensuring wide participation and sustained engagement of relevant PHC stakeholders and continuous orientation and capacity building of managers and staff with regular joint review of PHC systems performance.

3.6 Pillar 6: OPERATIONAL GUIDELINES

3.6.1 Introduction

Operational guidelines are a series of instructions regarding the proper implementation of PHCUOR that provides the details on how the SPHCB and the LGHA will be administered in accordance with the provisions of the enabling Law and Regulations.

The main objective of operational guidelines is to provide a clear direction to policy makers on the day-to-day activities/schedules of SPHCB and LGHA to ensure efficient delivery of PHC services. States normally have well developed policies and procedures for human resource management, procurement/supply chain management (SCM), accounting/financial management and M&E. The Law and/or Regulations specify the responsibilities of each entity i.e. (Governing Board, Management Team, LGHAs and facilities).The creation of the PHC Board is accompanied by statutory requirements for the PHC Board to develop specific policies, procedures and protocols related to its administrative and operational areas. It is critical for policies, procedures and protocols to be developed in written form and aligned with relevant National and State policies, protocols and procedures.

It is pertinent to note and stress that both the Governing Board of the SPHCB and the Advisory Committee of the LGHA are not permitted to meddle in the day-to-day administration of these organs.

3.6.2 Challenges

There are two key challenges states need to keep in mind as they move forward in “Bringing PHC under One Roof”.

- **Failure to develop and obtain assent to Regulations**
  Several states have only developed the Law. There are no accompanying Regulations. In some cases, Regulations have been developed but not assented to. It is key that the Bill and Regulations be developed together, with Regulations signed off in close proximity (time-wise) to the Law.
- **Failure to determine tasks required to fulfill the Law and Regulations**
  The Law and Regulations can only set out a high-level framework for governance and management. Fulfilling these depend on building effective systems, operational practice and guidelines. Both Governing Boards and Management Teams may lack experience in building new, successful institutions. Politicians and funders may underestimate the time, skills, funds and resources required to implement the changes required. Establishing a realistic plan for all operational procedures and guidelines is essential.

3.6.3 Key Requirements

- States should establish rules and regulations for SPHCB.
- The Law and/or regulations should specify which entity is responsible for developing the policies, procedures and protocols as well as the time frame within which they must be developed and in written form. These should also align with relevant national and state policies.
- States should draft management policies and procedures like transport and travels, security, store inventory and procurement for SPHCB.

- States should establish standard operational procedures and protocol for human resources for health, accounting and monitoring and evaluation.
- States should develop operational guidelines for the LGHA.

3.6.4 Implementation Steps

- **Step 1: Review the new Law and Regulations**

It is essential for the Governing Board and Management Team to review the new Law and Regulations and extract the key tasks to be completed within specified timeframes. Key tasks need to be compiled in an action list inclusive of timelines and stating responsibility for various obligations. The Governing Board and Management Team should track progress at regular meetings to ensure that timelines are met.

- **Step 2: Agree on a plan and obtain the resources required**

It is essential that a realistic plan is developed to establish operational procedures and guidelines.

- **Step 3: Finalize the administrative procedures and distribute to relevant personnel/stakeholders at all levels**

Policies, protocols and procedures need to be finalized according to timelines and aligned with relevant National and State policies, protocols and procedures. Once completed, they should be distributed to all relevant health workers under the SPHCB.

- **Step 4: Continuous training, orientation and capacity building**

Continuous training, orientation and capacity building of relevant stakeholders on all new administrative procedures should be undertaken. This should be budgeted for and funds sourced either from government or development partners.

