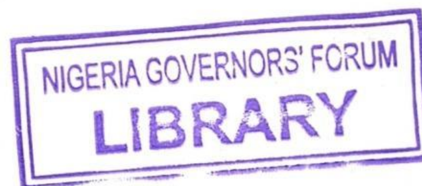
FEDERAL GOVERNMENT OF NIGERIA

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY
(NPHCDA)

IMPLEMENTATION STATUS OF PRIMARY HEALTH CARE UNDER ONE ROOF (PHCUOR): SCORECARD 4

MAY/JUNE 2018

Supported by:



FEDERAL GOVERNMENT OF NIGERIA

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY (NPHCDA)

IMPLEMENTATION STATUS OF PRIMARY HEALTH CARE UNDER ONE ROOF (PHCUOR)

SCORECARD 4

MAY/JUNE 2018

Table of Contents

FOREWORD i

ACKNOWLEDGEMENT iv

ABBREVIATIONS v

EXECUTIVE SUMMARY 6

BACKGROUND 9

METHODOLOGY 11

LIMITATIONS 14

LESSONS AND RECOMMENDATIONS 14

RESULTS 15

CHARTS SHOWING THE OVERALL RESULTS BY STATE 15

TABLE SHOWING OVERALL RESULT BY STATES, GEOPOLITICAL ZONES 16

SUMMARY OF FINDINGS 17

REQUIRED ACTIONS BY STATE 17

BREAKDOWN OF RESULTS BY STATES 19

SOUTH EAST ZONE 20

ABIA STATE (Overall Score 58%) *21*

ANAMBRA STATE (Overall Score 38%) *25*

EBONYI STATE (Overall Score 58%) *29*

ENUGU STATE (Overall Score 45%) *33*

IMO STATE (Overall Score 50%) *37*

SOUTH SOUTH ZONE 41

AKWA-IBOM STATE (Not Applicable) *42*

BAYELSA STATE (Overall Score 47%) *43*

CROSS RIVER STATE (Overall Score 39%) *47*

DELTA STATE (Overall Score 64%) *51*

EDO STATE (Overall Score 18%) *55*

RIVERS STATE (Overall Score 66%) *60*

SOUTH WEST ZONE 64

EKITI STATE (Overall Score 42%) *65*

LAGOS STATE (Overall Score 45%) *69*

OGUN STATE (Overall Score 59%) *73*

ONDO STATE (Overall Score 42%) 77
OSUN STATE (Overall Score 42%) 81
OYO STATE (Overall Score 59%) 85
NORTH WEST ZONE 89
JIGAWA STATE (Overall Score 57%) 90
KADUNA STATE (Overall Score 66%) 94
KANO STATE (Overall Score 57%) 98
KATSINA STATE (Overall Score 62%) 102
KEBBI STATE (Overall Score 54%) 106
SOKOTO STATE (Overall Score 56%) 111
ZAMFARA STATE (Overall Score 43%) 115
NORTH EAST ZONE 119
ADAMAWA STATE (Overall Score 65%) 120
BAUCHI STATE (Overall Score 70%) 124
BORNO STATE (Overall Score 35%) 128
GOMBE STATE (Overall Score 76%) 132
TARABA STATE (Overall Score 58%) 136
YOBE STATE (Overall Score 69%) 140
NORTH CENTRAL ZONE 144
BENUE STATE (Overall Score 54%) 145
FCT ABUJA (Overall Score 33%) 150
KOGI STATE (Overall Score 25%) 154
KWARA STATE (Overall Score 48%) 159
NASARAWA STATE (Overall Score 70%) 164
NIGER STATE (Overall Score 73%) 168
PLATEAU STATE (Overall Score 52%) 170
CONCLUSION AND RECOMMENDATIONS 177
ANNEX 1: SCORECARD 4 ASSESSMENT TOOL 178
ANNEX 2: ASSESSMENT PROTOCOL 183
ANNEX 3: LISTS OF ASSESSORS 185
ANNEX 4: EDITORIAL TEAM FOR PHCUOR SCORECARD 4 REPORT 187
REFERENCES 188

Foreword

This is the report of the Implementation Status of Primary Health Care Under One Roof (PHCUOR): Scorecard 4 assessment exercise conducted by NPHCDA and partners to assess the functionality of the thirty-six (36) States and the FCT Primary Health Care Boards. The Scorecard 4 tool assessed the progress recorded on the implementation of each of the nine (9) pillars of the "Primary Health Care Under One Roof" policy. This report ranks the performance of the State Primary Health Care Boards and identifies gaps in the implementation of the reform agenda for primary health care development in Nigeria.

The purpose of the PHCUOR Scorecard 4 was to assess the adherence of states to the national guidelines on establishment of governance structures at State and LGA levels for implementing PHCUOR as well as identify areas in which States need further support. Also, the scorecard provides a basis for peer review on PHC reforms in Nigeria.

I strongly recommend that the 36 States and the FCT study the report and implement the recommendations contained which are in line with the national guidelines for PHCUOR implementation to accelerate efforts aimed at making the SPHCBs functional and deliver on their mandate, vision and mission in their respective States. On our part, the NPHCDA will continue to support the SPHCBs and LGHAs in the implementation of the PHCUOR policy and improvement in the quality and coverage of health service delivery.

Dr. Faisal Shuaib MD, MPH, Dr.PH
Executive Director/CEO NPHCDA
Abuja

Acknowledgement

NPHCDA is grateful to the Primary Health Care Top Management Team (PHC TMT) partners and members for the successful conduct of the Scorecard 4 Assessment exercise in May/June, 2018.

We acknowledge with thanks all the partners that supported our efforts during the process. Worthy of note is the Nigeria Governors' Forum (NGF) Secretariat which funded the entire process (start-to-finish). The Federal Ministry of Health, the Network for Health Equity and Development (NHED) and the Health Reform Foundation of Nigeria (HERFON) supported the field exercise immensely. Adaafrique Community Health Foundation (ACHF) supported the development of this report.

Our gratitude also goes to the Hon. Commissioners of Health and the Executive Secretaries of the thirty-six (36) States and the FCT and their State Primary Health Care Boards for the cooperation with all our field assessors/data collectors during the field exercise.

We equally thank all the members of the PHC TMT for their contributions to the success of the process. The successful conduct of the Scorecard 4 Assessment exercise was made possible under the guidance and leadership of the Executive Director/CEO of the National Primary Health Care Development Agency, Dr. Faisal Shuaib and his management team.

Thank you all.

Dr. Oladimeji Olayinka
Director Primary Health Care Systems Development
National Primary Health Care Development Agency

Abbreviations

AC	Area Council
ES	Executive Secretary
FCT	Federal Capital Territory
FMoH	Federal Ministry of Health
HMIS	Health Management Information System
HERFON	Health Reform Foundation of Nigeria
HRH	Human Resources for Health
HRIS	Human Resource Information System
IMR	Infant Mortality Rate
ISS	Integrated Supportive Supervision
LGA	Local Government Area
LGHA	Local Government Health Authorities
LGSC	Local Government Service Commission
MSP	Minimum Service Package
NGF	Nigeria Governors' Forum
NMR	Neonatal Mortality Rate
NPHCDA	National Primary Health Care Development Agency
ODK	Open Data Kit
PHC	Primary Health Care
PHC TMT	Primary Health Care Top Management Team
PHCUOR	Primary Health Care Under One Roof
SHC	Secondary Health Care
SMoLG	State Ministry of Local Government
SMoH	State Ministry of Health
SPHCB	State Primary Health Care Board
U5	Under Five
WDC	Ward Development Committee
WMHCP	Ward Minimum Health Care Package

Executive Summary

Primary Health Care Under One Roof (PHCUOR) is a reform agenda that addresses the fragmentation in the delivery of Primary Health Care at the State and LGA levels by integrating all PHC structures, programmes and funding under the State Primary Health Care Board (SPHCB) within the framework of a decentralized health system. The policy is based on the principle of "three ones" - one management, one plan and one monitoring and evaluation system.

The conceptual framework for implementing the PHCUOR policy consists of nine (9) pillars which are: Governance and Ownership, Legislation, Minimum Service Package, Repositioning, Systems Development, Operational Guidelines, Human Resources, Funding Sources & Structure and Office Set-up. Each pillar has specific operational requirements for ensuring a functional SPHCB. The thirty-six (36) SPHCBs are at different levels of functionality with different levels of progress in the implementation of each of the nine (9) pillars.

The purpose of the PHCUOR scorecard is to systematically assist the States and FCT identify areas within the PHCUOR framework that they require support. The scorecard is also a peer review mechanism as well as an advocacy tool to all State governments and relevant stakeholders for the purpose of achieving a seamless implementation of the policy nationwide.

The 2018 PHCUOR Scorecard 4 Assessment tool was a modified and improved version of the previous scorecard tools: the large number of questions was substantially reduced to fewer but critical questions, which enhanced the sensitivity of detecting gaps in the implementation of PHCUOR. Each question had a score and each pillar was weighted to reflect its importance in the functionality of the SPHCBs. The final assessment tool was coded on to an android enabled platform - Survey CTO - to enhance data collection processes including tool administration, data uploading to a central server for analysis and data quality assurance.

Data collection was done by a team of three assessors led by an NPHCDA/FMoH officer in each State. The application of the assessment tool was done at the State Ministry of Health, State Primary Health Care Board, Local Government Area and

PHC facility levels. The results obtained from the data analysis were further validated by an external consultant to ensure a credible, unbiased result of the 2018 PHCUOR Scorecard 4.

The PHCUOR Scorecard 4 assessment revealed that as at June 2018, 35 States and the FCT have established their SPHCBs. It further revealed the gap between the best performing and the least performing states, zones and pillars in the country. The best performing states were Gombe (76%), Niger (70%), Bauchi and Nasarawa (70%) while the worst performing states were Akwa Ibom (0%), Edo State (18%), Kogi (25%). The best performing zone was North East (62%) while the worst performed zone was South South (39%). Among the nine (9) pillars, Office Setup was the best performing pillar (85%) while Repositioning, Minimum Service Package (MSP) and Legislation all scored below 50%. Under the Governance & Ownership pillar, many States that had constituted and inaugurated their governing boards but did not fully comply with the national guidelines for setting up governing boards. None of the states had a HR plan which is one of the requirements of the Human Resource pillar. While it is obvious that the PHCUOR Scorecard 4 recorded progress in the implementation of the PHCUOR reform nationwide, the exercise did not go without some limitations.

a. States that claimed to have some PHCUOR requirements but were unable to produce evidence of such requirements at the time of data collection were not credited for such claims. This was to ensure that all accepted claims are valid. This means that some states may have been scored lower than they performed because they could not provide documents to support their claims despite being provided with the list of required documents a week before assessment.
b. The Scorecard 4 assessment focused on the process of implementing the PHCUOR policy at the State and LGA level and not on PHC service delivery at the facility and household levels. Therefore, high performance on the scorecard cannot be interpreted to mean high performance on health outcome.
c. A lot of improvement has been made to enhance the validity, data collection and analysis of the PHCUOR Scorecard 4 tool. However, there is still room for improvement on these factors in future PHCUOR Scorecards.

Despite the limitations, the PHCUOR Scorecard 4 serves as a useful tool to track the progress of SPHCBs, identify bottlenecks, gaps and offer solutions for implementing

PHCUOR. It also serves as an advocacy tool to political leaders to increase the support for implementing PHCUOR policy in the States. Furthermore, the Scorecard 4 will assist the NPHCDA to identify priority areas to support the States in strengthening PHCUOR implementation. It is hoped that Scorecard 5 will record substantial progress on the implementation of PHCUOR reform in all the 36 States and the FCT.

Background

Primary Health Care Under One Roof (PHCUOR) is a Primary Health Care (PHC) reform agenda driven by the Federal Government of Nigeria (FGN). This reform seeks to reverse the fragmentation of the PHC delivery at sub-national levels (States and LGAs) by centralizing PHC management, human resources, financing and operational responsibilities under one State-level body – the State Primary Health Care Board (SPHCB).

The goal of the PHCUOR reform is to address the fragmentation in the management of PHC delivery, which stems from the multiplicity of PHC stakeholders with undefined roles and responsibilities. This has led to service gaps, duplication and weak accountability. The result is poor quality and inadequate provision of health services, low service utilization and demand as well as erosion of community confidence.

In 2011, the 56th National Council on Health (NCH) adopted Primary Health Care Under One Roof as a national policy for implementation by the States and FCT. Further to the adoption, the 58th NCH in 2013 adopted the PHCUOR Implementation Guidelines. The guidelines call for specific structural changes around nine pillars:

Governance and Ownership, Legislation, Minimum Service Package (MSP), Repositioning, Systems Development, Operational Guidelines, Human Resources, Funding Sources and Structure and Office Setup. Based on these nine pillars, a scorecard was developed to track State governments' progress on the implementation of the PHCUOR reforms along the pillars.

The goal of the scorecard is to serve as an advocacy tool to help stakeholders, health policy advisors, legislators, governing bodies and managers drive the changes needed to strengthen PHC systems in their States.

The PHCUOR Scorecard 4 is the fourth in the series of scorecard assessment which commenced with Scorecard 1 conducted by HERFON in 2012, Scorecard 2 conducted by NPHCDA, IVAC, HERFON and Partners in 2013, Scorecard 3

conducted by NPHCDA, UNICEF, IVAC, HERFON, NHED and Partners in 2015 and the Scorecard 4 conducted by NPHCDA, NGF and Partners in 2018.

The objectives of PHCUOR Scorecard 4 were:

a. to assess the current implementation status of PHCUOR in the 36 States and the FCT,
b. to monitor the progress of implementation overtime,
c. to identify specific areas within the PHCUOR framework in which States need further support,
d. to promote peer review and learning mechanism among the States and
e. to generate evidence for use in advocacy to governmental and non-governmental stakeholders on PHC reform in Nigeria.

Methodology

A 10 - step process was adopted for the PHCUOR Scorecard 4 Assessment

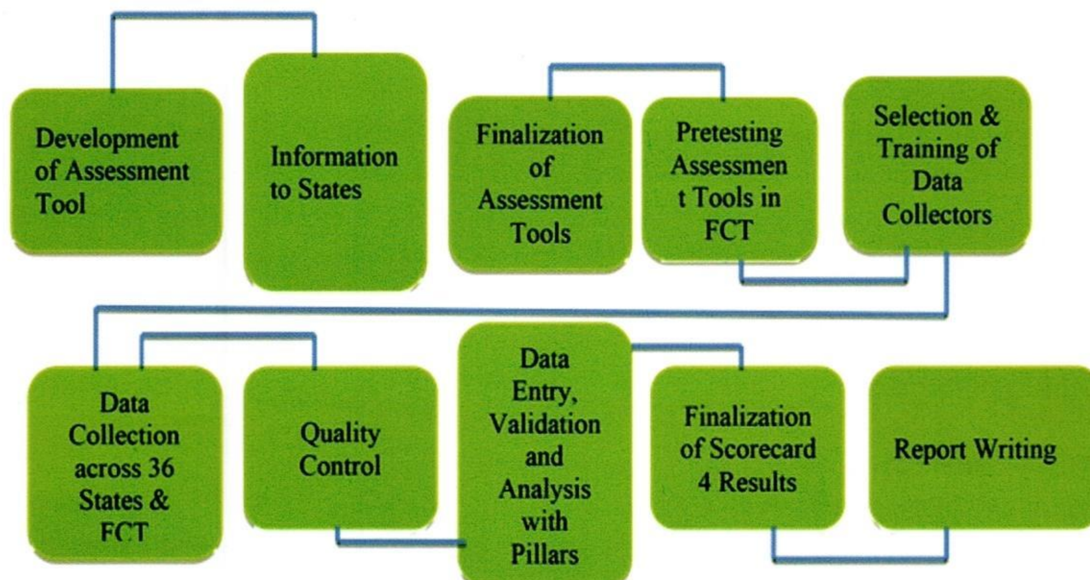


Figure 1: Scorecard 4 Methodology

I. Development of Assessment tool

Preparations for the Scorecard 4 assessment commenced with the revision of previous tool to ensure collection of relevant data. Specifically, one of the PHC TMT Partners, the NGF, was mandated to review the Scorecard 3 tool with a view to reduce the unwieldy number of questions to only critical questions that address the objectives of the Scorecard 4 assessment. To enhance the sensitivity of the tool, each question was allotted a score while each of the nine pillars was weighted according to its relevance. The final tool was presented to the PHC TMT which included partners for additional inputs and adoption for assessment.

II. Information to States

Information on assessment dates for each State, names of the assessors in each team and the proposed method of assessment was disseminated to the States along with a list of materials to be prepared for collection by the assessors.

III. Finalization of the Assessment Tool

Following the adoption of the Scorecard 4 tool, the tool was coded onto Survey CTO

to facilitate data collection by the assessors. The software enabled data collection and uploading to a central server electronically. In addition, there were in-built mechanisms to track dates, geo-coordinates and time of assessment at different levels in every state. This was done to enhance the validity of the assessment. The Scorecard 4 assessment tool was the first electronic assessment tool for PHCUOR.

IV. Pretesting Assessment Tool in FCT

To ascertain the reliability and validity of the Scorecard 4 tool, a pretest exercise was carried out in the FCT using the android phones by a team of PHC TMT members led by the NPHCDA. Some of the questions were observed to be insensitive or improperly framed. The tool was further revised by the team in line with lessons learnt/feedback from the pretest exercise.

V. Selection and Training of Data Collectors

The data collectors/assessors in each State consisted of three members: NPHCDA/FMoH team-leads supported by NPHCDA State Coordinators and a Partner representative. The NPHCDA State Coordinators were re-deployed to States other than their States of primary assignment but within their geopolitical zones to avoid bias and each team had a representative from one of the PHC TMT Partners including NGF Secretariat, HERFON, NHED and IHP+. One-day training was conducted for all team leaders (37 teams) at NPHCDA headquarters in Abuja on the new data collection approach as well as the expected deliverables.

VI. Data Collection across 36 States & FCT

Data collection/assessmen.t was carried out in all States in two phases (first in the southern States and then in the northern States) between 21st – 25th May, 2018 and 28th May – 1st June, 2018 respectively. Prior to the deployment of data collectors (assessors), States were notified in writing about the procedures. A copy of the PHCUOR Scorecard 4 tool was also dispatched to each State ahead of the assessment visits. Three data collectors/assessors were assigned to each State with clear instruction to collect evidence for positive responses and visit at least one LGA outside the State capital.

VII. Quality Control

Data was collected using android phones and uploaded to a central server where a data analysis tool had been installed for coordinated quality control, analysis of uploaded data and generation of the first (actual) result. Data was cleaned and unclear responses double-checked with the concerned State for clarity and correction.

VIII. Data Entry, Validation and Analysis with weighing of the PHCUOR Pillars

Subsequently, a consultant was engaged to manually carry out data entry, validate the evidence and analyse which yielded a result different from the actual result and was adapted as the validated result of the 2018 PHCUOR Scorecard 4. As a rule, any positive answer to the scorecard tool which was not backed by documented evidence was changed to a negative response. It was also agreed that only evidence available as of the time of data collection and analysis would be accepted. Any progress made by any State outside the period under review was excluded from the validation process.

IX. Finalization of Scorecard 4 Results

The validated results for all 36 States and the FCT were presented by the consultant to the PHC TMT. This allowed for clarification of grey areas and misunderstandings encountered in the analytical process to the satisfaction of all PHC TMT members and partners. The validated results were unanimously accepted as the final and official results of the PHCUOR Scorecard 4 assessment.

X. Report Writing

The report of PHCUOR Scorecard 4 Assessment was prepared by the NPHCDA and ACHF and printed with support from the Nigeria Governors' Forum Secretariat.

Limitations

While it is obvious that the PHCUOR Scorecard 4 recorded progress in the implementation of the PHCUOR reform nationwide, the exercise did not go without some limitations.

a. States claimed to have some PHCUOR requirements but were unable produce evidence of such requirements at the time of data collection were not credited for such claims. This was to ensure that all accepted claims are valid. This means that some states may have been scored lower than they performed because they could not provide documents to support their claims despite being provided with the list of required documents a week before assessment.

b. The Scorecard 4 assessment focused on the process of implementing the PHCUOR policy at the State and LGA level and not on PHC services delivery at the facility and household levels. Therefore, high performance on the scorecard cannot be interpreted to mean high performance on health care delivery or outcome.

c. A lot of improvement has been made to enhance the sensitivity, specificity, data collection and analysis of the PHCUOR Scorecard 4 tool. However, there is still room for improvement on these factors in future PHCUOR Scorecards.

Lessons and Recommendations

- Validity of the Scorecard tool - Although the validity of the scorecard 4 tool overall is better than the previous tools especially in terms of correlation with the actual functionality of the boards, the inclusion of health outcomes under the MSP pillars resulted in some confusion in the scores for that pillar. For instance, states that have not implemented any of the MSP components but have improving health outcomes score high marks for the pillar even though no action has been taken under the MSP pillar. This needs to be corrected in future assessment to remove the health outputs component and to introduce a better measurement of health performance.

- Correlation with Health Outcomes: Even though some institutional (facility-based) health outcomes were included under the MSP pillar, the overall score measures more of PHC governance and less of health outcomes. The

correlation between health governance and health outcome is a not linear because of the complexity of factors relating to health outcomes. Future scorecards therefore need to be reviewed to ensure that the focus on measurement of health sector i.e. how it is organized and managed. The introduction of the global PHC Performance Initiative Vital Sign Profile is recommended to compliment PHCUOR score card as they can both be used to reinforce the strengthening of the PHC system, the first focusing on overall governance while the latter focuses on the greater details of health system.