3.6.5 Key Success Factors

- Availability of enabling Laws and Regulations assented to by relevant authorities.
- Availability of drafted management policies and procedures e.g. on transport and travels, security, store inventory and procurement for SPHCB.
- Developed standard operational procedures and protocol for the day to day management of all its resources including human resources for health, accounting, commodities, vaccines and supplies, PHC service delivery, utility services (light, water, sanitation, security etc) and monitoring and evaluation.
- Adequate resources for planning and managing HR are critical for success. Budgeted funds will be needed for staffing or temporary support, and to manage data relating to many hundreds or thousands of posts and staff. States may want to establish a specialist HR function at an early stage as a critical component for driving repositioning and development
- Movement of staff is a critical issue. Staff are accountable to those who manage and pay them. Thus, it is critical for the new SPHCB to manage and remunerate all PHC staff. The data in the Human Resource Information System (HRIS) will establish the numbers and the types of staff available. Staff whose services are not needed in the new arrangement are to remain with LGAs and not be transferred to the new SPHCB. This also includes excess of non-professional staff, for example, security staff and cleaners.

3.6.6 Key Indicators for Success

- Fully functional SPHCB established.
- Costed plan and timeline for establishment of procedures and operational guidelines for both SPHCB and LGHA developed.
- Management policies and procedures for Human Resource Management, procurement, accounting/financial management and M&E developed.

3.6.7 Conclusion

Operational guidelines consist of all relevant administrative instruments required for the day to day management of the SPHCB. They form the key ingredients to guide managers and staff on basic procedures to follow for the smooth operation of the organization. Documentation of these procedures is essential for standardization of operations, improve efficiency and effectiveness, promote communication and improve harmonious relationship within and across departments and among individuals in the organization. They are modern day standard management tools that each SPHCB must have.

3.7 Pillar 7: HUMAN RESOURCES FOR HEALTH

3.7.1 Introduction

Human Resources for Health (HRH) is defined as “all people, engaged in actions whose primary intent is to enhance health.” (WHO, 2006)

Human resources constitute one of the most important resources in health and therefore demands effective planning and management for an efficient and effective PHC system to achieve better health outcomes.

Apart from cost, human resources have the ability to mobilize and manage other resources in the health care system. This section will provide the SPHCB with insight and understanding to be able to plan, develop and manage human resources:

- Human resource capacity plan including assessment and gap analysis.
- Conduct human resource recruitment, selection, placement and transfers.
- Design appropriate job descriptions and contracts for staff.
- Conduct orientations for staff on their jobs.
- Establish and maintain a reliable human resource data base to ensure the right number of staff with the rights skills are in the right place carrying out the right services.
- Promote staff motivation through appropriate leadership and provision of the right incentives.
- Carry out effective supervision and performance appraisal, reward and sanctions for HRH.
- Communicate effectively with staff.
- Promotecontinuing education in the delivery of health services; coordinate various activities in the state/LGA for effective integration.

3.7.2 Challenges

- Inadequate numbers of skilled Human Resources for Health and the ‘’ghost worker’’ syndrome
- Inappropriate distribution of staff
- Lack of clear guidance on the process of movement of PHC staff from the Ministry of Health and Local Government Areas to the State PHC Board.
- Weakness in the succession planning of managers and other staff
- Delay in moving staff from old structure to the PHC Board
- Poor attitude of staff to work and weak supervision and technical support of staff
- Weak HRH planning and management capacity
- HRH is not given the required position in the health management structure

3.7.3 Key Requirements

- Human Resource for Health Policy
- Human Resource for Health Plans
- Establishment of Human Resource Department/Unit with adequate HRH planning and management capacity
- Human Resources Information System (HRIS)

3.7.4 Implementation Steps

- **Step 1: Establishment of a HR Committee**

Most HR issues have governance and/or political dimensions. Simply adopting a technical approach will not suffice. Thus, the HR committee needs to be comprised of sufficiently high profile individuals with excellent links with state political actors. This HR Committee must have enough seniority inclusive of the ear of the Governor, the Executive Secretary and Board Chairman to address critical issues.