Results

Charts Showing the Overall Results by State

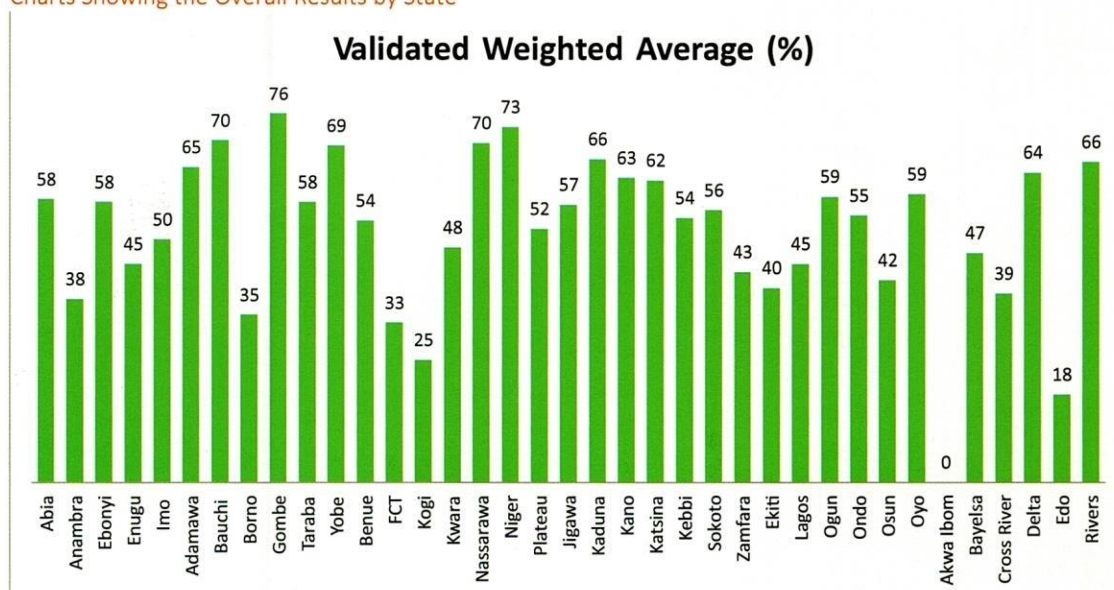


Table Showing Overall Result by States, Geopolitical Zones

Table 1: Validated Weighted Averages for States, Zones and National

Zones	State	Validated Weighted Average	Zonal Average	National Average
South East	Abia	58%	50%	52%
	Anambra	38%		
	Ebonyi	58%		
	Enugu	45%		
	Imo	50%		
North East	Adamawa	65%	62%	
	Bauchi	70%		
	Borno	35%		
	Gombe	76%		
	Taraba	58%		
	Yobe	69%		
North Central	Benue	54%	51%	
	FCT	33%		
	Kogi	25%		
	Kwara	48%		
	Nasarawa	70%		
	Niger	73%		
	Plateau	52%		
North West	Jigawa	57%	57%	
	Kaduna	66%		
	Kano	63%		
	Katsina	62%		
	Kebbi	54%		
	Sokoto	56%		
	Zamfara	43%		
South West	Ekiti	40%	50%	
	Lagos	45%		
	Ogun	59%		
	Ondo	55%		
	Osun	42%		
	Oyo	59%		
South South	Akwa Ibom	0%	39%	
	Bayelsa	47%		
	Cross River	39%		
	Delta	64%		
	Edo	18%		
	Rivers	66%		

Summary of Findings

- There was no submission by Akwa Ibom State during the assessment exercise
- Gombe State had the highest score (76%) while Edo State had the lowest (18%)
- 62% (23 States) scored 50% while 38% (14 States) scored <50%
- The poor performing pillars were Repositioning, Minimum Service Package and Legislation
- Adequate Legislation is critical for improved performance by the SPHCBs
- The States require technical support with adequate follow-up to ensure improvement especially in the poor performing pillars

Required Actions by State

Governance and Ownership

- Constitute/reconstitute SPHCB governing boards in line with national guidelines.
- Ensure full complement of management team (substantive Executive Secretary and Directors)
- Resuscitate WDCs and make them functional

Legislation

- Review and amend SPHCB Law to include provisions for the transfer of staff, programmes, funds and PHC facilities to the SPHCB
- Develop Regulations for the operationalization of the SPHCB Law

Minimum Service Package (MSP)

- Develop a costed and approved MSP document including investment/service delivery plan for PHC facilities in the State

Repositioning

- Move PHC departments, staff and programmes to the SPHCB
- Transform LGA PHC departments into Local Government Health Authority (LGHAs) with established lines of reporting to the SPHCB

Systems Development

- Develop PHC annual operational plan incorporating LGA PHC annual operational plans

- Develop M&E/results/performance framework with clear milestones and targets for the SPHCB
- Conduct performance review of the SPHCB

Human Resources

- Develop a functional HRIS to guide HR plan for recruitment, forecasting, redistribution, production, capacity building, performance management etc

Funding Sources and Structure

- Advocate for a dedicated budget line for PHC in the annual State budget.
- Support LGHAs when established to open dedicated bank accounts.
- Ensure regular funding for PHC facilities to cover operational expenses and provide integrated service delivery.

Operational Guidelines

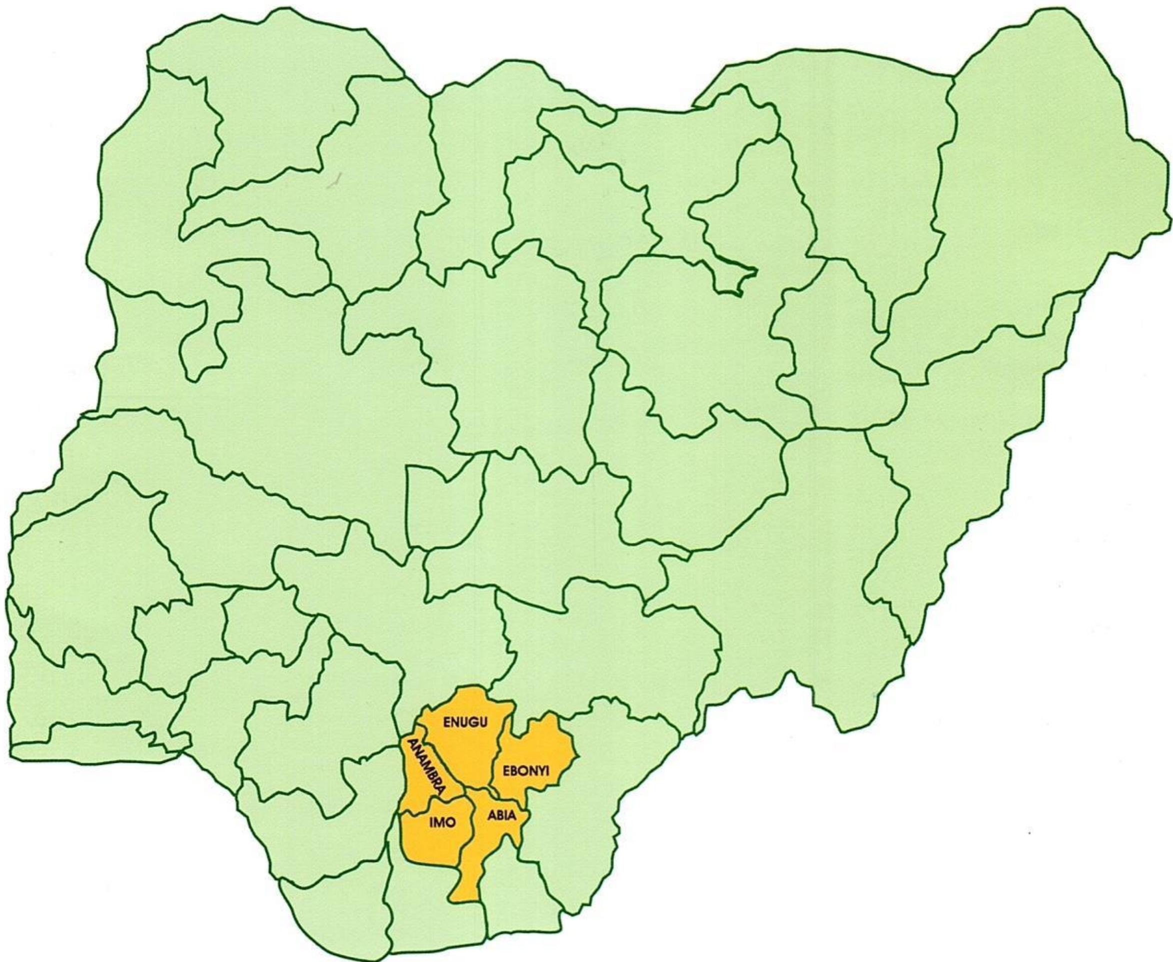
- Develop SPHCB Operational Guidelines and distribute to all SPHCB and LGHA staff.
- Conduct orientation to familiarize all staff with the mandate, vision and mission of the SPHCB.

Office Setup

- Provide designated office space that is adequate for the operations of the SPHCB and the LGHAs

Breakdown of Results by States

SOUTH EAST ZONE



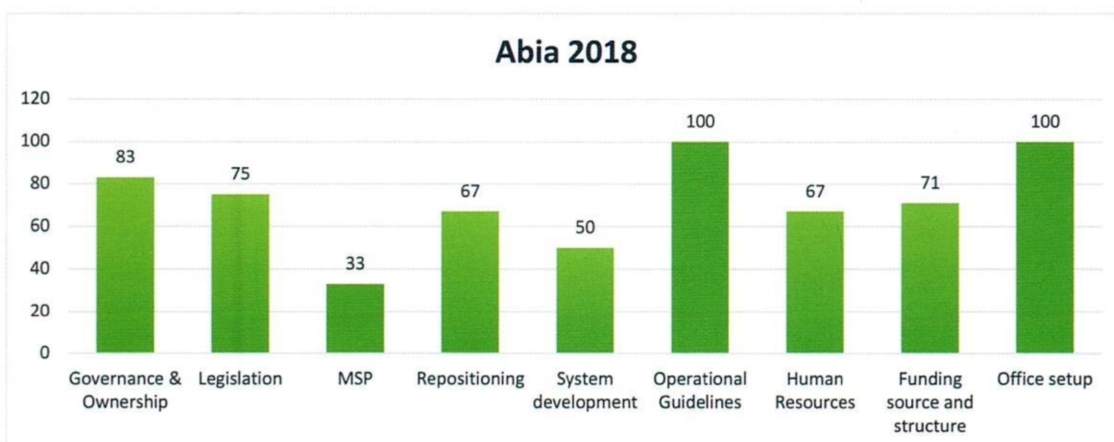
ABIA STATE (Overall Score 58%)

Background

Abia State was created in 1991 from Imo state and its capital is Umuahia. It has a land mass of 5,243 sq. km with 2016 projected population of 3,727,300 (NPC 2006). It has 17 Local Government Areas (LGAs). There are 615 health facilities in the State: 518 (84%) are PHC facilities and 96 (16%) are SHC facilities. 481 (93%) of the PHC facilities are public health facilities and 37 (7%) are private health facilities. Some of the State health indices are IMR 55, U5MR 83, NMR 32 and U5 Stunting 21 (MICS 2016).

Main Findings

Abia State scored 58% in the PHCUOR Scorecard 4 assessment placing it in the 11th position nationwide. Its best performing pillars include Operational Guidelines and Office Setup at 100% each and poor performing pillar is MSP 33%.



Governance & Ownership: 83%

- Abia SPHCB has a governing board and a management team.
- WDCs are available but not functional.

Legislation: 75%

- Abia SPHCB has a Law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 33%

- No costed and approved MSP document as well as investment plan available.
- Very poor outcomes recorded in the measured health indices.

Repositioning: 67%

- PHC department, programmes including FP/MCH/Nutrition in the SMoH have moved to the SPHCB. SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.

Systems Development: 50%

- SPHCB has strategic health development plan. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system and has conducted a State-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.
- No SPHCB and LGHA PHC annual operational plans.
- No M&E/results/performance framework with clear milestones and targets
- No ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.

Operational Guidelines: 100%

- The PHCUOR manual has been distributed to all staff at SPHCB and LGHAs and SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB. There is an administrative/office manual to standardize the administrative processes in the SPHCB.

Human Resources: 67%

- All PHC staff in the LGAs, MoLG, LGSC have been moved to the SPHCB and onboarded. There are job descriptions for all SPHCB staff and positions including those at the LGHAs.
- No HR plan or HRIS available.

Funding Sources and Structure: 71%

- The SPHCB and LGHAs have dedicated bank accounts. All PHC staff are on the SPHCB payroll. PHC budget performance is periodically tracked and annual audit of the PHC income and expenditure for the preceding year was conducted.
- No dedicated budget line for the SPHCB.
- No evidence that health facilities received operational funding in the last three months.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 50%:

- Reconstitute SPHCB governing board according to national guidelines

Legislation - 63%:

- Amend SPHCB law to reflect clear oversight function of the SMoH on the SPHCB
- Develop regulations for the operationalization of the law

MSP - 67%:

- Develop a costed and approved MSP document for all PHC facilities in the State
- Incorporate annual investment plan derived from approved MSP document into annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities Repositioning - 56%:
- Transfer Malaria, HIV/AIDS, TBL programmes to the SPHCB

Systems Development – 50%:

- Develop PHC annual operational plan incorporating the LGHA PHC annual operational plans
- Develop M&E/results/performance framework with clear milestones and targets for the SPHCB
- Develop ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule

Human Resources - 50%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to guide HRH strategic plan
- Develop staff nominal roll

Funding Sources and Structure - 71%:

- Establish PHC dedicated budget line
- Provide regular funding for health facilities to cover operational expenses and uninterrupted PHC service delivery

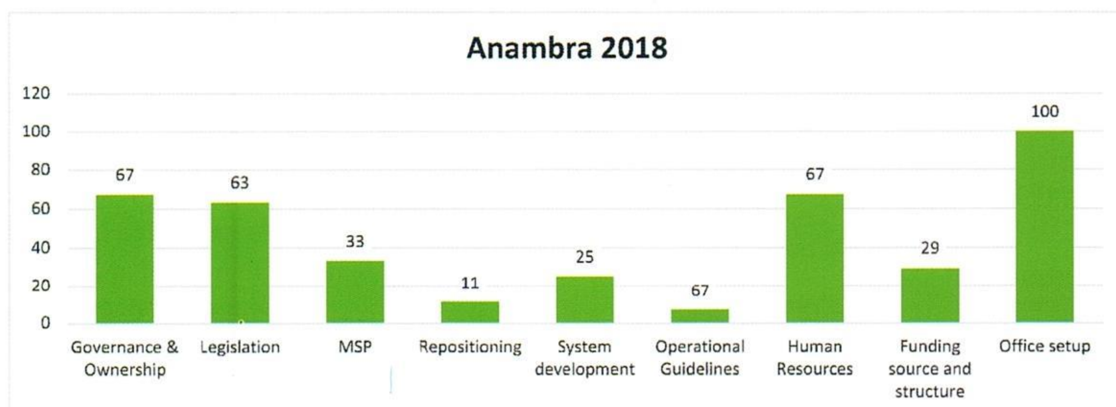
ANAMBRA STATE (Overall Score 38%)

Background

Anambra State was created in 1976 and its capital is Awka. It has a land mass of 4,844 sq. km with 2016 projected population of 5,527,800 (NPC 2006). It has 21 Local Government Areas (LGAs). There are 1,485 health facilities in the State: 1,360 (92%) are PHC facilities. 392 (29%) of the PHC facilities are public health facilities and 968 (71%) are private health facilities (NPHCDA 2015). Some of the State's health indices are IMR 39, U5MR 53, NMR 23 and U5 Stunting 14 (MICS 2016).

Main Findings

Anambra State scored 38% in the PHCUOR Scorecard 4 assessment placing it on the 25th position nationwide. Its best performing pillar is Office Setup 100% and poor performing pillars are Repositioning 11%, Systems Development 25%, Operational Guidelines 7% and Funding Sources and Structure 29%.



Governance & Ownership: 67%

- Anambra SPHCB has a governing board and a management team. WDCs are available but not functional.
- No LGHAs established in the State.

Legislation: 63%

- There is SPHCB Law in place.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 33%

- No costed and approved MSP document or investment/service delivery plan.
- Very poor outcomes recorded in the measured health indices.

Repositioning: 11%

- Only the Immunization programme has moved to the SPHCB.
- PHC department, staff and programmes such as Malaria, HIV/AIDS, TBL, FP/MCH/Nutrition are yet to be transferred from SMoH to the SPHCB.
- LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.

Systems Development: 25%

- The SPHCB has strategic health development plan, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.
- No SPHCB PHC annual operational plan and LGA PHC annual operational plans.
- No M&E /results/performance framework with clear milestones and targets.
- No performance review conducted on SPHCB in the last one year.
- No functional data quality assurance system and State-wide DQA not conducted in the last one year.
- HMIS facility reporting rate for the last 12 months is <80%.

Human Resources: 67%

- PHC staff in the LGAs, SMoLG and LGSC have not moved to the SPHCB. There are job descriptions for all SPHCB staff and positions. The SPHCB has staff nominal roll. Staff are yet to be on-boarded.
- No HR plan or HRIS available.

Funding Sources and Structure: 29% SPHCB has a dedicated bank account.

- SPHCB has no dedicated budget line.
- PHC staff are not on the SPHCB payroll.

Operational Guidelines: 67%

- The PHCUOR manual has been distributed to SPHCB staff.
- Administrative/office manual available.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.
- Required Actions
- Governance & Ownership - 67%:
- Reconstitute SPHCB governing board according to national guidelines
- Establish LGHAs in all LGAs of the State

Legislation - 63%:

- Amend SPHCB Law
  - To reflect clear oversight function of the SMoH on the SPHCB
  - To make provision for the movement of PHC department, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
- Develop regulations for the operationalization of the SPHCB Law

MSP - 33%:

- Develop a costed and approved MSP document for all PHC facilities in the State
- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 11%:

- Transfer Malaria, HIV/AIDS, TBL, FP/MCH/Nutrition programmes from SMoH to SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB
- The SMoH should restructure its departments in line with SPHCB reforms
- The SMoH should conduct orientation for staff on the new roles and responsibilities of the SMoH

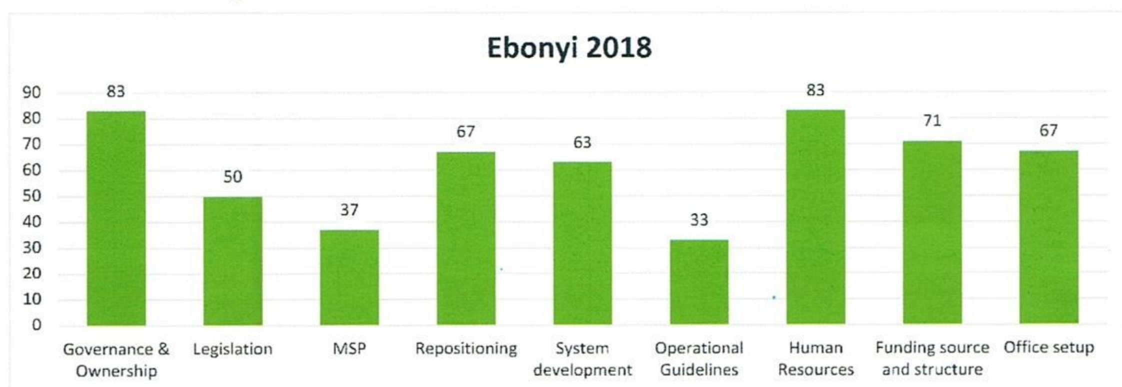
EBONYI STATE (Overall Score 58%)

Background

Ebonyi State was created in 1996 from parts of Enugu and Abia States and its capital is Abakaliki. It has a land mass of 5,935 sq. km with 2016 projected population of 2,880,400 (NPC 2006). It has 13 Local Government Areas (LGAs). There are 567 health facilities in the State: 516 (91%) are PHC facilities. 383 (74%) of the PHC facilities are public health facilities and 133 (26%) are private health facilities. Some of the State's health indices are IMR 47, U5MR 62, NMR 30 and U5 Stunting 25 (MICS 2016).

Main Findings

Ebonyi State scored 58% in the PHCUOR Scorecard 4 assessment placing it in the 11th position nationwide. Its best performing pillars are Governance and Ownership and Human Resources at 83% each and poor performing pillars are MSP 37% and Operational Guidelines 33%.



Governance & Ownership: 83%

- Ebonyi SPHCB has a governing board and a management team.

Legislation: 50%

- Ebonyi SPHCB has a Law establishing it.
- No regulations developed for the operationalization of SPHCB Law.

MSP: 37%

- Ebonyi SPHCB has a costed and approved MSP document.
- MSP document lacks investment/service delivery plan.
- Poor outcomes recorded in the measured health indices.

Repositioning: 67%

- PHC department, programmes (FP/MCH/Nutrition and Immunization) in the SMoH have moved to the SPHCB. The LGA PHC departments have transformed into LGHAs with definite reporting lines to the SPHCB. The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- Malaria, HIV/AIDS, TBL programmes are yet to be transferred to the SPHCB.

Systems Development: 63%

- SPHCB has strategic health development plan, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system, and has conducted a State-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.
- Ebonyi SPHCB has no State and LGHA PHC annual operational plans.
- No M&E /results/performance framework with clear milestones and targets developed.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have moved to the SPHCB and on-boarded. There are job descriptions for all SPHCB staff and positions. The SPHCB has staff nominal roll.
- No HR plan or HRIS availability for the strategic management of PHC HRH.

Funding Sources and Structure: 71%

- SPHCB has a dedicated budget line and bank account. SPHCB staff are on the SPHCB payroll.

Operational Guidelines: 33%

- There is administrative/office manual to standardize the administrative processes in the SPHCB.
- SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Office Setup: 67%

- The SPHCB has a physical office lacking requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 83%:

- Reconstitute SPHCB governing board according to national guidelines

Legislation - 50%:

- Amend SPHCB Law o To delineate roles and responsibilities of governing board from that of management team o To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
- Develop regulations for the operationalization of SPHCB Law

MSP - 37%:

- Develop investment/service delivery plan
- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 67%:

- Transfer Malaria, HIV/AIDS, TBL programmes to the SPHCB

Systems Development – 63%:

- Develop PHC annual operational plan incorporating LGA PHC annual operational plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

Human Resources - 83%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan

Funding Sources and Structure - 71%:

- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and uninterrupted PHC service delivery

Operational Guidelines - 33%:

- Distribute PHCUOR manual to all staff and LGHAs
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the agency

Office Setup – 67%

- Provide requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

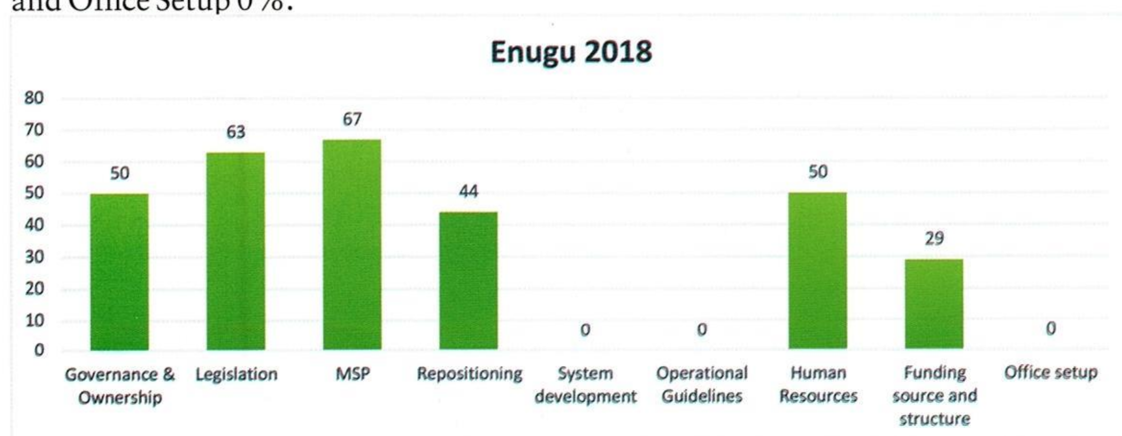
ENUGU STATE (Overall Score 45%)

Background

Its capital is Enugu. It has a land mass of 7,161 sq. km with 2016 projected population of 4,411,100 (NPopC 200Schneidler B6). It has 17 Local Government Areas (LGAs). There are 868 health facilities in the State: 524 (60%) are PHC facilities and 342 (39%) are SHC facilities. 322 (37%) of the PHC facilities are public health facilities and 549 (63%) are private health facilities. The State's under five Stunting rate is 9 (MICS 2016).

Main Findings

Enugu State scored 45% in the PHCUOR Scorecard 4 assessment placing it in the 20th position nationwide. Its best performing pillar is MSP 67% and poor performing pillars include Systems Development 0%, Operational Guidelines 0% and Office Setup 0%.



Governance & Ownership: 50%

- Enugu SPHCB has no governing board.
- LGA PHC departments have not transformed to LGHAs

Legislation: 63%

- SPHCB Law is in place.
- No regulations developed for the operationalization of SPHCB Law.

MSP: 67%

- Enugu SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.

Repositioning: 44%

- FP/MCH/Nutrition and immunization programmes and staff have moved from the SMoH to SPHCB.
- Malaria, HIV/AIDS, TBL programmes are yet to be transferred to the SPHCB.
- LGA PHC departments have not transformed into LGHAs with definite reporting lines to the SPHCB.

Systems Development: 0%

- The SPHCB does not have strategic health development plan, SPHCB & LGA annual operational plans, M&E
- /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has not been conducted on the SPHCB in the last one year. State has no functional data quality assurance system, and has not conducted a state-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is <80%.

Human Resources: 50%

- PHC staff in the LGAs, SMoLG and LGSC have not moved to SPHCB.
- There is no staff nominal roll.
- No HR plan for the strategic management of PHC HRH.

Funding Sources and Structure: 29%

- The SPHCB has a dedicated budget line and bank account.

- PHC staff are not on the SPHCB payroll.

Operational Guidelines: 0%
- SPHCB Operational Guidelines is not yet developed.

Office Setup: 0%
- The SPHCB has no physical office and no requisite amenities and equipment such as power, water, computers, furniture, internet access and printer

Required Actions

Governance & Ownership - 50%:
- Constitute and inaugurate SPHCB governing board according to national guidelines Establish LGHAs in all LGAs of the state

Legislation - 63%:
- Amend SPHCB Law
  - To reflect clear oversight function of the SMoH on the SPHCB
  - To make provision for the transfer of all PHC health facilities in the State to the SPHCB
- Develop regulations for the operationalization of SPHCB Law

MSP - 67%:
- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 44%:
- Transfer Malaria, HIV/AIDS and TBL programmes to SPHCB
- Transform LGA PHC departments into LGHAs with established reporting line to the SPHCB

Systems Development– 0%:
- Develop PHC strategic health development plan, PHC annual operational plan incorporating the LGA PHC annual operational plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

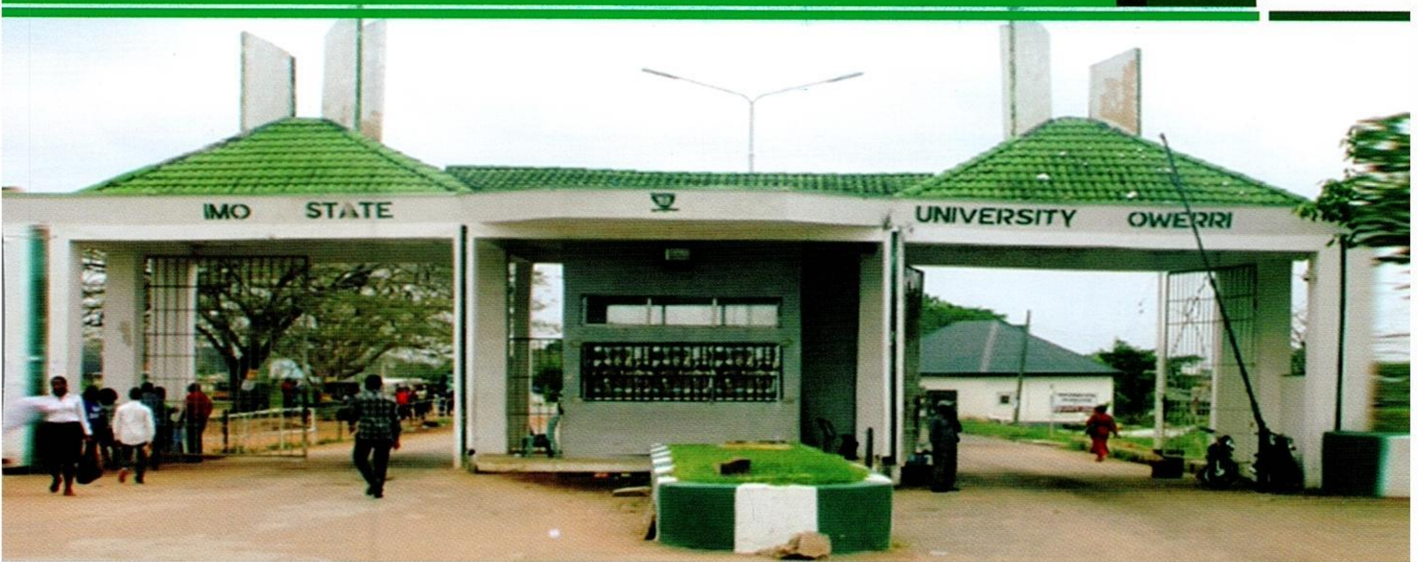
- Develop ISS checklist, list of ISS team (including state and LGA members), and supervisory schedule
- Conduct performance review of SPHCB
- Establish functional State data quality assurance system
- Conduct periodic State-wide DQA
- Improve HMIS monthly facility reporting rate to >80

Human Resources - 50%:
- Transfer all PHC staff in LGAs to the SPHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition   Develop functional HRIS to support HRH strategic plan
- Develop staff nominal roll
- Onboard all staff on the mandate, mission and vision of SPHCB.

Funding Sources and Structure - 29%:
- Establish PHC dedicated budget line
- Include all PHC staff on SPHCB payroll
- Support LGHAs when established to open dedicated bank accounts
- Conduct periodic tracking of PHC budget performance
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and uninterrupted PHC service delivery

Operational Guidelines - 0%:
- Develop Operational Guidelines for SPHCB
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB

Office Setup – 0%
- Secure physical office building for the SPHCB and provide requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.



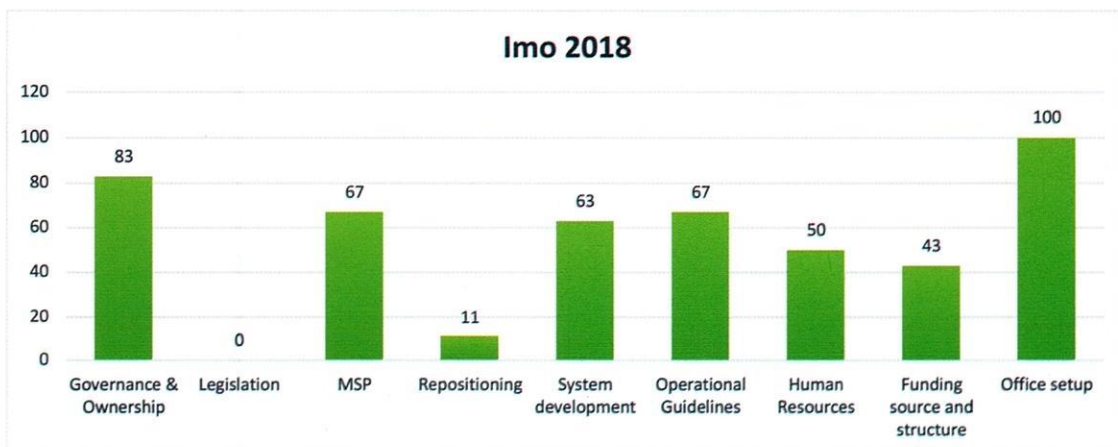
IMO STATE (Overall Score 50%)

Background

Imo State was created in 1976 and its capital is Owerri. It has a land mass of 5,530 sq. km with 2016 projected population of 5,408,800 (NPC 2006). It has 27 Local Government Areas (LGAs). There are 1,337 health facilities in the State: 805 (60%) are PHC facilities and 530 (40%) are SHC facilities. 416 (52%) of the PHC facilities are public health facilities and 389 (48%) are private health facilities (NPHCDA 2015). Some of the State's health indices are IMR 66, U5MR 96, NMR 35 and U5 Stunting 17 (MICS 2016).

Main Findings

Imo state scored 50% in the PHCUOR Scorecard 4 assessment placing it in the 17th position nationwide. Its best performing pillars are Governance & Ownership 83% and Office Setup 100% and poor performing pillars include Legislation 0% and Repositioning 11%.



Governance & Ownership: 83%

- Imo SPHCB has a governing board with roles and responsibilities clearly delineated from that of the management team.

Legislation: 0%

- The SPHCB Law was not sighted.

MSP: 67%

- Imo SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.

Repositioning: 11%

- The LGA PHC departments have transformed into LGHAs with definite reporting lines to the SPHCB.
- PHC programmess including malaria, HIV/AIDS, TBL, FP/MCH/Nutrition and Immunization have moved to the SPHCB. However, SMoH has not restructured its departments in line with the SPHCB reform and has not conducted orientation for the staff on the new roles and responsibilities of the SMoH.

Systems Development: 63%

- The SPHCB has M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system, and has conducted a state-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.
- Imo SPHCB does not have key strategic documents such as strategic health development plan, PHC & LGA annual operational plans.

Human Resources: 50%

- There is no staff nominal roll.
- No HR plan for the strategic management of PHC HRH.

Funding Sources and Structure: 43%

- SPHCB has a dedicated bank account but no dedicated budget line. PHC staff are not on the SPHCB payroll.

Operational Guidelines: 67%

- Operational guidelines have been developed for SPHCB but SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate, vision and mission of SPHCB.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 83%:

- Reconstitute SPHCB governing board according to national guidelines to include women and other stakeholders

Legislation - 0%:

- Develop, pass, assent and gazette Law for establishing and empowering the SPHCB o Law should: o Delineate roles and responsibilities of governing board from that of management team o Reflect clear oversight function of the SMoH on the SPHCB
- Make provision for the transfer of all PHC health facilities in the State to the SPHCB
- Make provision for the movement of PHC departments, staff and programmes in the SMoH, SMoLG and all LGAs to the SPHCB
- Indicate different sources of PHC funding and expected contributions from the State and LGAs. o Develop regulations for the operationalization of the Law

MSP - 67%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 11%:

- Transfer all PHC staff and programmes including malaria, HIV/AIDS, TBL, FP/MCH/Nutrition and Immunization programmes in the SMoH to the SPHCB
- SMoH should restructure its departments in line with SPHCB reforms
- SMoH should conduct orientation for staff on the new roles and responsibilities of the SMoH

Systems Development- 63%:

- Develop strategic health development plan, PHC annual operational plan incorporating LGA PHC annual operational plans

Human Resources - 50%:

- Transfer all PHC staff in SMoH, SMoLG and LGSC to the SPHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition o Develop functional HRIS to support HRH strategic plan
- Develop staff nominal roll
- Onboard all staff on the mandate, mission and vision of the SPHCB.

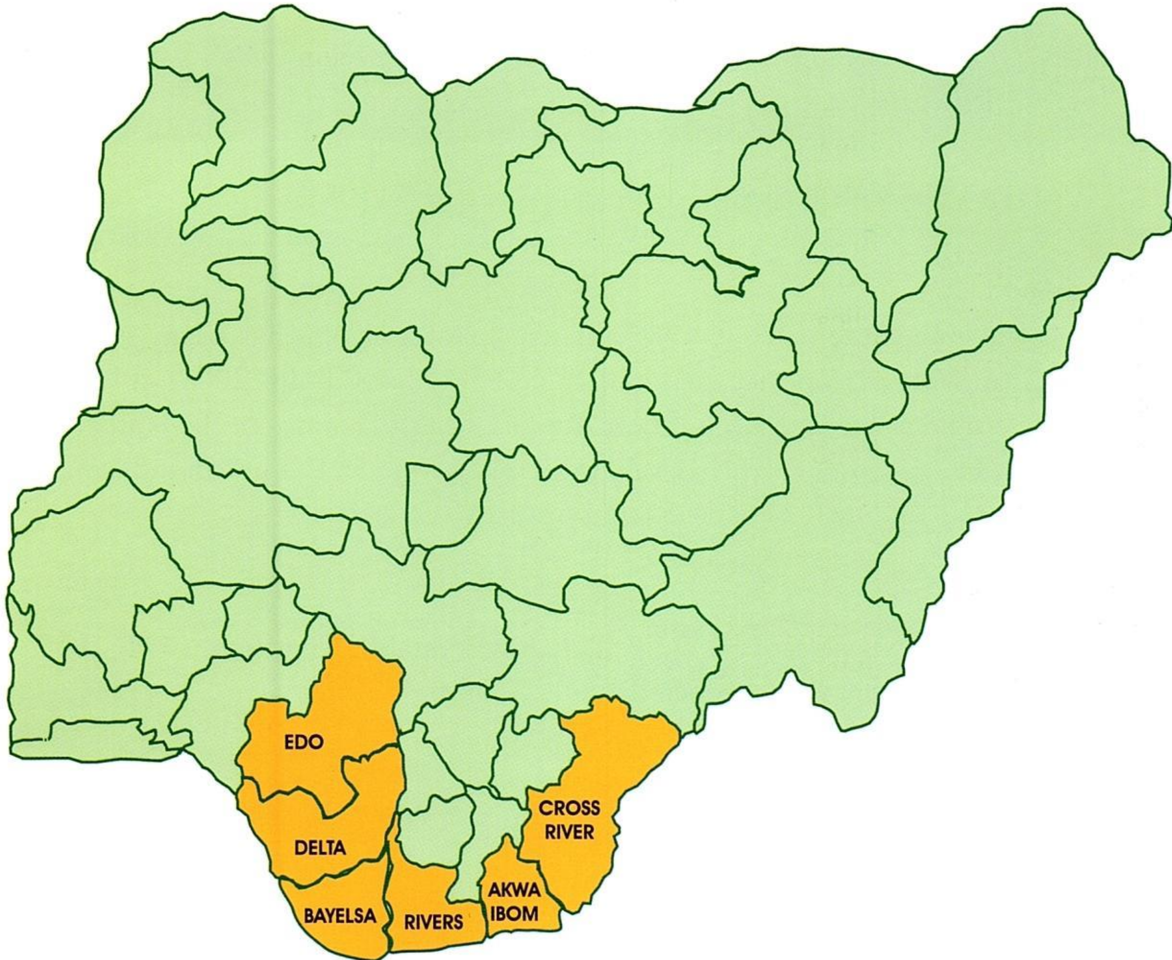
Funding Sources and Structures - 43%:

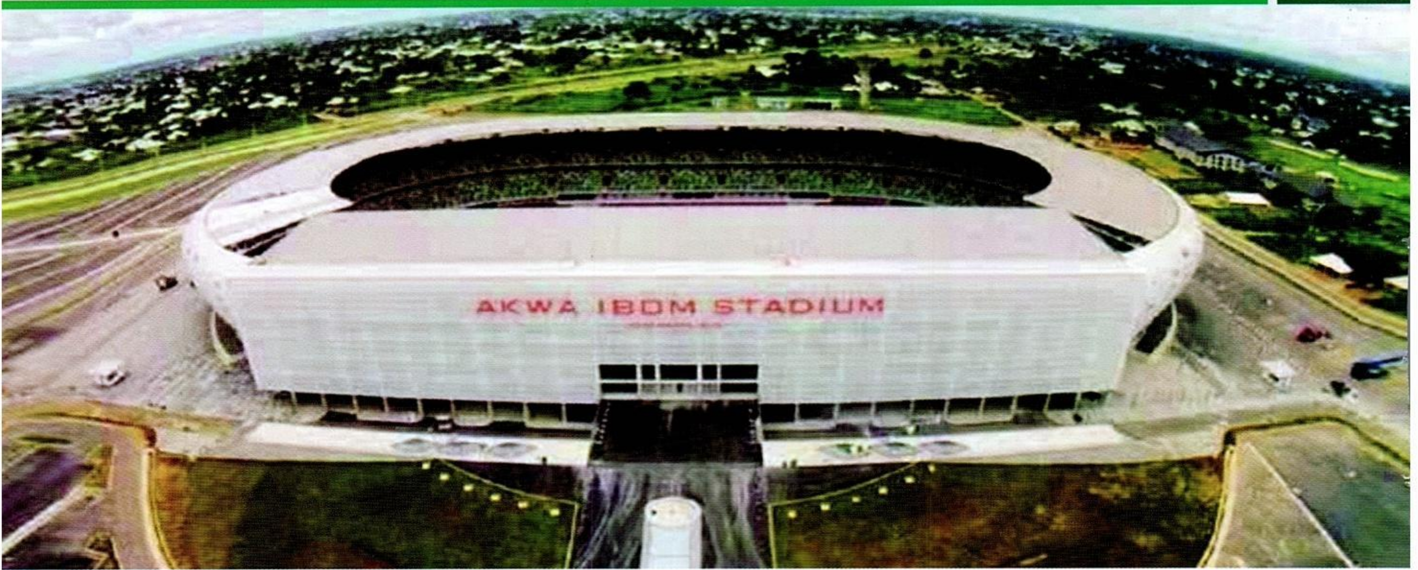
- Establish PHC dedicated budget line
- Include staff on the SPHCB payroll
- Support LGHAs to open dedicated bank accounts
- Provide regular funding for health facilities to cover operational expenses and provide integrated service delivery

Operational Guidelines - 67%:

- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB

SOUTH SOUTH ZONE





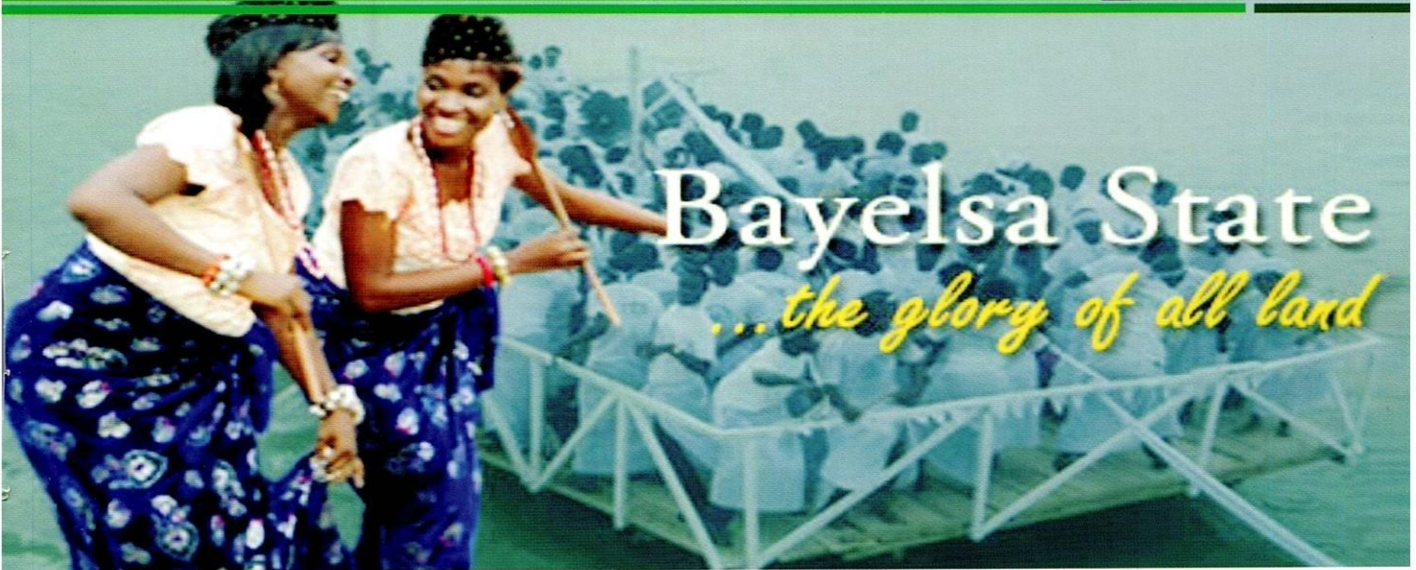
AKWA-IBOM STATE (Not Applicable)

Background

Akwa-Ibom State was created in 1987 and its capital is Uyo. It has a land mass of 7,249 sq. km with 2016 projected population of 5,482,200 (NPC 2006). It has 31 Local Government Areas (LGAs). There are 543 health facilities in the State: 355 (65%) are PHC facilities (NPHCDA 2015). Some of the State's health indices are IMR 42, U5MR 73, NMR 21 and U5 Stunting 29 (MICS 2016).

Main Findings

Akwa-Ibom State has no score as their SPHCB was established after the PHCUOR Scorecard 4 Assessment was conducted.



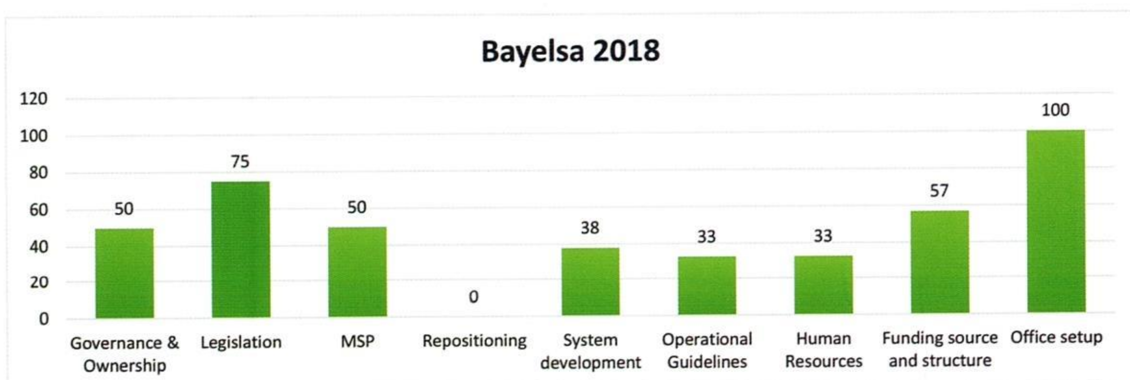
BAYELSA STATE (Overall Score 47%)

Background

Bayelsa State was created in 1996 from parts of Rivers State and its capital is Yenagoa. It has a land mass of 10,773 sq. km with 2016 projected population of 2,278,000 (NPC 2006). It has 8 Local Government Areas (LGAs). There are 232 health facilities in the State with 172 (74%) are PHC facilities and 59 (25%) are SHC facilities. All the PHC facilities are public health facilities (NPHCDA 2015). Some of the State's health indices are IMR 57, U5MR 95, NMR 29 and U5 Stunting 15 (MICS 2016).

Main Findings

Bayelsa State scored 47% in the PHCUOR Scorecard 4 assessment placing it in the 19th position nationwide. Its best performing pillars include Office Setup 100% and poor performing pillars include Repositioning 0%, Operational Guidelines 33% and Human Resources 33%.



Governance & Ownership: 50%

- Bayelsa SPHCB has a governing board and a management team.
- LGA PHC departments have not been transformed to LGHAs.

Legislation: 75%

- There is an SPHCB Law in place.
- No regulations developed for the operationalization of SPHCB Law.

MSP: 50%

- Bayelsa SPHCB has no costed and approved MSP document.
- Poor outcomes recorded in the measured health indices.

Repositioning: 0%

- Only Immunization programme has moved to the SPHCB. Other PHC staff and programmes, for example, Nutrition, Malaria, HIV/AIDS and TBL in the SMoH have not been moved to SPHCB.

Systems Development: 38%

- SPHCB does not have PHC annual operational plan, LGA PHC annual operational plans, M&E /results/performance framework with clear milestones and targets.
- Performance review has not been conducted on SPHCB in the last one year.
- The HMIS monthly facility reporting rate for the last 12 months is <80.

Operational Guidelines: 33%

- There is no Operational Guidelines to standardize the administrative processes in the SPHCB.

Human Resources: 33%

- PHC staff in the SMoH, SMoLG, LGSC and LGAs have not moved to the SPHCB.
- Staff nominal roll not available
- No HR plan for the strategic management of PHC HRH.