The HR Committee should be composed of not more than 10 members and should be a sub-committee of the Governing Board. The tenure of this committee should be between 6 months to a year, or till the SPHCB is stabilized from its set up status. The suggested membership of the Committee could be the following;

- Representative of the Governing Board of SPHCB
- Representative from Office of the State Head of Service
- Representative from Local Government Service Commission
- Representative from State Civil Service Commission
- Representative from the Technical Committee
- Representative from Professional Bodies
- Representative from Nigeria Labour Congress
- Executive Secretary, SPHCB
- Director PRS SPHCB
- Director Admin and Human Resource SPHCB

It is necessary that the HR Committee develops a Term of Reference (ToR) and ensure that their activities are reported to the Governing Board.

The HR committee will require orientation and training on such issues as the HRIS, movement of staff from other MDAs to the SPHCB and the MSP. The committee will require ongoing technical support on HRH issues from NPHCDA, development partners and the state government. A transition plan for movement of staff to the SPHCB including staff audit should be budgeted and funded.

- **Step 2: Establishment of a HR Department/Unit**

HRH requires strategic visioning, management authority, technical expertise, administrative capacity and good human resource information systems. The requirement depends on which HR functions are managed directly by the PHC Board. The head of HR Department is the Director who should be a member of the SPHCB management team. Planning and providing the HRH function in the SPHCB early is essential and will facilitate the rapid achievement of the other steps.

- Carry out an HRH audit followed by needs assessment to clearly identify HRH priorities and establish a key HRH mandate.
- Develop an HRH management organogram for the HRH Department/Division/Unit and produce functions.
- Appoint qualified and competent staff to fill vacancies on the organogram.
- Allocate an office space to the HRH Department/Division/Unit and furniture/equipment for optimal operation.
- Carry out orientation and training for management and other staff on HRH issues.

- **Step 3: Establishment of a Reliable HRH Database using HRIS**

It is critical that the new SPHCB carries out an assessment of the current HR situation and then link this to HR needs based on a MSP approach. To do this effectively, the SPHCB needs to utilize a HRIS. Currently, in some states a software tool called “HR Planner” is being used for this process. States most likely will need external technical assistance and training to develop and maintain this database. This can be achieved by:

- Conducting a human resource audit of the SPHCB.
- Establishing a human resource data base that should be reviewed periodically.
- Conducting regular analysis of the HRH data base to provide reports that will inform HR Planning, Coordination and Management.
- Presentation of the HRH report to the Governing Board and Management Team for informed decision making.
- Regular publication of HR reports for advocacy and accountability.

- **Step 4: Development of HRH Policy and Plans**

The data generated from the HRIS database should form the basis for the development of the State PHC HRH Policy and Plans to be incorporated into the State HRH Policy and Plans. To facilitate State HRH development, the national HRH policy framework can be used but with a focus on state specific priorities.

- **Step 5: Using the MSP to determine HR Needs at all Facilities**

The MSP addressed in Chapter 3 should be used to classify all facilities and thus determine the mix and numbers of staff required for each facility. This information can be used to compare the actual number, distribution of staff from the HRIS database and gaps in staff needs identified and used to plan and transfer existing staff to fill existing gaps based on MSP requirements and also to recruit additional ones . The MSP should also be used for state-wide planning and training of pre-service workforce and in-service training needs. Considering the implementation of the Basic Health Care Provision Fund (BHCPF), it is suggested that Finance and Administration Officers be included in the HR workforce of Primary Health Care Centers. Before distributing staff, a work load analysis should be conducted to provide evidence and criteria for distributing the workforce which must be in line with the MSP Guidelines.

- **Step 6: Negotiating with Previous Employers**

This step requires engagement with LGAs, SMoH, SMoLG, State Civil Service Commission and Local Government Service Commission. Several meetings may be required and the issue can be escalated to State Executive Council as the need arises to gain the highest political buy-in of government. This will improve the understanding of the rationale for the movement (to improve PHC service delivery outcomes through effective and efficient use of available human and material resources) and agree on appropriate use of existing government regulations and rules for the movement of staff to the SPHCB. The implementation of this step will be handled by the HR Committee.