Funding Sources and Structure: 57%

- SPHCB has a dedicated budget line and bank account.
- SPHCB staff are not on the SPHCB payroll.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer

Required Actions

Governance & Ownership - 50%:

- Roles and responsibilities of the governing board to be clearly delineated from that of the management team
- LGA PHC departments to transform to LGHAs with clear reporting lines to SPHCB
- Formation/reactivation of WDCs to strengthen health governance at ward level

Legislation - 63%:

- Amend SPHCB law to reflect clear oversight functions of the SMoH on the SPHCB
- Develop regulations for the operationalization of the SPHCB Law

MSP - 67%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 56%:

- Transfer FP/MCH/Nutrition, Malaria, HIV/AIDS and TBL programmes from SMoH to SPHCB
- SMoH should conduct orientation for key staff on the new roles and responsibilities of the SMoH,

Systems Development- 50%:

- Develop PHC annual operational plan incorporating the LGA PHC annual operational plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Conduct performance review of the SPHCB
- Improve HMIS monthly facility reporting rate to >80

Operational Guidelines - 67%:

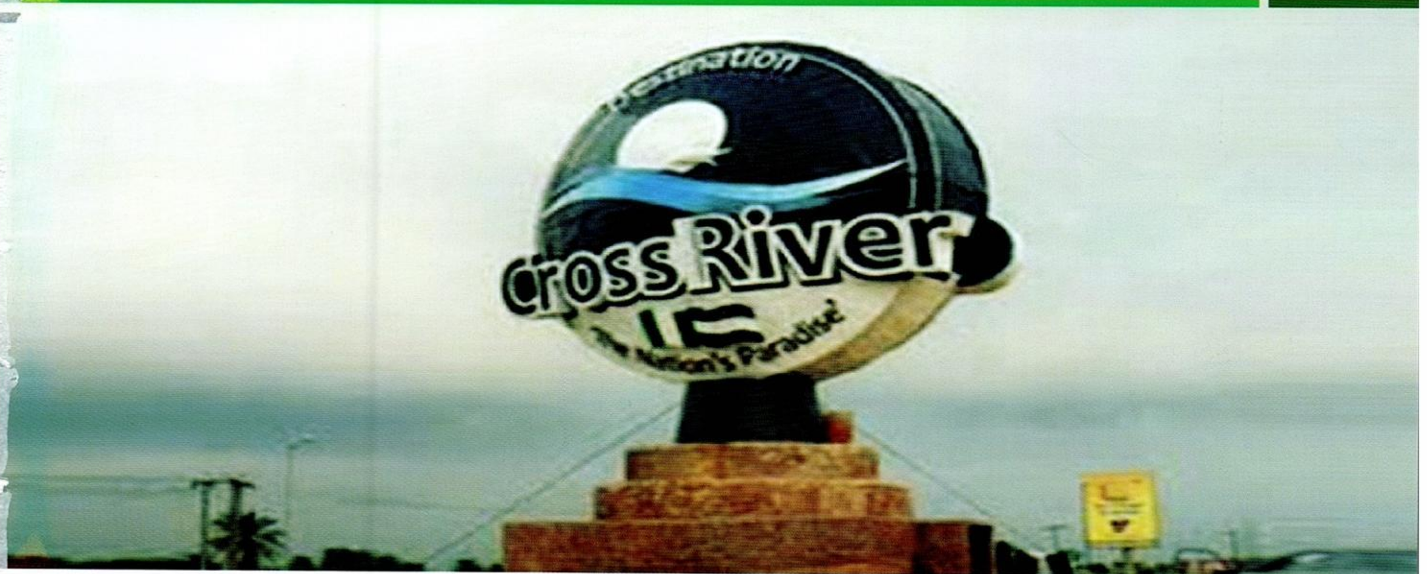
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB
- Develop Operational Guidelines for the SPHCB

Human Resources - 50%:

- Transfer all PHC staff in LGAs to the LGHAs
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to complement HRH strategic plan
- Develop staff nominal roll
- Onboard all staff on the mandate, mission and vision of the SPHCB

Funding Sources and Structures - 71%:

- Include all PHC staff on the SPHCB payroll
- Conduct periodic tracking of PHC budget performance
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and provide integrated service delivery



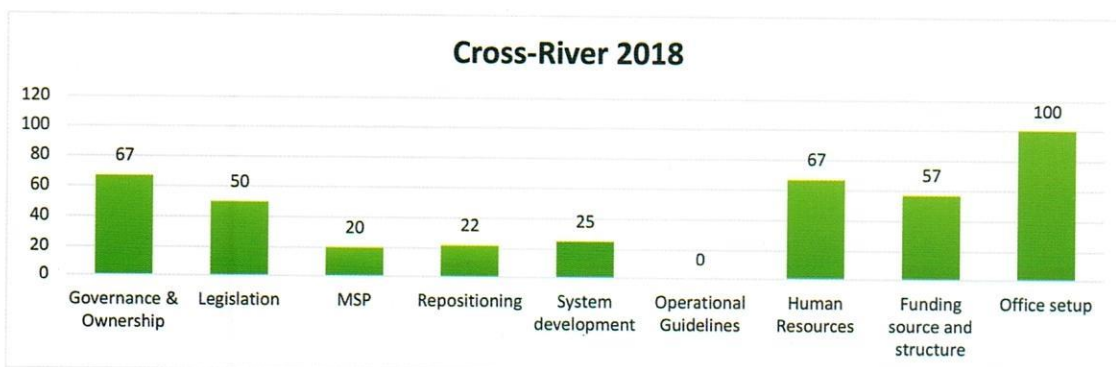
CROSS RIVER STATE (Overall Score 39%)

Background

Cross River State was created in 1967 and its capital is Calabar. It has a land mass of 20,156 sq. km with 2016 projected population of 3,866,300 (NPC 2006). It has 18 Local Government Areas (LGAs). There are 734 health facilities in the State: 593 (81%) are PHC facilities and 139 (19%) are SHC facilities. 575 (97%) of the PHC facilities are public health facilities and 18 (3%) are private health facilities. Some of the State's health indices are IMR 38, U5MR 52, NMR 20 and U5 Stunting 20 (MICS 2016).

Main Findings

Cross River State scored 39% in the PHCUOR Scorecard 4 assessment placing it in the 24th position nationwide. It best performing pillar is Office Setup 100% and poor performing pillars include MSP 20%, Repositioning 22% and Operational Guidelines 0%.



Governance & Ownership: 67%

- Cross River SPHCB has a governing board and a management team.
- LGA PHC departments have not been transformed to LGHAs with established reporting line to the SPHCB.

Legislation: 50%

- SPHCB Law is in place.
- No regulations developed for the operationalization of SPHCB Law.

MSP: 20%

- There is no costed and approved MSP document for PHC facilities in the State
- There is a decreasing trend in the number of institutional neonatal deaths, but an increasing trend in the number of institutional maternal deaths, still births, U5 deaths and under five with stunting.

Repositioning: 22%

- Some PHC staff and programmes in the SMoH have moved to the SPHCB. This includes FP/MCH/Nutrition and the immunization programmes.
- Other PHC programmes including Malaria, HIV/AIDS and TBL are yet to be transferred to the SPHCB.

Systems Development: 25%

- The SPHCB has strategic health development plan, M&E /results/performance framework with clear milestones and targets.
- SPHCB has no PHC annual operational plan, LGA PHC annual operational plans, ISS checklist, list of ISS team
- (including State and LGA members) and supervisory schedule. Performance review has not been conducted on SPHCB in the last one year. State has no functional data quality assurance system, and has not conducted a state-wide DQA in the previous year. The HMIS monthly facility reporting rate is <80.

Operational Guidelines: 0%

- SPHCB Operational Guidelines is not yet developed.

Human Resources: 67%

- There are job descriptions for all SPHCB staff and positions. SPHCB has staff nominal roll.

- SPHCB staff are yet to be on-boarded. There is no HR plan for the strategic management of PHC HRH.

Funding Sources and Structure: 57%
- SPHCB has a dedicated budget line and bank account.
- Annual audit of the PHC income and expenditure for the preceding year was conducted.
- SPHCB staff are not on the SPHCB payroll.

Office Setup: 100%
- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 67%:
- LGA PHC departments to transform into LGHAs

Legislation - 50%:
- Amend SPHCB Law o To reflect clear oversight function of the SMoH on the SPHCB
- To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
- Develop regulations for the operationalization of the law

MSP - 20%:
- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 22%:
- Transfer Malaria, HIV/AIDS, TBL and other PHC programmes to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB
- SMoH should restructure its departments in line with SPHCB reforms
- SMoH should conduct orientation for staff on the new roles and responsibilities of the SMoH

Systems Development- 25%:

- Develop PHC annual operational plan incorporating the LGA PHC annual operational plans
- Develop ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule
- Conduct performance review of the SPHCB
- Establish functional data quality assurance system
- Conduct State-wide DQA
- Improve HMIS monthly facility reporting rate to >80

Human Resources - 67%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition o Develop functional HRIS to support HRH strategic plan
- Develop staff nominal roll
- Onboard all staff on the mandate, mission and vision of the SPHCB

Operational Guidelines - 0%:

- Develop Operational Guidelines to standardize administrative processes of the SPHCB
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the agency

Funding Sources and Structure - 57%:

- Include all PHC staff on the SPHCB payroll
- Conduct periodic tracking of PHC budget performance
- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery

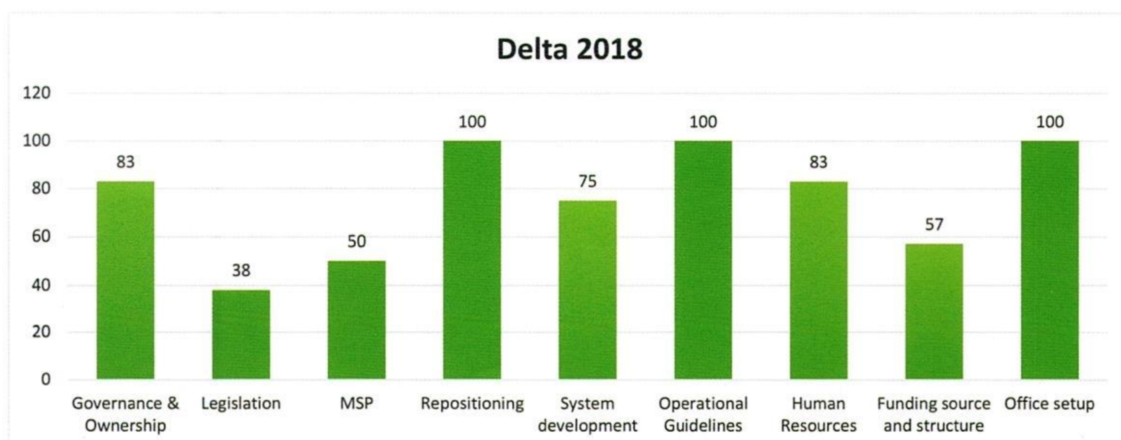
DELTA STATE (Overall Score 64%)

Background

Delta State was created in 1991 and its capital is Asaba. It has a land mass of 17,698 sq. km with 2016 projected population of 5,663,400 (NPopC 2006). It has 25 Local Government Areas (LGAs). There are 908 health facilities in the State: 804 (89%) are PHC facilities and 102 (11%) are SHC facilities. 437 (53%) of the PHC facilities are public health facilities and 383 (47%) are private health facilities. Some of the State's health indices are IMR 48, U5MR 63, NMR 28 and U5 Stunting 16 (MICS 2016).

Main Findings

Delta State scored 64% in the PHCUOR Scorecard 4 assessment placing it in the 7th position nationwide. Its best performing pillars are Repositioning, Operational Guidelines and Office Setup at 100% each and poor performing pillar is Legislation 38%.



Governance & Ownership: 67%

- Delta SPHCB has a governing board and a management team.
- LGHAs have been established with PHC management teams.

Legislation: 38%

- The SPHCB has a Law establishing it.
- There are no regulations for the operationalization of the SPHCB Law.

MSP: 50%

- Delta SPHCB has no costed and approved MSP document for PHC facilities in the State
- There is no investment or service delivery plan.
- Investment/service delivery plan is not captured in the State annual budget.
- There is a decreasing trend in the number of institutional still births, neonatal deaths and U5 deaths but an increasing trend in the number of institutional maternal deaths and under five with stunting.

Repositioning: 100%

- PHC programmes, staff and department in the SMoH have been moved to the SPHCB including Malaria, HIV/AIDS,
- TBL, FP/MCH/Nutrition and Immunization programmes. The LGA PHC departments have been transformed to LGHAs with definite reporting lines to the SPHCB. The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.

Systems Development: 75%

- Delta SPHCB has strategic health development plan, PHC annual operational plan incorporating LGA annual operational plans, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on SPHCB in the last one year. State has functional data quality assurance system and conducted a State-wide DQA in the previous year.
- SPHCB has no M&E /results/performance framework with clear milestones and targets. Its HMIS facility reporting rate for the last 12 months is <80%.

Operational Guidelines: 100%

- SPHCB Operational Guidelines has been developed and SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have been moved to the SPHCB and on-boarded. There are job descriptions for all SPHCB and LGHA staff and positions. The SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 57%

- SPHCB has a dedicated budget line and bank account.
- Not all PHC staff are on the SPHCB payroll.
- LGHAs have dedicated bank accounts.
- PHC facilities did not received any operational funding in the last three months.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer

Required Actions

Legislation - 38%:

- Amend SPHCB Law
  - To separate roles and responsibilities of governing board from that of management team
  - To reflect clear oversight function of the SMoH on the SPHCB Develop regulations for the operationalization of the SPHCB Law

MSP - 50%:

- Develop a costed and approved MSP document for PHC facilities in the State Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Systems Development – 75%:

- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

- Improve HMIS monthly facility reporting rate to >80

Human Resources - 83%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to complement HRH strategic plan

Funding Sources and Structure - 57%:

- Include all PHC staff on SPHCB payroll
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery

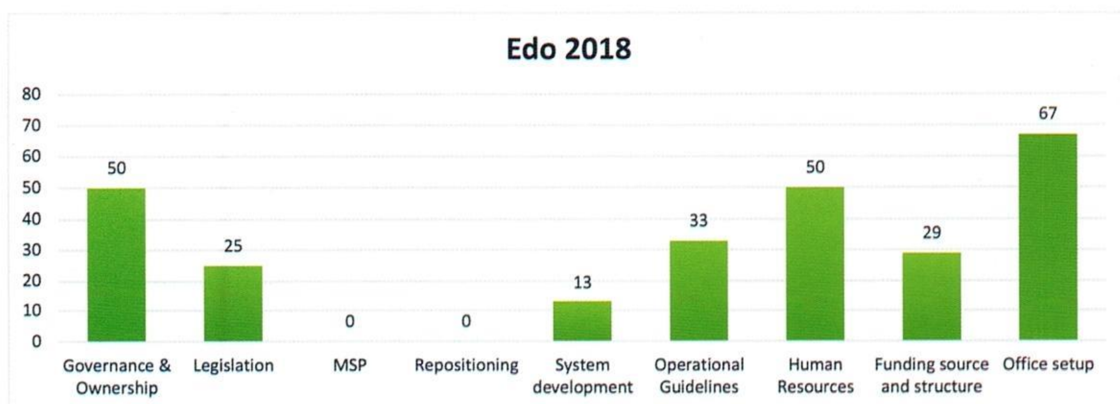
EDO STATE (Overall Score 18%)

Background

Edo State was created in 1991and its capital is Benin City. It has a land mass of 19,187 sq. km with 2016 projected population of 4,235,600 (NPC 2006). It has 18 Local Government Areas (LGAs). There are 724 health facilities in the State: 672 (93%) are PHC facilities and 46 (6%) are SHC facilities. 380 (52%) of the PHC facilities are public health facilities and 292 (48%) are private health facilities (NPHCDA 2015). The State has an U5 stunting rate of 14 (MICS 2016).

Main Findings

Edo State scored 18% in the PHCUOR Scorecard 4 assessment placing it in the 29th position nationwide. Its best performing pillar is Office Setup 67%. Other pillars are in critical state and require immediate strengthening interventions.



Governance & Ownership: 50%

- Edo SPHCB has a management team.
- SPHCB has no governing board.
- LGA PHC departments have not been transformed to LGHAs with established reporting line to the SPHCB. WDCs are available but not functional.

Legislation: 25%

- The SPHCB has a Law establishing it.
- SPHCB Law has no provision for the movement of PHC programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB.
- There are no regulations for the operationalization of the law.

MSP: 0%

- Edo SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.
- Investment/service delivery plan is not captured in the annual budget.
- There is an increasing trend in the number of institutional maternal deaths, still births, neonatal deaths, U5 deaths and under-fives with stunting.

Repositioning: 0%

- PHC department, staff and programmes in the SMoH have not moved to the SPHCB.
- LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.

Systems Development: 13%

- SPHCB has strategic health development plan.
- There are no PHC and LGA annual operational plans, M&E /results/ performance framework with clear milestones and targets for the SPHCB, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has not been conducted on the SPHCB in the last one year. State has no functional data quality assurance system and has not conducted a state-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is <80%.

Operational Guidelines: 33%

- SPHCB Operational Guidelines not yet developed.
- No orientation has not been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Human Resources: 50%

- There is no HR plan or HRIS in place for the strategic management of PHC HRH.

Funding Sources and Structure: 29%

- The SPHCB has a dedicated budget line and bank account.
- SPHCB staff are not on the SPHCB payroll.

Office Setup: 67%

- The SPHCB has a physical office without requisite amenities and equipment such as power, water, computers, furniture, internet access and printer

Required Actions

Governance & Ownership

- Constitute and inaugurate governing board in line with national guidelines.
- Transform LGA PHC departments into LGHAs with clear reporting lines to SPHCB

Legislation

- Amend SPHCB Law o To delineate roles and responsibilities of governing board from that of management team o To reflect clear oversight function of the SMoH on the SPHCB
    - To make provision for the transfer of all PHC facilities in the State to the SPHCB
    - To make provision for the movement of PHC programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
- Develop regulations for the operationalization of the SPHCB Law

MSP :

- Develop a costed and approved MSP document for health facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning:

- Transfer all PHC staff and programmes including Malaria, HIV/AIDS, TBL, FP/MNCH/Nutrition and Immunization to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting lines to the SPHCB
- The SMoH should restructure its departments in line with SPHCB reforms
- The SMoH should conduct orientation for its staff on the new roles and responsibilities of the SMoH

Systems Development:

- Develop PHC annual operational plan incorporating the LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Develop ISS checklist, list of ISS team (including State and LGA members), and supervisory schedule
- Conduct performance review for the SPHCB
- Establish State functional data quality assurance system
- Conduct State-wide DQA
- Improve HMIS monthly facility reporting rate to >80

Human Resources

- Transfer all PHC staff in LGAs, SMoLG and LGSC to the SPHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to support HRH strategic plan
- Develop staff nominal roll

Funding Sources and Structure:

- Include all PHC staff on SPHCB payroll
- Support LGHAs to open dedicated bank accounts
- Conduct periodic tracking of PHC budget performance
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and provide integrated service delivery

Operational Guidelines

- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB
- Develop Operational Guidelines for SPHCB

Office Setup

- Provide requisite office space, amenities and equipment such as power, water, computers, furniture, internet access and printer

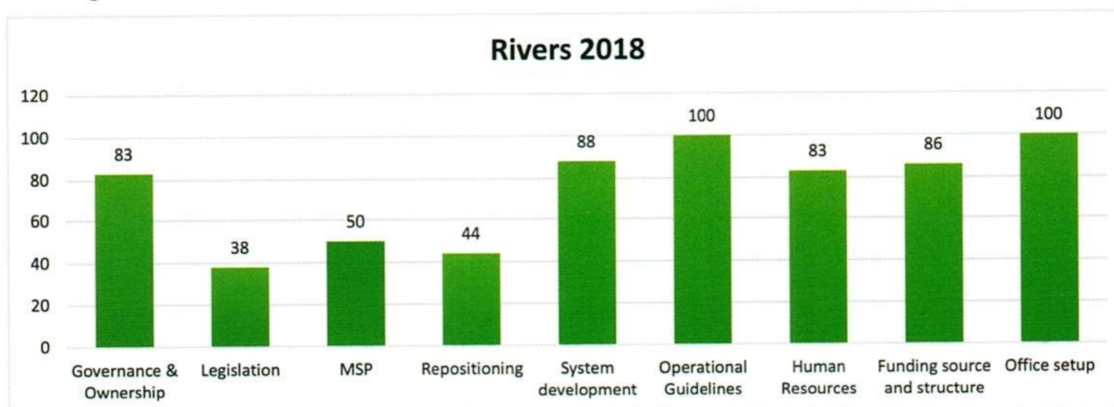
RIVERS STATE (Overall Score 66%)

Background

Rivers State was created in 1967. Its capital is Port-Harcourt. It has a land mass of 11,077 sq. km (NBS 2010) with 2016 projected population of 7,303,900 (NPC 2006). It has 23 Local Government Areas (LGAs). There are 476 health facilities in the State: 417 (88%) are PHC facilities and 54 (12%) are SHC facilities. 380 (91%) of the PHC facilities are public health facilities and 37 (%) are private health facilities (NPHCDA 2015). Some of the State's health indices are IMR 41, U5MR 58, NMR 27 and U5 Stunting 11 (MICS 2016).

Main Findings

Rivers State scored 66% in the PHCUOR Scorecard 4 assessment placing it in the 5th position nationwide. Its best performing pillars include Systems Development 88%, Operational Guidelines and Office Setup at 100% each and poor performing pillars are Legislation 38% and Repositioning 44%.



Governance & Ownership: 83%

- Rivers SPHCB has a governing board with clearly defined roles and responsibilities separate from that of the management team. The LGA PHC departments have transformed into LGHAs. WDCs are available across the
- State.

Legislation: 38%

- Rivers State has a SPHCB Law.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 50%

- Rivers SPHCB has not developed a costed and approved MSP document for PHC facilities in the State.
- There is, therefore, no investment or service delivery plan.
- There is a decreasing trend in the number of institutional still births, U5 deaths and under five with stunting, but an increasing trend in the number of institutional maternal deaths and neonatal deaths.

Repositioning: 44%

- The PHC department in the SMoH with its staff and programmes has moved to the SPHCB.
- The LGA PHC departments have also transformed to LGHAs with definite reporting lines to the SPHCB.
- However, Malaria, HIV/AIDS and TBL are yet to be transferred to the SPHCB.

Systems Development: 88%

- Rivers SPHCB has developed key strategic documents such as strategic health development plan, PHC annual operational plan incorporating LGA PHC annual operational plans, ISS checklist, list of ISS team (including state and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system, and has conducted a state-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.
- There is no M&E /results/performance framework with clear milestones and targets.

Operational Guidelines: 100%

- SPHCB Operational Guidelines has been developed and SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have been moved to the SPHCB and on-boarded.
- There are job descriptions for all SPHCB and LGHA staff and positions.
- The SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 86%

- SPHCB has a dedicated budget line and bank account.
- All PHC staff are on the SPHCB payroll.
- The LGHAs do not have dedicated bank accounts.
- None of the health facilities received regular operational funding in the last three months.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Legislation - 38%:

- Amend SPHCB law to reflect clear oversight function of the SMoH on the SPHCB
- Develop regulations for the operationalization of SPHCB Law

MSP - 50%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 44%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB
- The SMoH should conduct orientation for key staff on the new roles and responsibilities of the SMoH

Systems Development– 88%:

- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

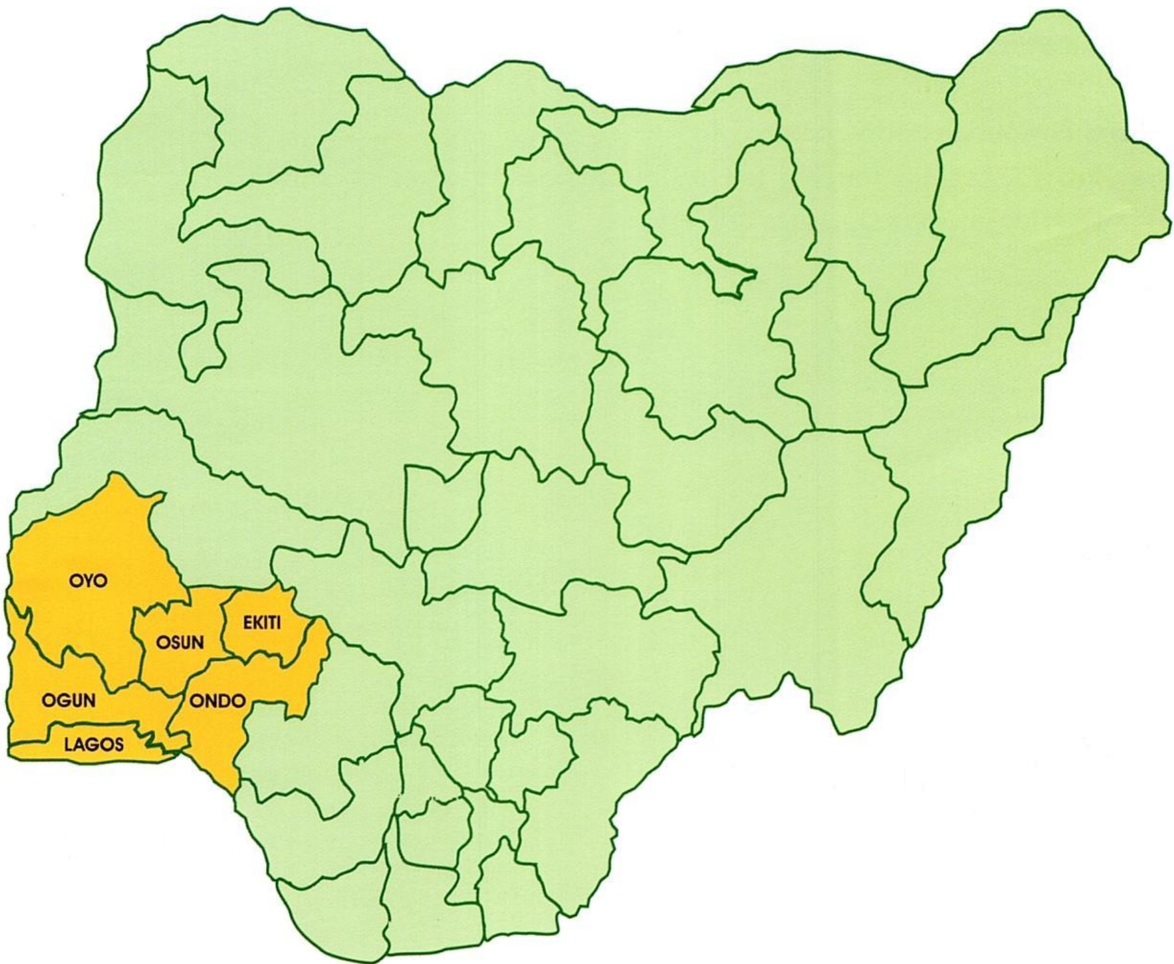
Human Resources - 83%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition   Develop functional HRIS to support HRH strategic plan

Funding Sources and Structure - 86%:

- Provide regular funding for health facilities to cover operational expenses and provide integrated service delivery

SOUTH WEST ZONE



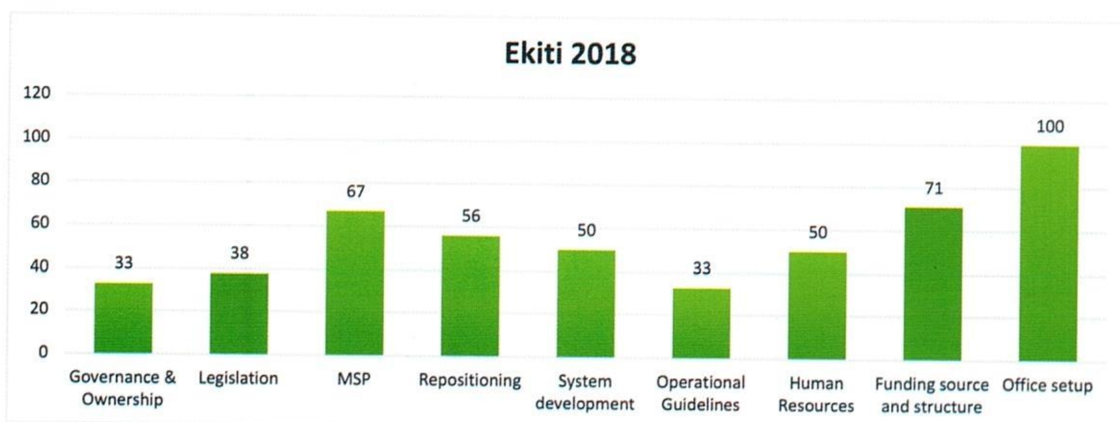
EKITI STATE (Overall Score 42%)

Background

Ekiti State was created in 1996 and its capital is Ado-Ekiti. It has a land mass of 6,353 sq. km with 2016 projected population of 3,270,800 (NPC 2006). It has 16 Local Government Areas (LGAs). There are 459 health facilities in the State: 395 (86%) are PHC facilities, 62 (14%) are SHC facilities. 294 (74%) of the PHC facilities are public health facilities and 101 (26%) are private health facilities (NPHCDA 2015). Some of the State's health indices are IMR 69, U5MR 86, NMR 46 and U5 Stunting 22 (MICS 2016).

Main Findings

Ekiti State scored 40% in the PHCUOR Scorecard 4 assessment placing it in the 23rd position nationwide. Its best performing pillar is Office Setup 100% and poor performing pillars include Governance and Ownership 33% and Legislation 38%.



Governance & Ownership: 33%

- Ekiti SPHCB has a management team.
- The SPHCB has no governing board.
- LGHAs have not been established in the State.

Legislation: 38%

- The SPHCB Law is available.
- The SPHCB Law lacks necessary provisions for the full implementation of PHCUOR in the State.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 67%

- Ekiti SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.
- Poor outcomes recorded in the measured health indices.

Repositioning: 56%

- Only immunization programme has been moved to the SPHCB.
- Other PHC programmes (Malaria, HIV/AIDS, TBL and FP/MCH/Nutrition) and staff are yet to be transferred to SPHCB.
- LGA PHC departments have not been transformed into LGHAs with definite reporting lines to SPHCB.

Systems Development: 50%

- The SPHCB has PHC and LGA PHC annual operational plans, ISS checklist, list of ISS team (including state and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system and has conducted state-wide DQA in the previous year. Its HMIS reporting rate is >80%.
- SPHCB has no strategic health development plan and no M&E /results/performance framework with clear milestones and targets.

Operational Guidelines: 33%

- SPHCB Operational Guidelines is not yet developed.

Human Resources: 50%

- Job descriptions are available for all SPHCB staff and positions.
- SPHCB has staff nominal roll.
- PHC staff in the LGAs, SMoLG and LGSC have not been moved to the SPHCB.
- Staff have not been on-boarded.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 71%

- SPHCB has a dedicated budget line and bank account.
- PHC staff are not on the SPHCB payroll. Annual audit of PHC income and expenditure for the preceding year was not conducted. None of the health facilities received regular operational funding in the last three months.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 33%:

- Constitute and inaugurate SPHCB governing board according to national guidelines
- Establish LGHAs in all LGAs of the state

Legislation - 38%:

- Amend SPHCB Law o To reflect clear oversight function of the SMoH on the SPHCB
    - To make provision for the transfer of all PHC facilities in the State to the SPHCB
    - To make provision for the movement of PHC programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
- Develop regulations for the operationalization of the SPHCB Law

MSP - 67%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 56%:

- Transfer all PHC programmes and staff to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB
- The SMoH should restructure its departments in line with the SPHCB reform
- The SMoH should conduct orientation for staff on the new roles and responsibilities of the SMoH.

Systems Development – 63%:

- Develop strategic health development plan
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

Human Resources - 67%:

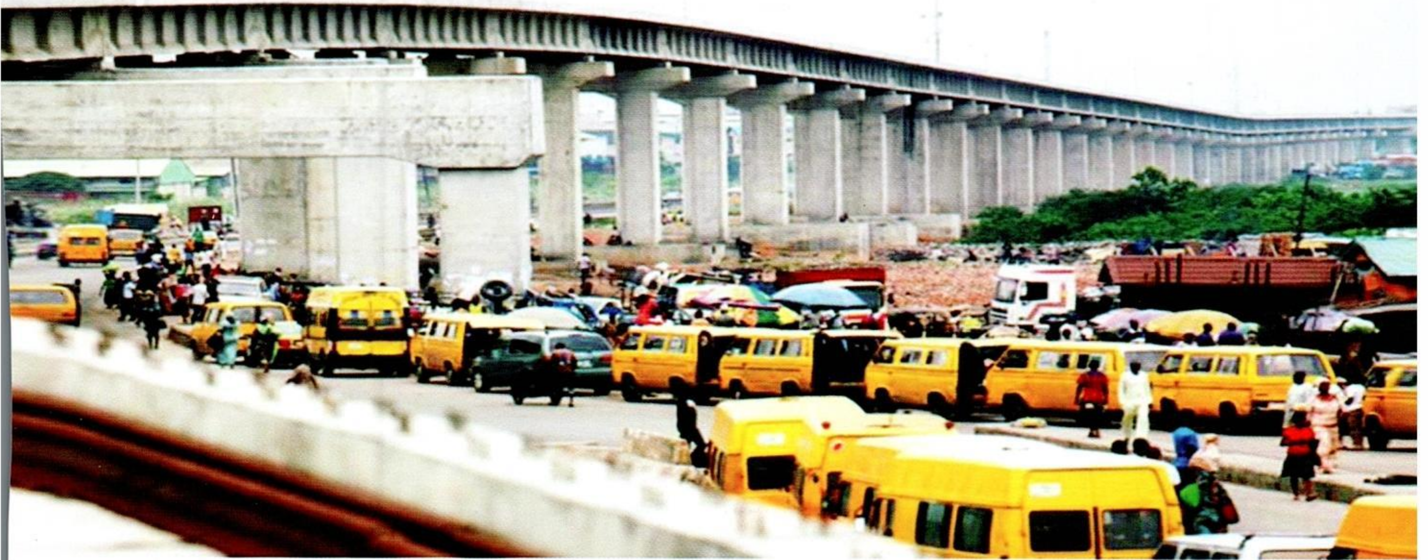
- Transfer all PHC staff in the LGAs, SMoLG and LGSC to the SPHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to support HRH strategic plan
- Onboard all staff on the mandate, mission and vision of the SPHCB

Funding Sources and Structure - 57%:

- Include all PHC staff on SPHCB payroll
- Support LGHAs to open dedicated bank accounts
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and provide integrated service delivery

Operational Guidelines - 33%:

- Develop SPHCB Operational Guidelines
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB



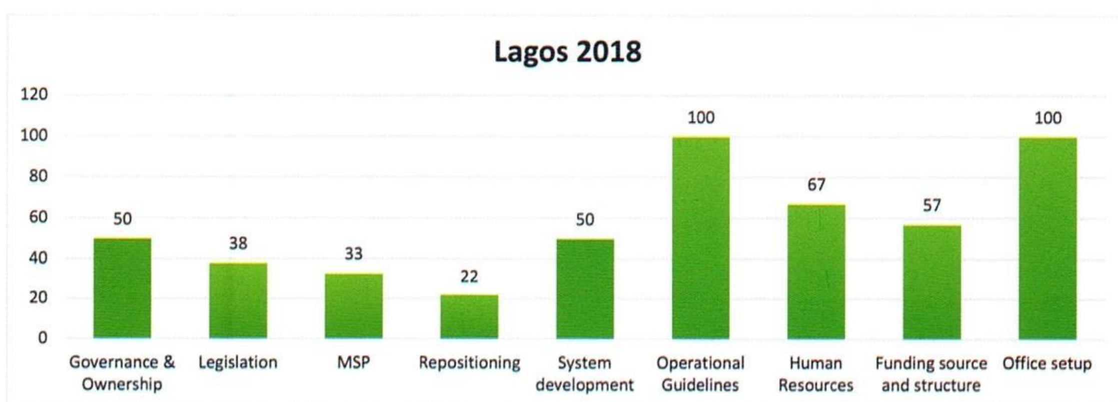
LAGOS STATE (Overall Score 45%)

Background

Lagos State was created in 1967 and its capital is Ikeja. It has a land mass of 3, 862 sq. km with a population of 24,600,000. It has 20 Local Government Areas (LGAs). There are 2,253 health facilities in the state: 1,786 (80%) are PHC facilities and 460 (20%) are SHC facilities. 257 (14%) of the PHC facilities are public health facilities and 1,529 (86%) are private health facilities. Some of the State's health indices are IMR 45, U5MR 50, NMR 29 and U5 Stunting 11 (MICS 2016).

Main Findings

Lagos State scored 45% in the PHCUOR Scorecard 4 assessment placing it in the 20th position nationwide. Its best performing pillars are Operational Guidelines and Office Setup at 100% each and poor performing pillars include Legislation 38%, MSP 33% and Repositioning 22%.



Governance & Ownership: 50%

- Lagos SPHCB has a management team.
- SPHCB has no governing board.
- There are no LGHAs in the State.

Legislation: 38%

- The SPHCB Law is in place.
- No regulations developed for the operationalization of SPHCB Law.

MSP: 33%

- Lagos SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan. Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional maternal deaths and under five with stunting but an increasing trend in the number of institutional still births, neonatal deaths and under five deaths.

Repositioning: 22%

- Some PHC programmes (notably immunization) and staff in the SMoH have been moved to the SPHCB.
- Other programmes (FP/MCH/Nutrition, Malaria, HIV/AIDS and TBL) are yet to be transferred to the SPHCB. LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.

Systems Development: 50%

- SPHCB has strategic PHC development plan and PHC annual operational plan. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system and has conducted State-wide DQA in the previous year.
- SPHCB has no LGA PHC annual operational plan, M&E/results/ performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule and no evidence on HMIS reporting for the last 12 months.

Operational Guidelines: 100%

- SPHCB Operational Guidelines is available and SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Human Resources: 67%

- PHC staff in the LGAs, SMoLG and LGSC have been moved to the SPHCB. There are job descriptions for all SPHCB staff and positions including those at the LGA. The SPHCB has staff nominal roll but HRIS is not available.
- PHC staff are yet to be on-boarded. There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 57%

- SPHCB has a dedicated budget line and bank account. PHC budget performance is periodically tracked, and annual audit of PHC income and expenditure for the preceding year was conducted.
- PHC staff are not on the SPHCB payroll.
- No PHC facilities received regular operational funding in the last three months.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 50%:

- Constitute and inaugurate SPHCB governing board based on the national guidelines
- Establish LGHAs in all LGAs in the State

Legislation - 38%:

- Amend SPHCB law o To delineate roles and responsibilities of governing board from that of management team
    - To make provision for the movement of PHC department and programmes in the SMoH, SMoLG and all LGAs to the SPHCB
    - To indicate different sources of PHC funding and expected contribution from the State and LGAs.
- Develop regulations for the operationalization of the SPHCB Law

MSP - 33%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 22%:

- Transfer all PHC programmes to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB
- The SMoH should restructure its departments in line with SPHCB reforms.

Human Resources - 67%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to support HRH strategic plan
- Onboard all staff on the mandate, mission and vision of the SPHCB

Systems Development– 50%:

- Develop PHC annual operational plan incorporating LGA PHC annual operational plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Develop ISS checklist, list of ISS team (including state and LGA members) and supervisory schedule
- Conduct performance review of the SPHCB
- Facilitate HMIS reporting and improve HMIS monthly facility reporting rate to >80

Funding Sources and Structure - 57%:

- Include all PHC staff on the SPHCB payroll
- Support LGHAs to open dedicated bank accounts
- Provide regular funding for health facilities to aid operational expenses and provide integrated service delivery

Consolidating the gains, Accelerating growth...

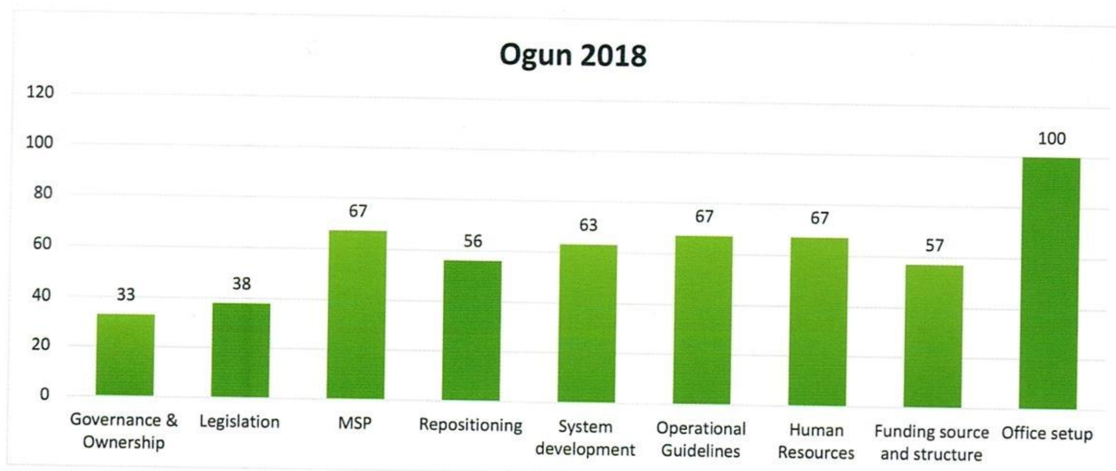
OGUN STATE (Overall Score 59%)

Background

Ogun State was created in 1976 and its capital is Abeokuta. It has a land mass of 16,432 sq. km with 2016 projected population of 5,217,700 (NPC 2006). It has 20 Local Government Areas (LGAs). There are 1,520 health facilities in the State: 1375 (90%) are PHC facilities. 474 (35%) of the PHC facilities are public health facilities and 899 (65%) are private health facilities. Some of the State's health indices are IMR 49, U5MR 66, NMR 28 and U5 Stunting 26 (MICS 2016).

Main Findings

Ogun State scored 59% in the PHCUOR Scorecard 4 assessment placing it in the 10th position nationwide. Its best performing pillar is Office Setup 100% and poor performing pillars are Governance and Ownership 33% and Legislation 38%.



Governance & Ownership: 33%

- Ogun SPHCB has management team.
- The SPHCB has no governing board.
- There are no LGHAs in the State.
- WDCs are not available.

Legislation: 38%

- Ogun SPHCB has a Law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 67%

- Ogun SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.
- There is a decreasing trend in the number of institutional maternal deaths, still births, neonatal deaths and under five but an increasing trend in the number of under five with stunting.

Repositioning: 56%

- Some PHC programmes (FP/MCH/Nutrition and Immunization) and staff in the SMoH have been moved to the SPHCB. The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- The Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.
- LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.

Systems Development: 63%

- Ogun SPHCB has a strategic PHC development plan, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system and has conducted state-wide DQA in the previous year. Its HMIS reporting is >80%.
- SPHCB has no PHC annual operational plan, LGA PHC annual operational plan, M&E /results/performance framework with clear milestones and targets.

Operational Guidelines: 67%

- There is SPHCB Operational Guidelines.
- SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Human Resources: 67%

- There are job descriptions for all SPHCB staff and positions.
- SPHCB has staff nominal roll.
- Staff have been on-boarded.
- PHC staff in the LGAs, SMoLG and LGSC have not been moved to the SPHCB.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 57%

- SPHCB has a dedicated budget line and bank account.
- SPHCB staff are on the SPHCB payroll.
- None of the PHC facilities received regular operational funding in the last three months.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 33%:

- Constitute and inaugurate SPHCB governing board in line with the national guidelines
- Establish LGHAs in all LGAs of the state
- Establish/reactivate WDCs to strengthen health governance at ward level

Legislation - 38%:

- Amend SPHCB law
    - o To delineate roles and responsibilities of governing board from that of management team
    - o To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
    - o To indicate different sources of PHC funding and expected contributions from the State and LGAs.

- Develop regulations for the operationalization of the SPHCB Law

MSP - 67%:
- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 56%:
- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB

Systems Development– 63%:
- Develop PHC annual operational plan incorporating LGA PHC annual operational plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

Human Resources - 67%:
- Transfer all PHC staff in the LGAs, SMoLG and LGSC to the SPHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to complement HRH strategic plan

Funding Sources and Structure - 57%:
- Support LGHAs to open dedicated bank accounts
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to aid operational expenses and provide integrated service delivery

Operational Guidelines - 67%:
- Distribute PHCUOR Implementation Guidelines to all PHC staff and LGHAs
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB.

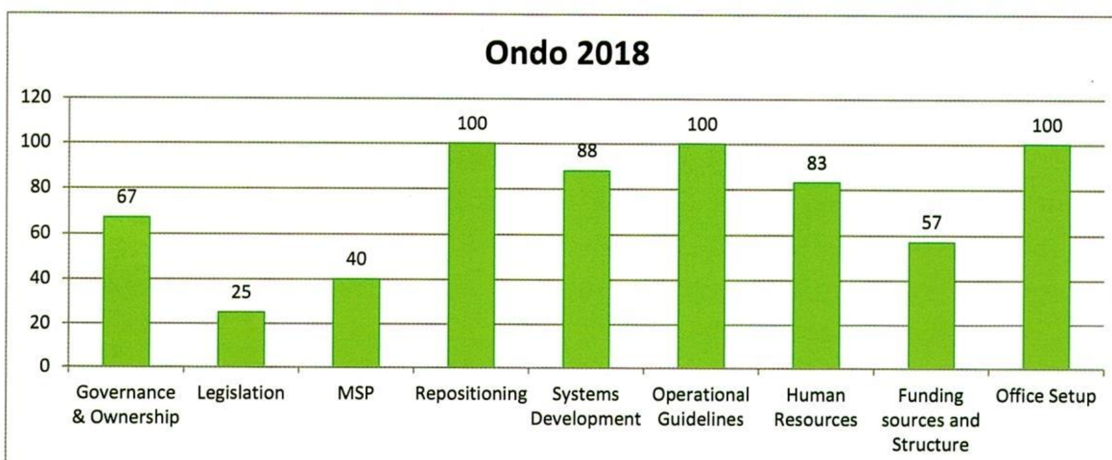
ONDO STATE (Overall Score 42%)

Background

Ondo State was created in 1976 and its capital is Akure. It has a land mass of 15,500 sq. km with 2016 projected population of 4,671,700 (NPC 2006). It has 18 Local Government Areas (LGAs). There are 811 health facilities in the State: 769 (94%) are PHC facilities while 40 (5%) are SHC facilities. 460 (60%) of the PHC facilities are public health facilities and 309 (40%) are private health facilities (NPHCDA 2015). Some of the State's indices are IMR 37, U5MR 67, NMR 30 and U5 Stunting 22 (MICS 2016).

Main Findings

Ondo State scored 55% in the PHCUOR Scorecard 4 assessment placing it in the 14th position nationwide. Its best performing pillars are Repositioning, Office Setup and Operational Guidelines at 100% each and poor performing pillars are Governance and Ownership 0%, Legislation 25% and MSP 40%.



Governance & Ownership: 67%

- Ondo SPHCB has a management team.
- There are LGHAs with management teams in the State.
- WDCs are available.
- SPHCB has no governing board.

Legislation: 25%

- Ondo SPHCB has a law establishing it.
- No regulations developed for operationalization of the SPHCB Law.

MSP: 40%

- Ondo SPHCB has an investment/service delivery plan which is captured in the annual budget.
- SPHCB has no costed and approved MSP document.
- There is a decreasing trend in the number of institutional maternal deaths and under five with stunting but an increasing trend in the number of institutional, still births, neonatal deaths and under five deaths.

Repositioning: 100%

- PHC department, programmes and staff in the SMoH have been moved to the SPHCB.
- LGA PHC departments have been transformed to LGHAs with definite reporting lines to the SPHCB.
- The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.

Systems Development: 88%

- SPHCB has strategic PHC development plan, PHC annual operational plan, LGA PHC annual operational plan, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system and has conducted state-wide DQA in the previous year. Its HMIS reporting rate is >80%.
- SPHCB has no M&E /results/performance framework with clear milestones and targets.