- **Step 7: Communicating Processes, Changes and Outcomes**

Any change creates uncertainty and fear of the unknown. It is vital that all aspects of the change are communicated widely to the different stakeholders in the state.

- **Steps 8: Development of Job Descriptions**

The Job Descriptions for all staff will be developed by the HR Department/Unit. This may require external technical assistance which the SPHCB must seek and get from NPHCDA and development partners as well as other arms of government with similar functions

3.7.5 Key Success Factors

- High level political will and commitment.
- Availability of required resources and institutional framework.
- Partnership, coordination and change management.
- Ensure the HR Committee/Department has a strong mandate, sufficient authority and the right skills.
- HR planning and management capacity and capability.
- Conducive working environment and office accommodation.

3.7.6 Key Indicators for Success

- High profile HR Committee in operation.
- HR Department with HR Director as head and team established.
- Up-to-date and reliable information about existing staff available from HRIS.
- Developed staffing requirements and affordable staffing norms for different facility types to provide MSP.
- Job descriptions developed and used by all staff.
- Rational redistribution of staff carried out.
- Transfer of payment of all PHC staff from other MDAs to the SPHCB.
- All key HRH functions reside with the governing board and management team.

3.7.7 Conclusion

Human resources for health being the cornerstone of the health system should be given very high priority and attention. It therefore becomes imperative that the state machinery under PHCUOR implementation be properly guided on its importance.

3.8 Pillar 8: FUNDING SOURCES AND STRUCTURES

3.8.1 Introduction

WHO building blocks identify health financing as one of the key pillars for health systems. Finances are among the most important resources of health services. Managing money in a health system is a complex and onerous task, which is done mainly by accountants or finance officers. Keeping account records accurately, up to date and adhering to financial regulations at all times is a major task of the accounts unit.

Adequate and sustainable financial resources are essential in ensuring that success of the PHCUOR implementation. It is critical that the SPHCB develop systems and processes to ensure that plans are developed and costed, that these are included in the annual budgets of the SMoH and successfully defended; and that budget release is tracked. It is also critical to develop an effective M&E system and to provide for an independent annual audit to ensure the SPHCB can show state government how the money has been spent and with what effect and impact.

Benefits of finance management systems in the implementation of PHCUOR include:

- The provision of an overview of financial requirements
- Identifies funding gaps and sources to fill the gaps
- Provides opportunity for pooling funds
- Efficient allocation and management of financial resources
- Enhances accountability of financial resources
- Ensure financial resource allocations are tired to results.

3.8.2 Challenges

Nevertheless, states face bottlenecks in setting financial management systems notably due to:

- **Lack of clear guidance**

States lack clear guidance on the funding sources and funding mechanisms for the SPHCBs and organs responsible for managing the funds of the SPHCBs.

- **Inadequate planning and budgeting processes**

Most states have poor capacity when it comes to annual planning and budgeting. Plans are often rolled over from year to year. It is vital that the SPHCB develop the capacity for annual planning and budgeting, including the development of viable Annual Operational Plans and bottom up budgeting. Inadequate capacity for managing financial resources at PHC level should be addressed. This should include building financial management capacity at the PHC facility level in preparedness for future implementation of direct facility financing.

- **Lack of effective M&E and audit systems**

If policy makers and politicians are not made aware of how allocated funds have been utilized and what differences the funds have made, they might not be prepared to be as generous in the future. The SPHCB needs to develop an effective M&E system that includes indicators linking funding to outputs, outcomes and impact and

an independent audit process. These are very powerful tools that are not utilized often enough.

- **Poor release of funds and budget tracking**

Budgeted funds often go unreleased and thus unspent, resulting in the frustration of PHC development plans, including Annual Operational Plans. There are many causes for failure to spend agreed budgets. Regular reports of expenditure against budget highlight where expenditure is behind plan. Little is done at state level to track budget releases and measure budget performance. The SPHCB needs to develop the capacity to track and measure budgetary releases from state level through the LGHAs to PHC facilities; and ensure that budget performance gets proper attention by the Governing Board and Management Team. Common causes for non-release of budgeted funds include over-projecting expected income; cash flow problems or reprioritization of funds by Federal or State government; delays or failures in procurement; administrative weaknesses in processing purchases and payments; and internal delays in implementing work plans. Whatever the reason, prompt budget tracking is essential to identify and address the problem.