Operational Guidelines: 100%

- SPHCB Operational Guidelines is available and SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have been moved to the SPHCB and on-boarded. There are job descriptions for all SPHCB staff and positions including those at the LGA. SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 57%

- SPHCB has a dedicated budget line and bank account.
- PHC staff are not on the SPHCB payroll.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & ownership - 67%:

- Constitute and inaugurate SPHCB governing board according to national guidelines.

Legislation - 25%:

- Amend SPHCB law
    - To separate roles and responsibilities of governing board from that of management team
    - To reflect clear oversight function of the SMoH on the SPHCB
    - To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
- Develop regulations for operationalization of the SPHCB Law

MSP - 40%:

- Develop a costed and approved MSP document for PHC facilities in the State

Human Resources - 83%:

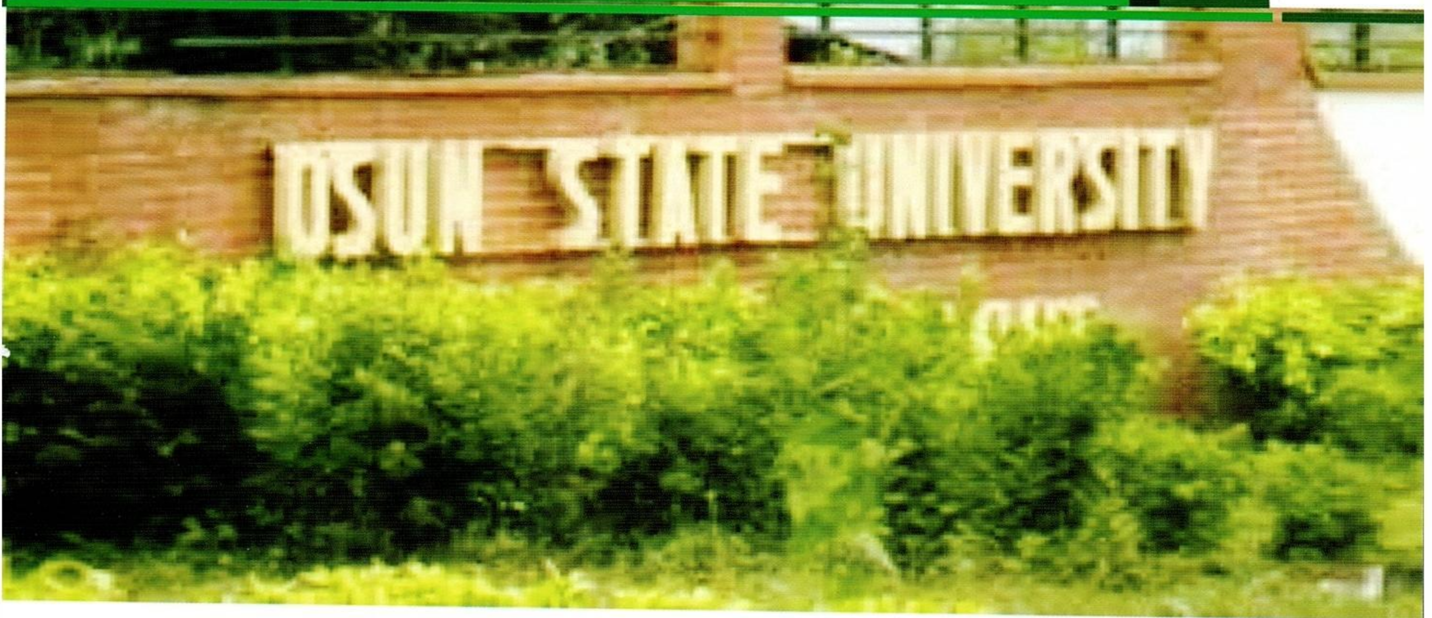
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan

Systems Development – 88%:

- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

Funding Sources and Structure - 57%:

- Include all PHC staff on SPHCB payroll



OSUN STATE (Overall Score 42%)

Background

Osun State was created in 1991 with Osogbo as the capital. It has a land mass of 14,875 sq. km (NBS 2010) with 2016 projected population of 4,705,600 (NPC 2006). It has 30 Local Government Areas (LGAs). There are 1,095 health facilities in the State: 1,031 (94%) are PHC facilities, 60 (6%) are SHC facilities. 678 (66%) of the PHC facilities are public health facilities and 353 (34%) are private health facilities. Some of the State's health indices are IMR 78, U5MR 101, NMR 56 and U5 Stunting 23 (MICS 2016).

Main Findings

Osun State scored 42% in the PHCUOR Scorecard 4 assessment placing it in the 22nd position nationwide. Its best performing pillars are Governance and Ownership 83%, Office Setup and Operational Guidelines at 100% each and poor performing pillars are MSP 0% and Legislation 25%.

Governance & Ownership: 83%

- Osun SPHCB has a governing board and a management team. There is a PHC management team in each of the LGHAs.

Legislation: 25%

- The SPHCB has a law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 0%

- Osun SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.
- There is increasing trend in the number of institutional maternal deaths, still births, neonatal deaths, under five deaths and under five with stunting.

Repositioning: 67%

- PHC programmes and staff in the SMoH have been moved to the SPHCB with the exception of Malaria,
- HIV/AIDS and TBL programmes. departments such as FP/MCH/Nutrition, immunization programmes. The LGA PHC departments have transformed into LGHAs with definite reporting lines to the SPHCB. The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.

Systems Development: 75%

- The SPHCB has strategic health development plan, LGA PHC annual operational plans, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system and has conducted State-wide DQA in the previous year. Its HMIS reporting rate is >80%.
- SPHCB has no PHC annual operational plan and no M&E /results/performance framework with clear milestones and targets.

Operational Guidelines: 100%

- SPHCB Operational Guidelines has been developed and SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Human Resources: 67%

- All PHC staff in the LGAs, SMoLG and LGSC have been moved to the SPHCB.
- Job descriptions are available for all SPHCB and LGHA staff and positions.
- SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 57%

- SPHCB and LGHAs have dedicated bank accounts.
- All PHC staff are on the SPHCB payroll.
- PHC budget performance is periodically tracked.
- SPHCB has no dedicated budget line.
- Annual audit of PHC income and expenditure for the preceding year was not conducted.
- No health facilities received regular operational funding in the last three months.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & ownership - 83%:

- Establish/reactivate WDCs to strengthen health governance at ward level

Legislation - 25%:

- Amend SPHCB Law
    - To separate roles and responsibilities of governing board from that of management team
    - To reflect clear oversight function of the SMoH on the SPHCB
    - To indicate different sources of PHC funding and expected contributions from the State and LGAs.
- Develop regulations for the operationalization of the SPHCB Law

MSP - 0%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 67%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB

Systems Development– 75%:

- Develop PHC annual operational plan incorporating LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

Human Resources - 67%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan

Funding Sources and Structure - 57%:

- Establish PHC dedicated budget line
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and provide integrated service delivery

OYO STATE

GOVERNMENT

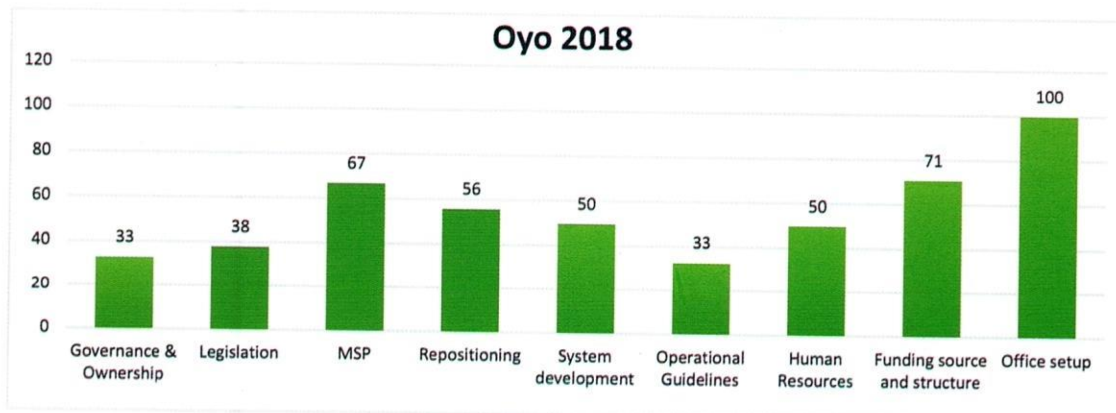
OYO STATE (Overall Score 59%)

Background

Oyo State was created in 1976 and its capital is Ibadan. It has a land mass of 28,454 sq. km with 2016 projected population of 7,840,900 (NPopC 2006). It has 33 Local Government Areas (LGAs). There are 1,237 health facilities in the State: 763 (62%) are PHC facilities and 470 (38%) are SHC facilities. 677 (89%) of the PHC facilities are public health facilities and 86 (11%) are private health facilities (NPHCDA 2015). Some of the State's health indices are IMR 59, U5MR 73, NMR 42 and U5 Stunting 24 (MICS 2016).

Main Findings

Oyo State scored 59% in the PHCUOR Scorecard 4 assessment placing it in the 10th position nationwide. Its best performing pillar is Office Setup 100% and poor performing pillars were Governance and Ownership 33%, Legislation 38% and Operational Guidelines 33%.



Governance & Ownership: 33%

- Oyo SPHCB has a governing board.
- The constitution of the governing board is not in line with the national guidelines.
- No substantive ES and management team.
- LGA PHC departments have not transformed to LGHAs.
- WDCs where available are not functional.

Legislation: 38%

- Oyo SPHCB has a Law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 67%

- Oyo SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan. Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional still births, neonatal deaths, under five deaths and under five with stunting, but an increasing trend in the number of institutional maternal deaths.

Repositioning: 56%

- FP/MCH/Nutrition and Immunization programmes have moved to the SPHCB. Malaria, HIV/AIDS and TBL programmes are yet to move to SPHCB.
- LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.

Systems Development: 50%

- The SPHCB has strategic health development plan, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. State has functional data quality assurance system, and has conducted state-wide DQA in the previous year. Its HMIS monthly reporting is >80.

- SPHCB has no PHC annual operational plan and LGA PHC annual operational plan, M&E /results/performance framework with clear milestones and targets. Performance review has not been conducted on the SPHCB in the last one year.

Human Resources: 50%

- Job descriptions available for all SPHCB staff and positions.
- Staff nominal roll also available but no HRIS.
- PHC staff in the LGAs, SMoLG and LGSC have not been moved to the SPHCB and available staff are yet to be on-boarded.

Funding Sources and Structure: 71%

- SPHCB has a dedicated budget line and bank account.
- State-level staff are on the SPHCB payroll.
- PHC budget performance is periodically tracked and annual audit of PHC income and expenditure for the preceding year was conducted.
- None of the health facilities received regular operational funding in the last three months.

Operational Guidelines: 33%

- SPHCB Operational Guidelines not yet developed.
- SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate, vision and mission of the SPHCB.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 33%:

- Reconstitute and inaugurate the governing board in line with national guidelines
- Establish LGHA for each of the 33 LGAs in the state
- Form/resuscitate WDCs to strengthen health governance at ward level

Legislation - 38%:

- Amend SPHCB law
  - To reflect clear oversight function of the SMoH on the SPHCB
  - To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
- Develop regulations for the operationalization of the SPHCB Law

MSP - 67%:

- Develop an approved and costed MSP document for health facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 56%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB

Systems Development– 50%:

- Develop PHC annual operational plan incorporating LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Conduct performance review of the SPHCB

Human Resources - 50%:

- Transfer all PHC staff in the LGAs to the SPHCB
- Develop HRH strategic plan comprising of recruitment, forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to support HRH strategic plan
- Onboard all staff on the mandate, mission and vision of the SPHCB.

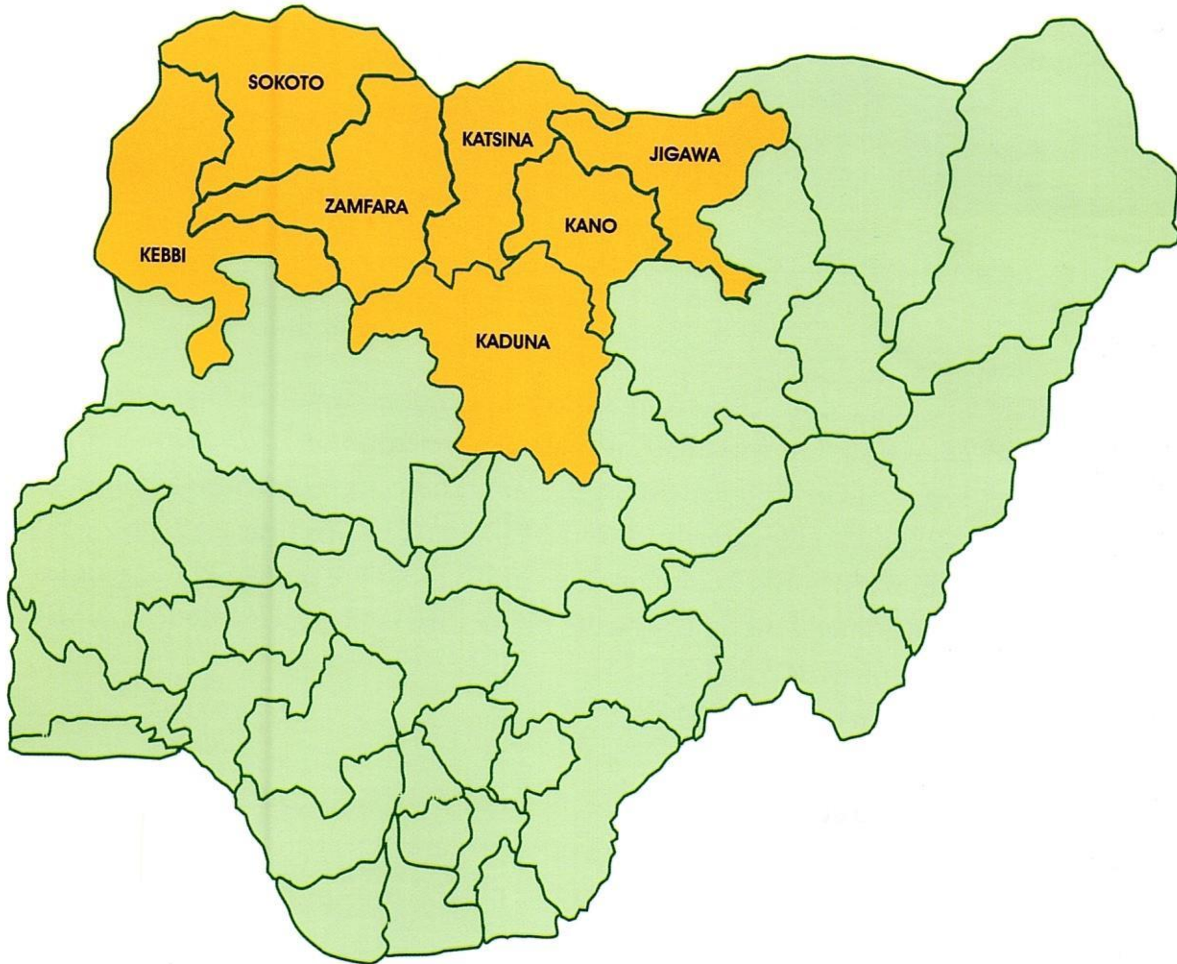
Funding Sources and Structure - 71%:

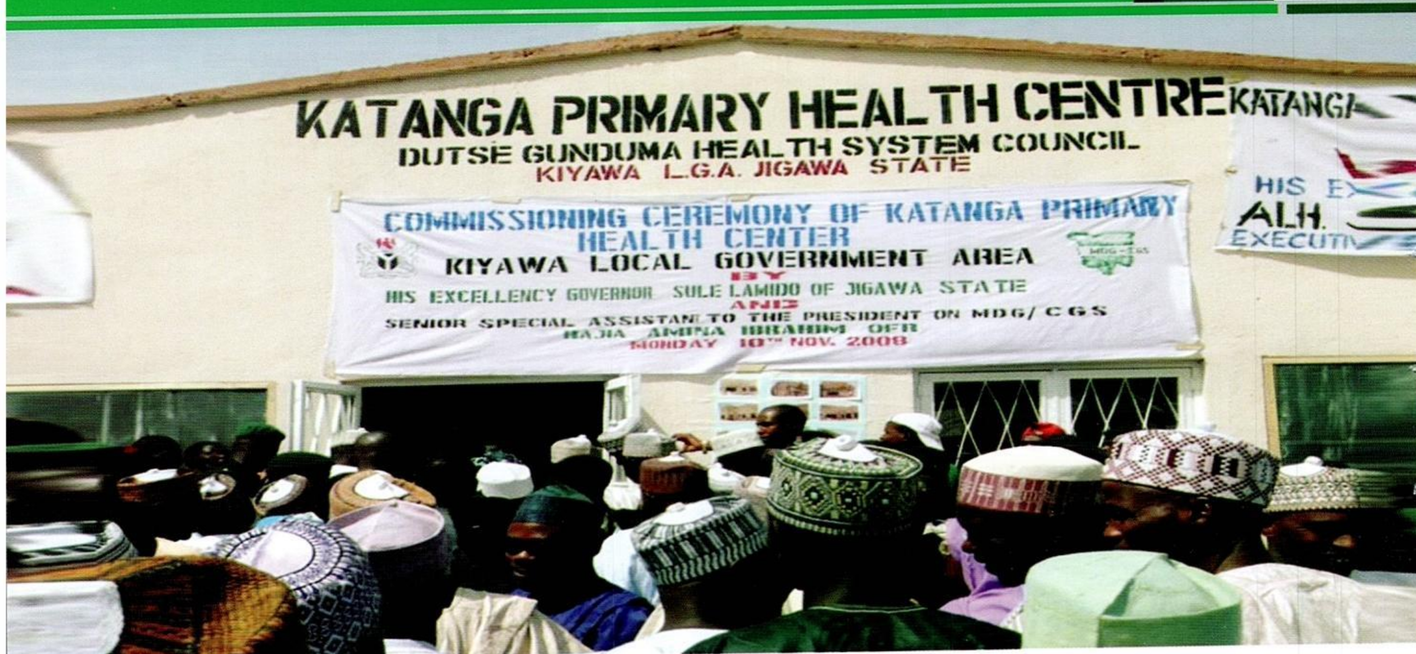
- Support LGHAs to open dedicated bank accounts
- Provide regular funding for health facilities to aid operational expenses and uninterrupted service delivery

Operational Guidelines - 33%:

- Develop SPHCB Operational Guidelines for all staff in the SPHCB and LGHAs
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB

NORTH WEST ZONE





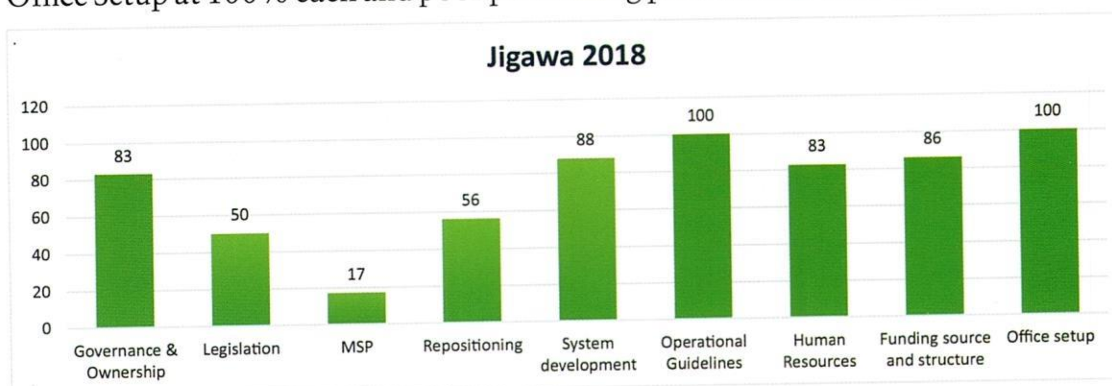
JIGAWA STATE (Overall Score 57%)

Background

Jigawa State was created in 1991 from Kano State and its capital is Dutse. It has a land mass of 22,410 sq. km with 2016 projected population of 5,828,200 (NPopC 2006). It has 27 Local Government Areas (LGAs). There are 614 health facilities in the State with 598 (97%) PHC facilities and 14 (2.3%) SHC facilities. 595 (99.5%) of the PHC facilities are public health facilities and 3 (1%) are private PHC facilities (NPHCDA 2015). Some of the State's health indices are IMR 83, U5MR 192, NMR 37 and U5 Stunting 66 (MICS 2016).

Main Findings

Jigawa State scored 57% in the PHCUOR Scorecard 4 assessment placing it in the 12th position nationwide. Its best performing pillars are Operational Guidelines and Office Setup at 100% each and poor performing pillar is MSP at 17%.



Governance & Ownership: 83%

- Jigawa SPHCB has a governing board and a management team. WDCs are available in the State.
- The governing board has no female member.

Legislation: 50%

- The SPHCB has a Law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 17%

- Jigawa SPHCB has not developed a costed and approved MSP document for PHC facilities in the State.
- There is no investment or service delivery plan.
- There is a decreasing trend in the number of U5 with stunting but an increasing trend in the number of institutional maternal deaths, still births, neonatal deaths and U5 deaths.

Repositioning: 56%

- FP/MCH/Nutrition and Immunization programmes and staff in the SMoH have been moved to the SPHCB.
- The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for its staff on the new roles and responsibilities of the SMoH.
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.

Systems Development: 88%

- SPHCB has developed key strategic documents such as Strategic health development plan, LGA PHC annual operational plan, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. At least one performance review has been conducted on the SPHCB in the past year. State has functional data quality assurance system, and has conducted a state-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.
- State has no annual PHC operational plan.

Operational Guidelines: 100%

- There is an administrative manual/operational guideline and a SPHCB-wide orientation has been conducted to familiarize staff at all levels with the SPHCB's mandate.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have been moved to the SPHCB.
- The SPHCB has staff nominal roll.
- There are job descriptions for all SPHCB and LGHA staff and positions.
- All PHC staff were onboarded on the new SPHCB's direction last year.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 86%

- SPHCB has a dedicated budget line and bank account. All PHC staff are on the SPHCB payroll. The LGHAs also have dedicated bank accounts and PHC budget performance is periodically tracked.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 83%:

- Include women and key stakeholders in the governing board

Legislation - 50%:

- Amend SPHCB Law to reflect clear oversight function of the SMoH on the SPHCB
- Develop regulations for the operationalization of the SPHCB Law

MSP - 17%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Develop an investment/service delivery plan using the one PHC per ward approach
- Incorporate investment plan in annual budget to address infrastructural and human resources gaps required to meet the MSP for PHC facilities

Repositioning - 56%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB Systems

Development - 88%:

- Develop PHC annual operational plan and other strategic documents to facilitate seamless implementation of PHC in the State
- Conduct at least two performance reviews of the PHC annual operational plan per annum

Human Resources - 83%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to support HRH strategic plan
- Conduct at least two performance reviews of the PHC annual operational plan per annum

Funding Sources and Structure - 86%:

- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery

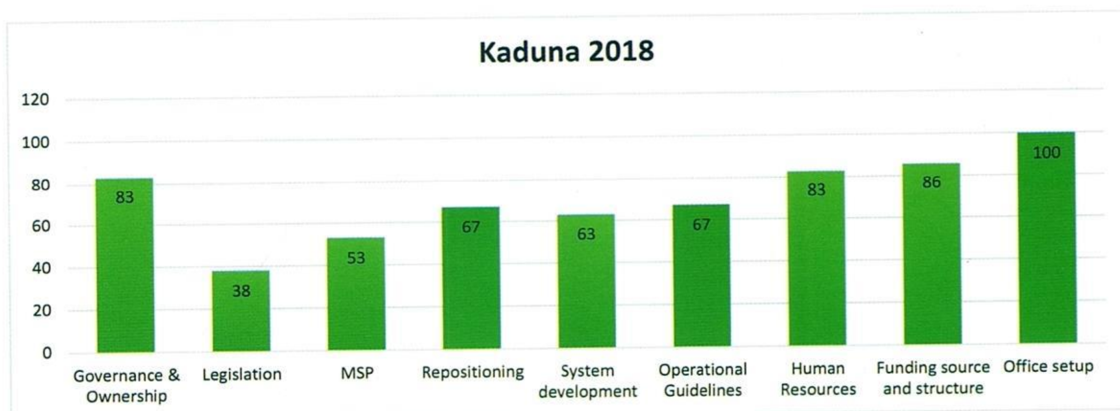
KADUNA STATE (Overall Score 66%)

Background

Kaduna State was created in 1967 and its capital is Kaduna. It has a land mass of 46,053 sq. km (NBS 2010) with 2016 projected population of 8,252,400 (NPopC 2006). It has 23 Local Government Areas (LGAs). There are 1,560 health facilities in the State: 1,523 (98%) are PHC facilities and 33 (2%) are SHC facilities. The PHC facilities are made up of 1,007 (66%) public health facilities and 516 (34%) private PHC facilities (NPHCDA 2015). Some of the state's health indices are IMR 66, U5MR 82, NMR 28 and U5 Stunting 47 (MICS 2016).

Main Findings

Kaduna State scored 66% in the PHCUOR Scorecard 4 assessment placing it in the 5th position nationwide. Its best performing pillars are Office Setup 100% and Funding Sources and Structure 86% and poor performing pillars are Legislation and MSP at 38% and 53% respectively.



Governance & Ownership: 83%

- Kaduna SPHCB has a governing board and a management team. WDCs are functional in the State.

Legislation: 38%

- The SPHCB has a Law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 53%

- Kaduna SPHCB has a costed and approved MSP document.
- Investment/service delivery plan is available but not captured in the annual budget.
- There is a decreasing trend in the number of institutional still births, neonatal deaths and U5 deaths but an increasing trend in the number of institutional maternal deaths and U5 with stunting.

Repositioning: 67%

- FP/MCH/Nutrition programmes and staff in the SMoH have been moved to the SPHCB.
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.

Systems Development: 63%

- SPHCB has developed key strategic documents such as Strategic health development plan, State and LGA PHC annual operational plans, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. At least one performance review has been conducted on the SPHCB in the past year. State has functional data quality assurance system, and has conducted a State-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.

Operational Guidelines: 67%

- SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB. There is administrative manual to standardize the administrative processes in the SPHCB.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have been moved to the SPHCB. SPHCB has staff nominal roll. There are job descriptions for all SPHCB and LGHA staff and positions. All PHC staff were on-boarded on the new SPHCB's direction last year.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 86%

- SPHCB has a dedicated budget line and bank account.
- All PHC staff are on the SPHCB payroll.
- The LGHAs also have dedicated bank accounts.
- PHC budget performance is periodically tracked and annual audit of the PHC income and expenditure for the preceding year was conducted.
- No PHC facility received regular operational funding in the last three months.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 83%:

- Include women and key stakeholders in the governing board

Legislation - 38%:

- Amend SPHCB law o To delineate roles and responsibilities of governing board from that of management team o To reflect clear oversight function of the SMoH on the SPHCB Develop regulations for the operationalization of the SPHCB Law

Repositioning - 67%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB

Systems Development - 63%:

- Conduct at least two performance reviews of the PHC annual operational plan per annum Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

- Improve HMIS facility reporting rate to>80%.

Human Resources - 83%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to support HRH strategic plan
- Conduct at least two performance reviews of the PHC annual operational plan per annum

Funding Sources and Structure - 86%:

- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery

KANO STATE
THE CENTER OF COMMERCE

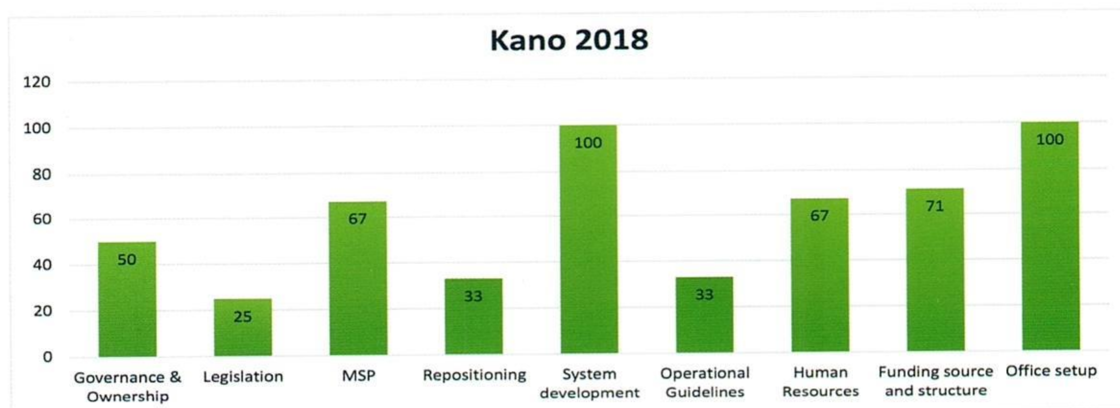
KANO STATE (Overall Score 57%)

Background

Kano State was created in 1967 and its capital is Kano. It has a land mass of 20,131sq. km with 2016 projected population of 13,076,900 (NPC 2006). It has 44 Local Government Areas (LGAs). There are 1,183 health facilities in the State with 1,142 (96%) PHC facilities and 39 (3.3%) SHC facilities. The PHC facilities are made up of 1,037 (91%) public health facilities and 105 (9%) private PHC facilities (NPHCDA 2015). Some of the State's health indices are IMR 112, U5MR203, NMR 69 and U5 Stunting 58 (MICS 2016).

Main Findings

Kano state scored 63% in the PHCUOR Scorecard 4 assessment placing it in the 8th position nationwide. Its best performing pillars are Systems Development and Office Setup at 100% each and poor performing pillars are Legislation 25%, Repositioning 33% and Operational Guidelines 33%.



Governance & Ownership: 50%

- Kano SPHCB has a management team.
- WDCs are available in the State.
- SPHCB does not have a governing board.
- LGA PHC departments have not transformed into LGHAs with established reporting line to the SPHCB.

Legislation: 25%

- The SPHCB Law is available; also regulations for the operationalization of the Law.

MSP: 67%

- Kano SPHCB has no costed and approved MSP document.
- There is a decreasing trend in the number of institutional maternal deaths, still births, neonatal deaths and U5 deaths but an increasing trend in the number of U5 with stunting.

Repositioning: 33%

- Only immunization programme has moved to the SPHCB.
- Malaria, HIV/AIDS, TBL and FP/MCH/Nutrition are yet to be transferred to the SPHCB.
- LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.
- The SMoH has not restructured its departments in line with SPHCB reforms.

Systems Development: 100%

- The SPHCB has developed key strategic documents such as Strategic health development plan, State and LGA PHC annual operational plans, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.
- At least one performance review has been conducted on the SPHCB in the past year.
- State has functional data quality assurance system, and has conducted a state-wide DQA in the previous year.
- Its HMIS facility reporting rate for the last 12 months is >80%.

Human Resources: 67%

- SPHCB staff were on-boarded on the new SPHCB's direction last year.
- No staff nominal roll, HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 71%

- SPHCB has a dedicated budget line and bank account.
- PHC staff are not on the SPHCB payroll.

Operational Guidelines: 33%

- SPHCB Operational Guidelines have not yet been developed.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 50%:

- Constitute and inaugurate SPHCB governing board in line with national guidelines
- Transform all LGA PHC departments to LGHAs with clear reporting line to the SPHCB.

Legislation - 25%:

- Amend SPHCB Law
    - To delineate roles and responsibilities of governing board from that of management team
    - To reflect clear oversight function of the SMoH on the SPHCB
    - To make provision for transfer of all PHC health facilities in the State to SPHCB
    - To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
    - To indicate different sources of PHC funding and expected contributions of the State and LGAs

MSP - 67%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 33%:

- Transfer all PHC programmes including Malaria HIV/AIDS, TBL, FP/MCH/Nutrition to the SPHCB Transform LGA PHC departments to LGHAs with definite reporting lines to the SPHCB
- The SMoH should restructure its departments in line with SPHCB reforms.

Human Resources - 67%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan
- Develop staff nominal roll

Funding Sources and Structure - 71%:

- Include all PHC staff on SPHCB payroll
- Provide regular funding for health facilities to cover operational expenses and provide integrated service

Operational Guidelines - 33%:

- Develop SPHCB Operational Guidelines
- Conduct a SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB

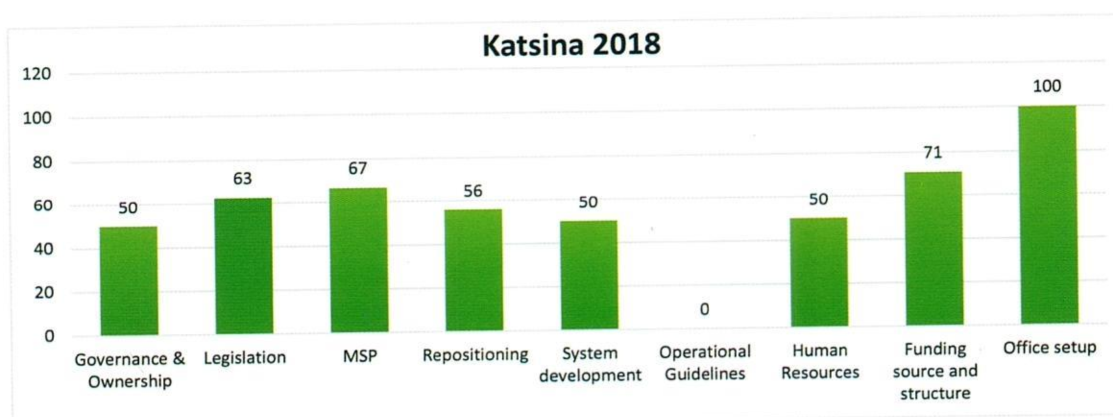
KATSINA STATE (Overall Score 62%)

Background

Katsina State was created in 1987 from Kaduna State and its capital is Katsina. It has a land mass of 24,971 sq. km, with 2016 projected population of 7,831,300 (NPopC 2006). It has 34 Local Government Areas (LGAs). There are 1,496 health facilities in the State with 1,463 (98%) PHC facilities and 32 (2%) SHC facilities. The PHC facilities are made up of 1,418 (86%) public health facilities and 45 (3.1) private PHC facilities (NPHCDA 2015). Some of the State's health indices are IMR 68, U5MR 135, NMR 35 and U5 Stunting 61 (MICS 2016).

Main Findings

Katsina State scored 62% in the PHCUOR Scorecard 4 assessment placing it in the 9th position nationwide. Its best performing pillar is Office Set-up (100%) and poor performing pillar is Operational Guidelines (0%).



Governance & Ownership: 50%

- Katsina SPHCB has a governing board and a management team.
- PHC LGA departments have not transformed into LGHAs with established reporting line to the SPHCB.
- WDCs are available and functional in the State.

Legislation: 63%

- The SPHCB Law exists. The Law makes provision for the transfer of all PHC facilities in the State to the SPHCB, provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB and indicates the different sources of funding and expected contributions from the State and LGAs.
- No regulations have been developed for the operationalization of the SPHCB Law.

MSP: 67%

- Katsina SPHCB has not developed a costed and approved MSP document for PHC facilities in the State.
- There is no investment or service delivery plan.
- There is a decreasing trend in the number of institutional still births, neonatal deaths, U5 deaths and U5 stunting but an increasing trend in the number of institutional maternal deaths.

Repositioning: 56%

- PHC department, programmes and staff in the SMoH have been moved to the SPHCB. The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.

Systems Development: 50%

- The SPHCB has developed key strategic documents such as PHC annual operational plan.
- State has functional data quality assurance system and has conducted a state-wide DQA in the previous year.

- Its HMIS facility reporting rate for the last 12 months is >80%.
- SPHCB has no strategic health development plan, LGA PHC annual operational plan, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.
- Performance review has not been conducted on SPHCB in the last one year.

Human Resources: 50%
- Job descriptions available for all SPHCB staff and positions.
- SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 71%
- SPHCB has a dedicated budget line and bank account.
- All SPHCB staff are on the SPHCB payroll.
- PHC budget performance is periodically tracked and annual audit of the PHC income and expenditure for the preceding year was conducted.

Operational Guidelines: 0%
- SPHCB has not developed Operational Guidelines for staff.

Office Setup: 100%
- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 50%:
- Include women and key stakeholders in the governing board

Legislation - 63%:
- Amend SPHCB Law to delineate roles and responsibilities of governing board from that of management team
- Develop regulations for the operationalization of the SPHCB Law

MSP - 67%:
- Develop a costed and approved MSP document for PHC facilities in the State

- Incorporate investment plan in annual budget to address infrastructural, HRH gaps required to meet the MSP for PHC facilities

Repositioning - 56%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB

Human Resources - 50%:

- Transfer all PHC staff in LGAs to the SPHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to support HRH strategic plan
- Onboard all staff on the mandate, mission and vision of the SPHCB.

Funding Sources and Structure - 71%:

- Support LGHAs to open dedicated bank accounts
- Provide regular funding for health facilities to cover operational expenses and uninterrupted PHC service delivery

Operational Guidelines - 0%:

- Distribute PHCUOR manual to all staff and LGHAs
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the agency
- Develop administrative manual to standardize administrative processes of the SPHCB

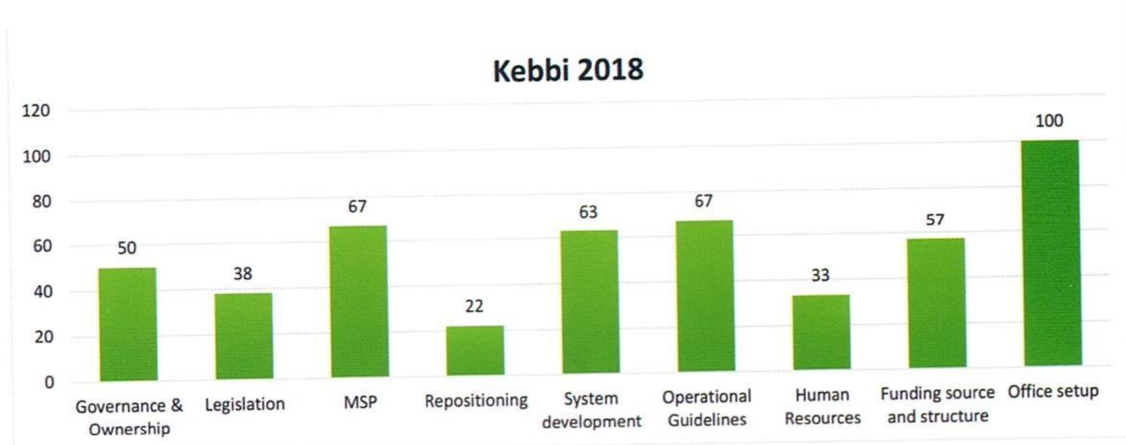
KEBBI STATE (Overall Score 54%)

Background

Kebbi State was created in 1991 from Sokoto state and its capital is Birnin Kebbi. It has a land mass of 37,699 sq. km with 2016 projected population of 4,440,000 (NPC 2006). It has 21 Local Government Areas (LGAs). There are 412 health facilities in the State with 380 (92%) PHC facilities and 31(8%) SHC facilities. The PHC facilities are made up of 375 (97%) public health facilities and 5 (1%) private PHC facilities (NPHCDA 2015). Some of the State's health indices are IMR 111, U5MR 174, neonatal deaths 55 and U5 Stunting 60 (MICS 2016).

Main Findings

Kebbi State scored 54% in the PHCUOR Scorecard 4 assessment placing it in the 15th position nationwide. It performed highly in Office Setup at 100% and poorly in Legislation (38%), Repositioning (22%) and Human Resources (33%).



Governance & Ownership: 50%

- Kebbi SPHCB has a management team.
- WDCs are available in the State not functional.
- SPHCB does not have a governing board.
- LGA PHC departments have not transformed into LGHAs with established reporting line to the SPHCB.

Legislation: 38%

- Kebbi SPHCB has a Law establishing it.
- SPHCB Law lacks provision for key requirements for full implementation of PHCUOR.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 67%

- Kebbi SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan. Therefore, investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional still births, neonatal deaths, U5 deaths and U5 stunting but an increasing trend in the number of institutional maternal deaths.

Repositioning: 22%

- Only immunization programme has been moved from the SMoH to the SPHCB.
- Other PHC programmes including FP/MCH/Nutrition, Malaria, HIV/AIDS and TBL are yet to move to the SPHCB from the SMoH.
- LGA PHC departments have not transformed into LGHAs with definite reporting lines to the SPHCB.
- SMoH has not restructured its departments in line with SPHCB reforms.

Systems Development: 63%

- State has functional data quality assurance system, and has conducted a state-wide DQA in the previous year.
- Its HMIS facility reporting rate for the last 12 months is >80%.
- Kebbi SPHCB has not developed key strategic documents such as SPHCB and LGA PHC annual operational plans, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.

- Kebbi SPHCB has no strategic health development plan, M&E/results/ performance framework with clear milestones and targets.
- Performance review has not been conducted on SPHCB in the last one year.

Human Resources: 50%

- There are job descriptions for all SPHCB staff and positions.
- PHC staff in the LGAs, SMoLG and LGSC have not moved to the SPHCB. There is no staff nominal roll. There is no HR plan for the strategic management of PHC HRH and staff are yet to be on-boarded.

Funding Sources and Structure: 57%

- SPHCB has a dedicated budget line and bank account.
- PHC staff are not on the SPHCB payroll.
- None of the PHC facilities received regular operational funding in the last three months.

Operational Guidelines: 67%

- SPHCB Operational Guidelines not yet developed.
- SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 50%:

- Constitute and inaugurate SPHCB governing board in line with the national guidelines
- Ensure all LGA PHC departments transform into LGHAs with clear lines of reporting to the SPHCB
- Reactivate WDCs to strengthen health governance at ward level

Legislation - 38%:

- Amend SPHCB law
    - To reflect clear oversight function of the SMoH on the SPHCB

- To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
- To indicate different sources of PHC funding and expected contributions from the State and LGAs Develop regulations for the operationalization of the SPHCB Law

MSP - 67%:
- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 22%:
- Transfer all PHC staff and programmes including Malaria, HIV/AIDS and TBL to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHC
- SMoH should restructure its departments in line with SPHCB reforms

Systems Development– 63%:
- SPHCB to develope key strategic documents such as SPHCB and LGA PHC annual operational plans, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule, strategic health development plan, M&E /results/performance framework with clear milestones and targets for the SPHCB
- Conduct at least one performance review on the SPHCB per annum

Human Resources - 50%:
- Transfer all PHC staff in LGAs to the SPHCB
- Develop staff nominal roll
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to complement HRH strategic plan
- Onboard all staff on the mandate, mission and vision of the SPHCB

Funding Sources and Structure - 57%:

- Include all PHC staff on the SPHCB payroll
- Provide regular funding for health facilities to cover operational expenses and provide integrated service delivery
- Conduct periodic tracking of PHC budget performance

Operational Guidelines - 67%:

- Develop SPHCB Operational Guidelines and conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the agency

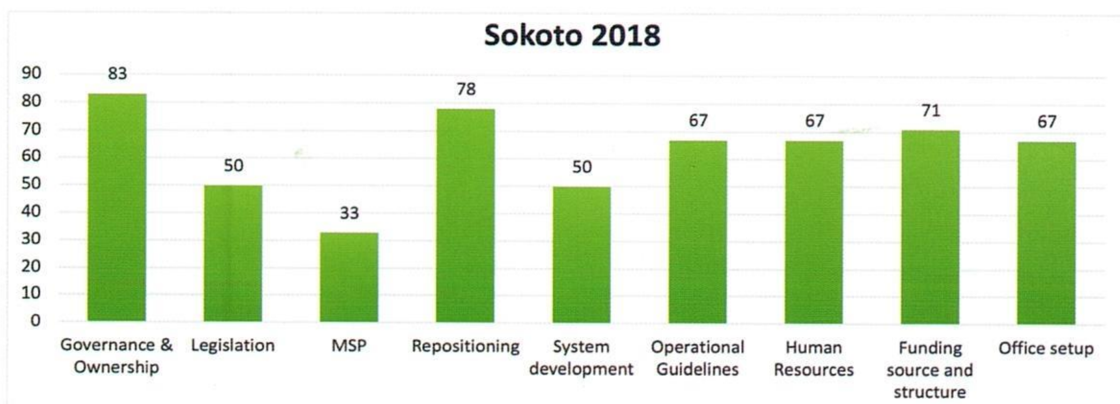
SOKOTO STATE (Overall Score 56%)

Background

Sokoto State was created in 1976 and its capital is Sokoto. It has a land mass of 25,973 sq. km with 2016 projected population of 4,998,100 (NPC 2006). It has 23 Local Government Areas (LGAs). There are 713 health facilities in the State with 668 (94%) PHC facilities and 43 (6%) SHC facilities. All PHC facilities are public. Some of the State's health indices are IMR 51, U5MR 119, NMR 28 and U5 Stunting 61 (MICS 2016).

Main Findings

performing pillar is Governance and Ownership at 83% and poor performing pillar is Legislation 33%.



Governance & Ownership: 83%

- Sokoto SPHCB has a governing board and a management team.

Legislation: 50%

- Sokoto SPHCB Law exists with regulations for the operationalization of the Law

MSP: 33%

- Sokoto SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.
- There is a decreasing trend in the number of institutional still births and U5 stunting but an increasing trend in the number of institutional maternal deaths, neonatal deaths and U5 deaths.

Repositioning: 78%

- FP/MCH/Nutrition and Immunization programmes and staff in the SMoH have moved to the SPHCB.
- PHC departments have not transformed into LGHAs with definite reposting lines to the SPHCB.
- Malaria, HIV/AIDS and TBL programmes are yet to move to the SPHCB.

Systems Development: 50%

- The SPHCB has developed key strategic documents such as strategic health development plan.
- Performance review has been conducted on the SPHCB in the last one year.
- State has functional data quality assurance system, and has conducted a state-wide DQA in the previous year.
- Its HMIS facility reporting rate for the last 12 months is >80%.
- No SPHCB and LGA PHC annual operational plans, M&E/results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.

Human Resources: 67%

- SPHCB has no staff nominal roll and HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 57%

- SPHCB has a bank account.

- SPHCB has no dedicated budget line.
- No PHC facilities received regular operational funding in the last three months.