- **Procurement delays**

Procurement systems are often weak or may be poorly understood by new managers. Managers may need training to understand the steps and time required to order supplies and equipment in line with extant procurement act.

3.8.3 Key Requirements

- Take-off Grant
- Budget line
- Financial Manual
- Mechanism for expenditure tracking
- Establishment of a clear audit mechanism/process
- Establishment of ‘’Pooled Funding’’ mechanism
- Accounts for all levels: SPHCB, LGHA, Primary Health Centres (Service delivery)
- Financial Unit in SPHCB
- Published annual financial reports

3.8.4 Implementation Steps

- **Step 1**: **Constitute a Finance Technical Working Group (TWG) at both the state and sub-state levels with specific Terms of Reference (ToR)**

They should provide financial oversight and ensure efficient utilization of funds and resources towards strengthening the state’s PHC programmes. They should oversee quarterly internal audits and annual external audit exercises. They should also ensure that financial statements are shared with all stakeholders. The capacity of this committee will need to be built. Key members of the SPHCB Finance TWG are:

  - Director Finance (Chair)
  - Representative of the LGHA
  - Representative of the WDCs (One per three senatorial zones)
  - Development Partners.

There should also be the LGHA Finance TWG in each of the LGAs in the State. The LGHA TWG should work with relevant stakeholders to support business plan

development and auditing in states/ LGAs practicing any form of direct facility financing.

- **Step 2: Develop the Financial Manual**

The Financial Manual must be comprehensive and should provide clear guidelines for all transactions at all levels.

- **Step 3: Open accounts for all levels: SPHCB, LGHA and Primary Health Centres respectively**

At each level, accounts should be opened with reputable commercial banks. Other types of facilities like health posts or health clinics will receive an imprest.

- **Step 4: Create pooled funds**

The finance TWG will determine the proportions to be contributed by the different groups. In other words, determine the proportion of funds for: state, LGAs and development partners to commit. This ensures transparency and accountability as well as introduces sufficient checks and balances to satisfy all the contributors.

- **Step 5: Develop the capacity to plan, budget and track release of funds**

It is imperative for the SPHCB Management Team to have the capacity to plan, budget and track budget releases. This capacity will need to be built and funds for this need to be sourced from government or external development partners.

- **Step 6: Put in place strategies to ensure release of funds**

Lobby to ensure the release of the budgeted funds. Deduct from source as first line charge. Where states have adopted direct facility financing models such as Results-Based Financing (RBF) or benefitting from the Basic Health Care Provision Fund (BHCPF), releases should be made directly to points of utilization.

3.8.5 Key Success Factors

- Set up a Finance Technical Working Group (TWG)
- Accountant to manage funds at the LGHA
- Financial autonomy at the SPHCB, LGHA and facility level
- Funds tracking mechanism in place

3.8.6 Key Indicators for Success

- PHC take-off grant released
- Annual plan developed, costed and approved
- Budget performance over 90%
- SPHCB Annual financial reports published

3.8.7 Conclusion

The Finance TWG will coordinate and oversee the finance management system to ensure efficient execution of PHC services. Contributions from State, LGA, partners and other sources should be pooled together and the pooled funds managed for each level by the relevant group. All funds should be released in a timely manner in line with the approved costed strategic plan for implementation of PHC programmes and effective service delivery.

3.9 Pillar 9: OFFICE SET UP

3.9.1 Introduction

The establishment of suitable, adequate, secured and relatively independent offices for the State Primary Health Care Board and Local Government Health Authorities is a basic requirement for the implementation of PHCUOR. There should be a permanent office space. However, in the initial phase a temporary (borrowed, rented) space can be utilized by the SPHCB. The Primary Health Care Department at the LGA transforms into the LGHA. To make the office functional, there should be adequate furniture, equipment, vehicles and computers, laptops, photocopiers, scanners, internet facilities etc. The take-off grant for the state should make provision to facilitate the process of setting up an office. If the office is rented, provision should be made in the budget for purchase of a permanent office space or renewal of the rent.

3.9.2 Challenges

There are two key challenges that states need to keep in mind as they move forward in “Bringing PHC under One Roof”.

- Inadequate funding to purchase, build or rent and properly equip a suitable office space**.** Although funding could be released, this might be inadequate for the needs of the SPHCB. It is important that the technical committee draws up a clear costed plan to engage with the Governor and other key stakeholders.

- Unsuitable office selection. Selection of offices is key both at State and LGA levels. It is important that the technical committee draws up clear criteria to guide the selection process of a suitable office space.

3.9.3 Key Requirements

- A building that accommodates all staff
    - Have a clean water source (public water supply and or from a motorized borehole)
    - Functional toilet facilities (male/female)
    - Office connected to the national grid and other regular alternative power source
    - Provision of crèche
- Adequate furniture and equipment (computers, printers, photocopiers, scanners, internet facilities, generator/inverter etc.)
- Provision of official/project vehicles
- Inventory and maintenance plan in the SPHCB budget

3.9.4 Implementation Steps

- **Step 1: Mandate of the technical committee to include the setting up of office space as one of its initial crucial assignments**

The Committee must consult widely with key officers and policy makers before taking major decisions on issues such as in paying for building/rent, procuring furniture, equipment etc. as well as setting date for movement.

- **Step 2: Develop start up budget and plans**

It is critical to ensure that realistic costs for the office and equipment are made at both state and LGA levels.

- **Step 3: Obtain a take-off grant.**

Seek the Governor's approval for the release of funds. The take-off grant is a one off fund from the State Government to start off the SPHCB.

- **Step 4: Monitoring**

Implement and monitor the activities of the office set-up which includes procurement of budgeted items and conduct of periodic inventories and maintenance where necessary.

3.9.5 Key Success Factors

- Technical Committee with mandate to source for appropriate office building.
- Approved budget for office set up.
- Take-off grant for office space, furniture, equipment, vehicles etc.
- Availability of Inventory and Maintenance Plan.

3.9.6 Key Indicators for Success

- Offices set up at all levels (State PHC Board and LGHAs).
- Offices provided with adequate furniture at all levels.
- Offices equipped with computers, printers, photocopiers, scanners and internet facilities etc at all levels.
- Functional vehicles provided.

3.9.7 Conclusion

To ensure effective planning, coordination and supervision of PHC system, there is need for provision of adequate office space, furniture, equipment and tools for an enabling work environment. The inventory and maintenance plan will be applied for efficiency of the office set-up.

4 MONITORING AND EVALUATION

4.1 Introduction

To track progress, measure success and identify challenges, a simple M&E system needs to be designed as a matter of urgency. This is necessary for collecting and analyzing the identified indicators and then utilizing the information generated to guide the review of the Strategic and Annual Operational Health Plans. Monitoring and Evaluation cut across the nine pillars of the PHCUOR.

A Monitoring and Evaluation (M&E) framework provides the strategy and guidelines to monitor and evaluate Primary Health Care programmes at all levels. The scope of the M&E framework include providing guidelines for building partnership, advocacy and communications for promoting the culture for M&E and the use of its products for decision-making and improving the quality of planning cycle processes in Primary Health Care. It is important to develop an M&E framework before developing annual work plans, as this serves as a guide to expected outcomes.

4.2 Purpose of the M & E framework

The main purpose of M&E framework is to provide guidance for carrying out M&E activities for PHC across all levels aimed at providing accurate, reliable and timely information on progress made in the implementation of Primary Health Care.

Objectives
The broad objective of the M&E framework is to guide the conduct of PHC M&E processes while ensuring best practices. The specific objectives are to provide guidelines for the development of processes which are robust enough to:

- Provide data with appropriate disaggregation to meet the reporting requirements of the strategic plan, programs in the health sector, development partners and other stakeholders.
- Identify sub-groups that are consistently missing out services to promote equitable access.
- Provide guidelines for the conduct of evaluations and independent assessments of health programs.
- Have clearly defined roles and responsibilities for M&E data collection, analysis and use to ensure accountability.
- Provide performance data for innovative financing instruments such as the Results-Based Financing, Conditional Cash Transfers and Contracting which require more precision in measuring results.
- Identify appropriate tools and methods covering both supply and demand side issues for providing accurate data.
- Disseminate M&E results with widely used approaches such as report cards to enable better-informed programme decisions.

4.3 Challenges

Some of the challenges encountered in monitoring and evaluation include: poor funding, poor data quality, inadequate manpower and inadequate utilization of available data for local decision making.

4.4 Key Requirements

- M&E Technical Working Group
- M &E unit in the Department of Planning, Research and Statistics
- M &E framework
  - Indicators
  - Data source
  - Numerators and denominators
  - Frequency of collection
  - Milestones and targets
  - Accountability (connects results to departments)
- Data collection tools and processes
- Platform for joint performance review
- Data quality assurance system
- Dissemination and feedback mechanism

4.5 Implementation Steps

- **Step 1: Constitute M&E TWG**

Constitute a multi-sectoral M&E TWG chaired by the Director PRS with the M&E unit of the Department of Planning, Research & Statistics as the Secretariat.
(Use ToRs of existing TWGs in NPHCDA as a guide).

- **Step 2: Capacity-Building**

Build capacity of the M&E team for framework development, data collection and analysis.

- **Step 3: Develop an M&E framework**

TWG should develop the M&E framework. The framework should align with the M&E framework of the State and National Health Strategic Plan. Key indicators included in the framework should be guided by the key requirements and indicators for success agreed for each pillar and the scorecard; service delivery indicators should also be included in the framework. It is important to note that the list of indicators outlined under each pillar is not exhaustive; others can be added as deemed appropriate. All the indicators should have realistic milestones and targets and relevant departments/unit responsible for each indicator for accountability. The M&E framework should also clearly define the indicators (i.e. numerator and denominator) as well as the data source and frequency of collection for each indicator to avoid ambiguity in data collection and calculations. As much as possible, the framework should key-in into existing data sources such as NHMIS001 and other datasets on the DHIS2 and other routine information systems.

- **Step 4: Develop appropriate tools for data collection**

Relevant tools should be developed for use in collecting the data to compute the indicators. The tools should be simple and easy to administer and should not duplicate existing tools. The use of computer assisted data collection tools should be explored were feasible.

- **Step 5:Set up system for data demand and use**

Have an open platform where stakeholders can easily access data; web-based platforms like DHIS2, iHRIS that promote easy access data should be encouraged.

- **Step 6:Joint Performance Review**

Performance reviews should be carried out at all levels. The SPHCB and LGHA should agree on the frequency for these review meetings. The SPHCB should invite representatives from the LGHA and the LGHA should invite representatives from the ward level to their review meetings. Performance review meetings should have wide stakeholder representation.

4.6 Key Success Factors

- M&E framework should be developed before annual work plans.
- Capacity building of M&E team.
- Internal and external coordination is important to avoid parallel data collection systems.
- Multi-stakeholder platform for joint performance review

4.7 Key Indicators for Success

- M&E framework developed.
- Capacity of M&E team built.
- Performance review meetings held.
- Data used for decision making.

4.8 Conclusion

Monitoring and evaluation is very important because it is the means of assessing the system, identifying challenges and gathering evidence that will support advocacy efforts and inform planning and decision making. States should ensure that their M&E systems are in place from the outset and capacity of the team built to ensure the quality of their output. Beyond carrying out monitoring and evaluation, it is vital that the data generated from this process is utilized in planning.

Annex 1: Supportive Steps at Federal Level

The entire PHC governance reform process will require high level advocacy to State Governors, including clear messages on the need for and benefits of “Bringing PHC under One Roof”. In addition, there needs to be, throughout the process, an extensive communication and advocacy campaign to not only keep all stakeholders informed but to ensure they actively participate in the evolving change process and jointly address issues/challenges on the path to progress and improvement.

It is envisaged that NPHCDA will play the key role in bringing “PHC under One Roof” but it is important that, as with all other levels, that the roles and responsibilities of the different bodies at federal level are clearly defined.

Step 1: Define the framework for bringing “PHC under One Roof”. In the absence of legislation (and noting the National Health Act does not prescribe to state and LGA levels), it is critical that the NPHCDA produce policies, guidelines and protocols for the states to use. The policy documentation and these Implementation Guidelines should assist states with developing legislation, regulations and implementation plans for “Bringing PHC under One Roof”. The NPHCDA should take a lead in these activities.

Step 2: Harmonize the activities of the different role players at federal level. As with the state level, it is critical for the roles and functions of the different bodies that support PHC at federal level to be clarified and harmonized. This includes the support offered by the FMoH, the NPHCDA, and the National Health Insurance Scheme (NHIS). All these bodies are fundamental in strengthening PHC service delivery, but they need to work synergistically. In essence, these bodies need to meet on a regular basis to track progress in “Bringing PHC under One Roof”.

Step 3: Secure sufficient resources for strengthening PHC. Resources are potentially available in the National Health Act, the NHIS and through other bilateral and multilateral partnerships. It is imperative that the NPHCDA develop annually a clear plan and budget to harness and use these resources. Where necessary, guidelines need to be developed for accessing, utilizing and retiring these funds. The resources will be utilized to realize state developed service/facility plans based on the MSP. In addition, the key role of strengthening the capacity of mid-level PHC managers has been realized by both the FMoH and the NPHCDA. Thus, adequate resources need to be made available for this key activity.

Step 4: Strengthen advocacy initiatives around “Bringing PHC under One Roof”. For the initiative to move forward and the PHC system to be unified and decentralized, many stakeholders need to be informed and involved in the discussion and development of reforms, so they can come to realize the advantages, the challenges and the pitfalls and provide support for the initiative. This includes politicians from federal to LGA levels, health workers and health managers at all levels, health professions organizations, traditional and religious leaders and the community at large. In addition, the process requires strong, skilled, experienced and influential leadership at the highest levels, as well as considerable advocacy, communication and coalition building at the local community levels to achieve the critical mass of change agents required for this transformation

Thus, a carefully-planned advocacy campaign needs to be developed and implemented.

Step 5: Strengthening the capacity of the NPHCDA to lead the process. The capacity of the NPHCDA at federal and zonal levels needs to be strengthened for the NPHCDA to provide leadership and technical know-how in the restructuring process, including but hardly limited to transformation and repositioning. It is strongly recommended that the NPHCDA planning processes needs to ensure that capacity is built within the NPHCDA and the structures at state and LGA levels responsible for the restructuring and transformation.

Step 6: Design and implement an M&E strategy. To track progress, measure success and identify challenges, a simple M&E system needs to be designed as a matter of urgency. All three levels need to be responsible for collecting and analyzing the identified indicators and then utilizing the information generated to alter the Strategic and Annual Operational Health Plans.

Step 7: Hold regular dissemination workshops and meetings. It is proposed that the NPHCDA host annual national workshops to review progress on “Bringing PHC under One Roof”. In addition, the NPHCDA needs to facilitate zonal level workshops to ensure that the key messages are conveyed and understood.

Annex 2: References

PHCUOR Management Guidelines 2016
PHCUOR Implementation Guide 2013
Minimum Standards for Primary Health Care in Nigeria
National Health Act 2014
Developing a State Minimum Service Package- A manual produced by PRRINN-MNCH programmes