Operational Guidelines: 67%

- SPHCB Operational Guidelines not yet developed

Office Setup: 67%

- The SPHCB has a physical office but lack requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 83%:

- Reconstitute the governing board to include women and other key stakeholders as contained in the national guidelines

Legislation - 50%:

- Amend SPHCB law
    - o To reflect clear oversight function of the SMoH on the SPHCB
    - o To include provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
    - o To indicate different sources of PHC funding and expected contributions from the State and LGAs.
- Develop regulations for the operationalization of the SPHCB Law

MSP - 33%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 78%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB

Systems Development– 50%:

- Develop PHC annual operational plan incorporating the LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

- Develop ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule

Human Resources - 67%:

- Develop staff nominal roll
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan

Funding Sources and Structure - 71%:

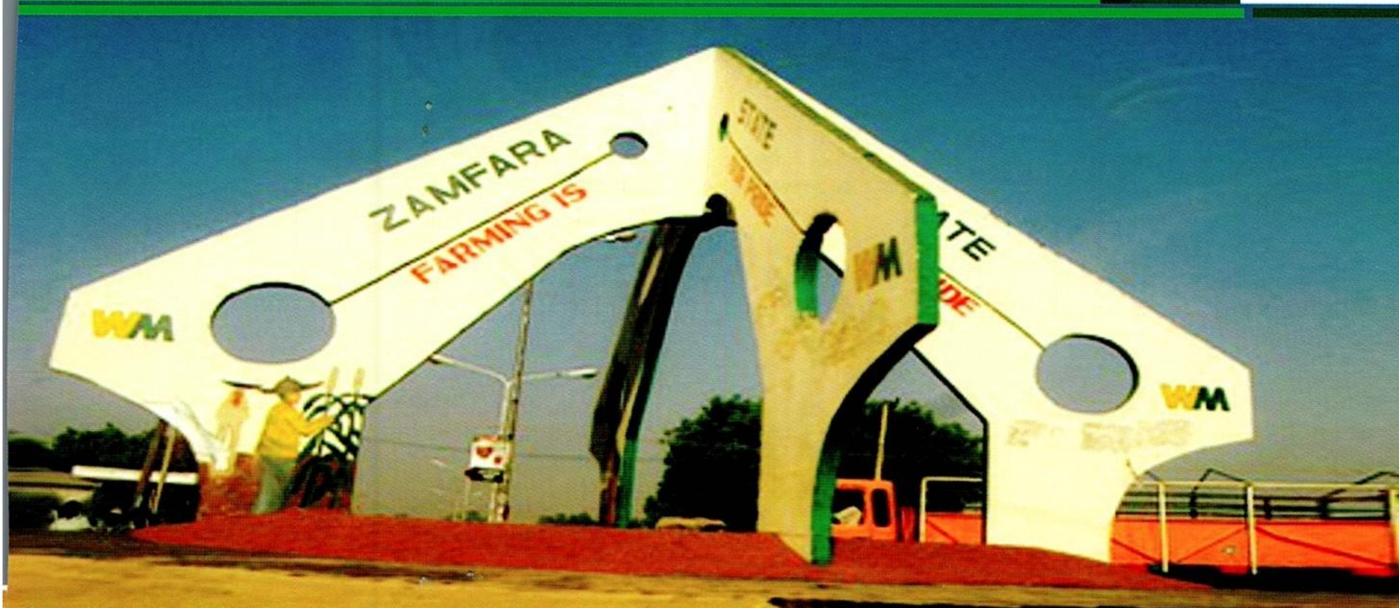
- Establish a dedicated budget line for SPHCB in the state annual budgets
- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery

Operational Guidelines - 67%:

- Develop SPHCB Operational Guidelines for all SPHCB staff and LGHAs staff

Office Setup – 67%:

- Provide requisite amenities and equipment such as power, water, computer, furniture, internet access and printer in SPHCB office building.



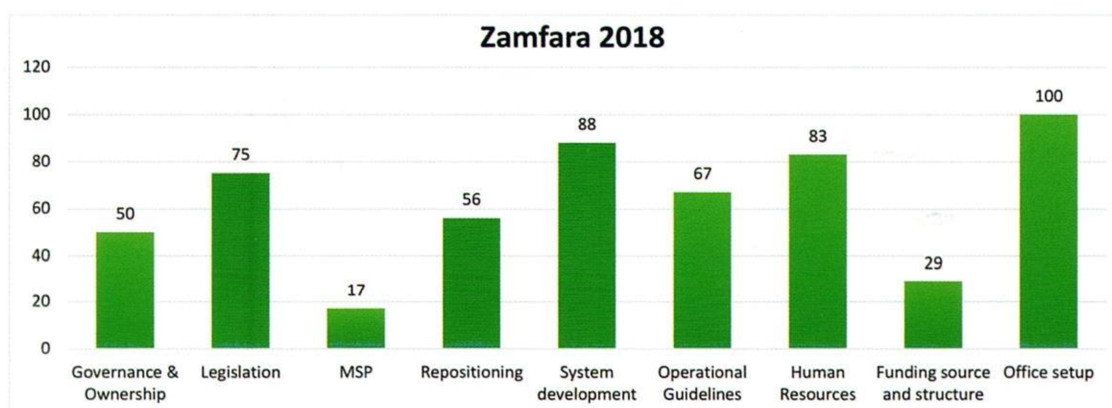
ZAMFARA STATE (Overall Score 43%)

Background

Zamfara State was created in 1996 and its capital is Gusau. It has a land mass of 38,418 sq. km with 2016 projected population of 4,515,400 (NPC 2006). It has 14 Local Government Areas (LGAs). There are 697 health facilities in the State with 677 (97%) PHC facilities and 19 (3%) SHC facilities. Among the PHC facilities, 664 (98%) are public health facilities and 13 (2%) are private health facilities. Some of the state indices are IMR 104, U5MR 210, NMR 53 and U5 Stunting 56 (MICS 2016).

Main Findings

Zamfara State scored 43% in the PHCUOR Scorecard 4 assessment placing it in the 21stposition nationwide. Its best performing pillars are Systems Development 88% and Office Setup 100%, and poor performing pillars are MSP 17% and Funding Source and Structure 29%.



Governance & Ownership: 50%

- Zamfara SPHCB has a management team.
- SPHCB has no governing board.
- LGHAs not yet established

Legislation: 75%

- Zamfara SPHCB has a Law establishing it and regulations for the operationalization of the Law.

MSP: 17%

- Zamfara SPHCB has no costed and approved MSP document for the PHC facilities in the State.
- There is no investment or service delivery plan.
- There is a decreasing trend in the number of institutional maternal deaths but an increasing trend in the number of institutional still births, neonatal deaths, U5 deaths and U5 stunting.

Repositioning: 56%

- FP/MCH/Nutrition and Immunization programmes and staff in the SMoH have moved to the SPHCB.
- SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.
- LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.

Systems Development: 88%

- SPHCB has developed key strategic documents including strategic health development plan, State and LGA PHC annual operational plans, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system and has conducted a State-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.

- SPHCB does not have M&E /results/performance framework with clear milestones and targets.

Human Resources: 83%

- SPHCB staff have been on-boarded. There are job descriptions for all SPHCB staff and positions.
- SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 29%

- SPHCB has a dedicated budget line and bank account.
- SPHCB staff are not on the SPHCB payroll.
- PHC facilities did not receive regular operational funding in the last three months.

Operational Guidelines: 67%

- SPHCB Operational Guidelines has not yet been developed.

Office Setup: 67%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 50%:

- Constitute and inaugurate governing body inclusive of women and key stakeholders as recommended in the national guidelines
- Form/reactivate WDCs to strengthen health governance at ward level

Legislation - 75%:

- Amend SPHCB Law
    - To delineate roles and responsibilities of governing board from that of management team
    - To reflect clear oversight function of the SMoH on the SPHCB

MSP - 17%:

- Develop a costed and approved MSP document for PHC facilities in the State

- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 56%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB

Systems Development – 88%:

- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

Human Resources - 83%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan

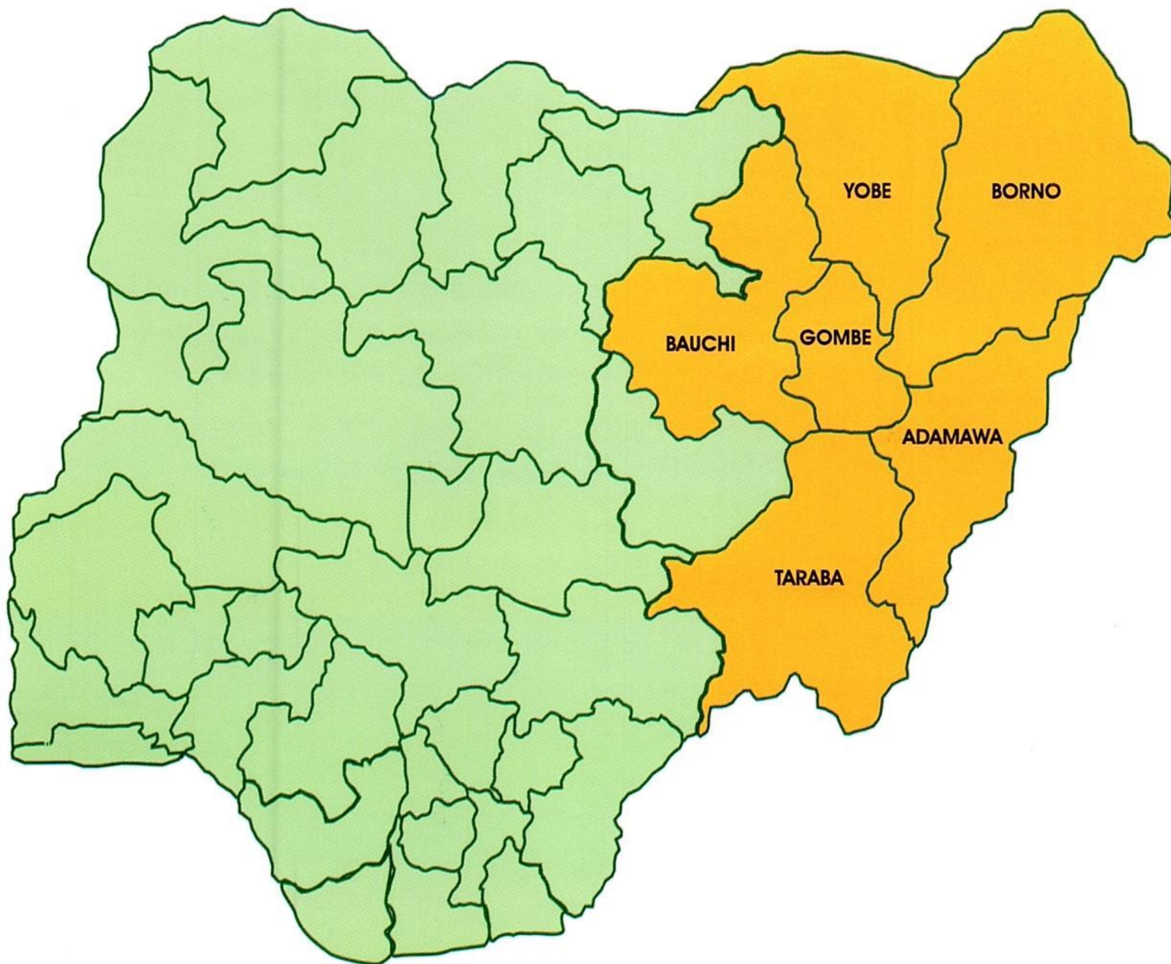
Funding Sources and Structure - 29%:

- Include PHC staff on the SPHCB payroll
- Support LGHAs when established to open dedicated bank accounts
- Conduct periodic tracking of PHC budget performance
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery

Operational Guidelines - 67%:

- Develop SPHCB Operational Guidelines for all staff

NORTH EAST ZONE



ADAMAWA STATE
MINISTRY OF HEALTH

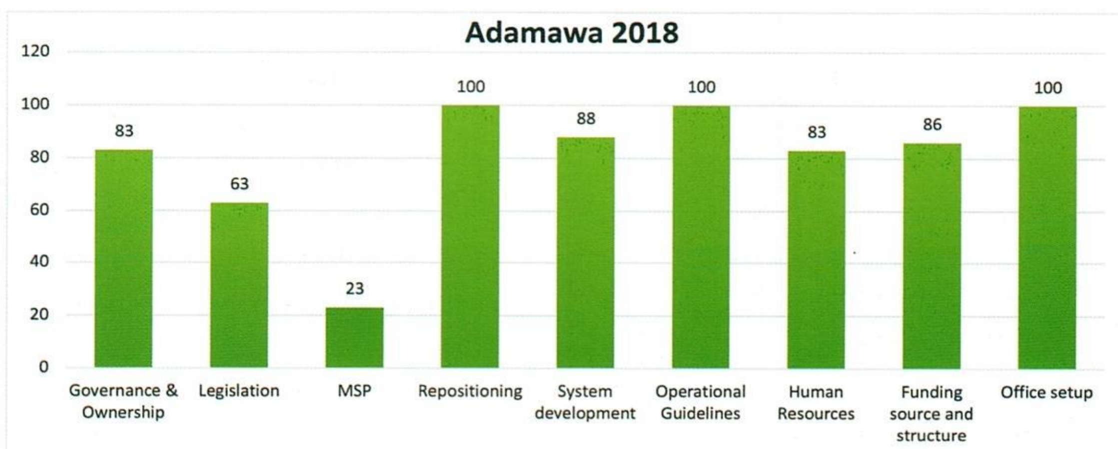
ADAMAWA STATE (Overall Score 65%)

Background

Adamawa State was created in 1991 and its capital is Yola. It has a land mass of 36,917 sq. km with 2016 projected population of 4,248,400 (NPopC 2006). It has 21 Local Government Areas (LGAs). There are 1,027 health facilities in the State of which 998 (97%) are PHC facilities. Some of the State's health indices are IMR49, U5MR 84, NMR 21 and U5 Stunting 38 (MICS 2016).

Main Findings

Adamawa State scored 65% in the PHCUOR Scorecard 4 assessment placing it in the 6th position nationwide. Its best performing pillars are Repositioning, Operational Guidelines and Office Setup at 100% each and poor performing pillar is MSP 23%.



Governance & Ownership: 83%

- Adamawa SPHCB has a governing board and a management team.
- LGHAs have been established for all LGAs.
- WDCs are available in the State.

Legislation: 63%

- Adamawa SPHCB has a law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 23%

- Adamawa SPHCB has a costed and approved MSP document which provides MNCH services although it is not classified as free. Health facilities have been classified based on identified typology in the MSP.
- There is no investment or service delivery plan or budget line for investment/service delivery plan in the annual budget. There is an increasing trend in the number of institutional maternal deaths, still births, neonatal deaths, U5 deaths and U5 stunting.

Repositioning: 100%

- All PHC department, programmes and staff in the SMoH have moved to the SPHCB. LGA PHC departments have been transformed to LGHAs with definite reporting lines to the SPHCB.
- The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.

Systems Development: 88%

- SPHCB has developed key strategic documents which include LGA PHC annual operational plans, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.
- Performance review has been conducted on SPHCB in the last one year. State has functional data quality assurance system, and has conducted a State-wide DQA in the previous year.
- Its HMIS facility reporting rate for the last 12 months is >80%.
- SPHCB has no PHC annual operational plan.

Human Resources: 83%

- All PHC staff in the LGAs, SMoLG and LGSC have been moved to the SPHCB and on-boarded. There are job descriptions for all SPHCB and LGHA staff and positions. The SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 86%

- The SPHCB has a bank account. All PHC staff are on the SPHCB payroll. The LGHAs have dedicated bank accounts. PHC budget performance is periodically tracked and annual audit of the PHC income and expenditure for the preceding year was conducted.
- SPHCB has no dedicated budget line.

Operational Guidelines: 100%

- There is administrative manual for the SPHCB and a SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 83%:

- Include women and key stakeholders in the governing board

Legislation - 63%:

- Amend SPHCB law o To delineate roles and responsibilities of governing board from that of management team o To reflect clear oversight function of the SMoH on the SPHCB Develop regulations for the operationalization of the SPHCB Law

MSP - 23%:

- Develop investment/service delivery plan and incorporate the plan in state annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Systems Development – 88%:
- Develop PHC annual operational plan incorporating the LGA PHC annual plans.

Human Resources - 83%:
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition   Develop functional HRIS to guide HRH strategic plan

Funding Sources and Structure - 86%:
- Establish a dedicated budget line for the SPHCB in the State budget
- Provide regular funding for health facilities to cover operational expenses and uninterrupted service delivery

Bauchi State Government

. . . the pearl of tourism!

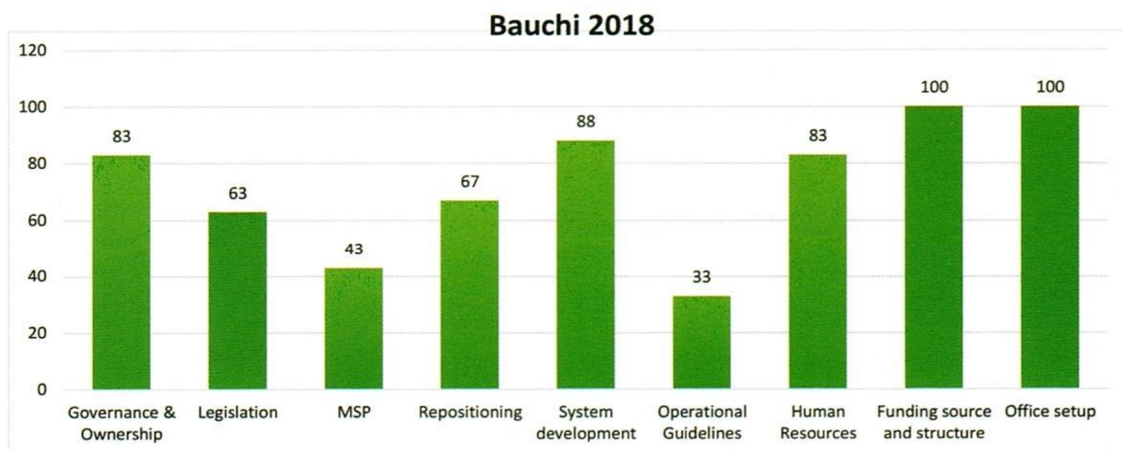
BAUCHI STATE (Overall Score 70%)

Background

Bauchi State was created in 1976, its capital is Bauchi. It has a land mass of 49,119 sq. km with 2016 projected population of 6,537,300 (NPC 2006). It has 20 Local Government Areas (LGAs). There are 1,034 health facilities in the State. 1,010 (98%) are PHC facilities. 960 (95%) of the PHC facilities are public health facilities and 50 (5%) are private health facilities (NPHCDA 2015). Some of the State's indices are IMR 81, U5MR 161, NMR 41 and U5 Stunting 65 (MICS 2016).

Main Findings

Bauchi State scored 70% in the PHCUOR Scorecard 4 assessment placing it in the 3rd position nationwide. It performed highly in Systems Development 88%, Funding Source and Structure and Office Setup at 100% each and poorly in Operational Guidelines 33% and MSP 43%.



Governance & Ownership: 83%

- Bauchi SPHCB has a governing board and a management team.

Legislation: 63%

- The SPHCB has a Law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 43%

- Bauchi SPHCB has a costed and approved MSP document that runs from 2017-2021.
- Health facilities have been classification based on the typology in the MSP.
- There is investment/service delivery plan.
- Investment/service delivery plan is not captured in the State annual budget.
- There is a decreasing trend in the number of under five with stunting but an increasing trend in the number of institutional maternal deaths, still births, neonatal deaths and U5 deaths.

Repositioning: 67%

- PHC department, programmes (FP/MCH/Nutrition and Immunization) and staff in the SMoH have moved to the SPHCB. LGA PHC departments have transformed into LGHAs with definite reporting lines to the SPHCB. The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.

Systems Development: 88%

- SPHCB has developed key strategic documents such as strategic health development plan, LGA PHC annual operational plan, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.
- Performance review has been conducted on SPHCB in the last one year.
- State has functional data quality assurance system, and has conducted a State-wide DQA in the previous year.
- Its HMIS facility reporting rate for the last 12 months is >80%.
- SPHCB has no PHC annual operational plan.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have not been moved to the SPHCB and on-boarded. There are job descriptions for all SPHCB staff and positions. SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 100%

- SPHCB has a dedicated budget line and bank account.
- SPHCB staff are on the SPHCB payroll.
- LGHAs have dedicated bank accounts.
- PHC budget performance is periodically tracked, and annual audit of the PHC income and expenditure for the preceding year was conducted.
- No PHC facility received regular operational funding in the last three months.

Operational Guidelines: 33%

- SPHCB has not developed Operational Guidelines and a SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 83%:

- Include women and other stakeholders in the governing board

Legislation - 63%:

- Amend SPHCB Law to delineate roles and responsibilities of governing board from that of management team
- Develop regulations for the operationalization of the SPHCB Law

MSP - 43%:

- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHCs

Repositioning - 67%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB

Systems Development – 88%:

- Develop PHC annual operational plan incorporating the LGA PHC annual plans

Human Resources - 83%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to guide HRH strategic plan

Operational Guidelines - 33%:

- Develop SPHCB Operational Guidelines for all SPHCB and LGHAs staff
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB

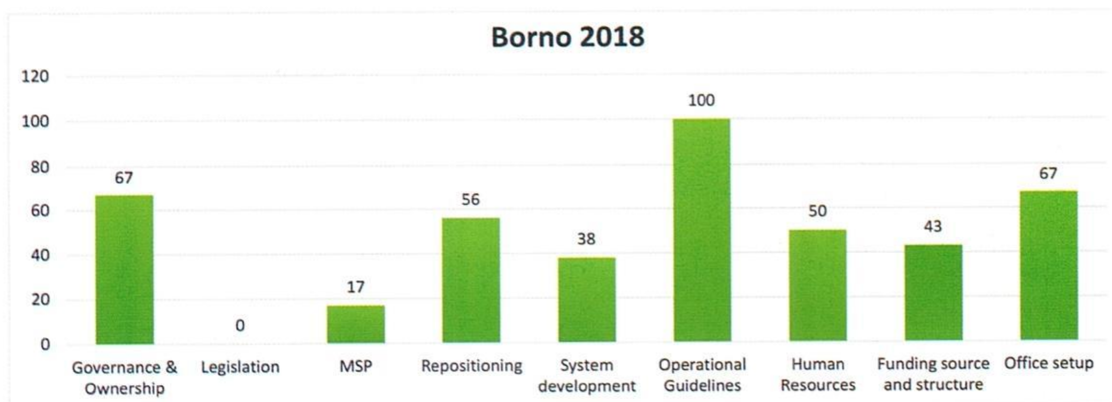
BORNO STATE (Overall Score 35%)

Background

Borno State was created in 1976 and its capital is Maiduguri. It has a land mass of 57,799 sq. km (NBS 2010) with 2016 projected population of 5,860,200 (NPopC 2006). It has 27 Local Government Areas (LGAs). There are 474 health facilities in the state. 421 (89%) are PHC facilities while 52 (11%) are SHC facilities. 409 (97%) of the PHC facilities are public health facilities and 12 (3%) are private health facilities. Some of the State's health indices are IMR 42, U5MR 82, NMR 26 and U5 Stunting 45 (MICS 2016).

Main Findings

Borno State scored 35% in the PHCUOR Scorecard 4 assessment placing it in the 26th position nationwide. Its best performing pillar is Operational Guidelines 100% and poor performing pillars include Legislation 0%, MSP 17%, Systems Development 38% and Funding Sources and Structure 43%.



Governance & Ownership: 67%

- Borno SPHCB has a management team.
- SPHCB has no governing board.

Legislation: 0%

- Borno SPHCB Law was not available during the assessment.

MSP: 17%

- Borno SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.
- Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional maternal deaths but an increasing trend in the number of institutional still births, neonatal deaths, U5 deaths and U5 stunting.

Repositioning: 56%

- PHC department, programmes including FP/MCH/Nutrition and Immunization and staff in the SMoH have been moved to the SPHCB. The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.
- LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB

Systems Development: 38%

- SPHCB has developed key strategic documents including strategic health development plan. Performance review has been conducted on SPHCB in the last one year. State has functional data quality assurance system and has conducted a state-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.
- SPHCB has no State or LGA PHC annual operational plans, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.

Human Resources: 50%

- There are job descriptions for all SPHCB staff and positions.

- SPHCB has staff nominal roll.
- No HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 43% SPHCB has a dedicated bank account.
- •SPHCB has no dedicated budget line.
- •SPHCB staff are not on the SPHCB payroll.

Operational Guidelines: 100%
- SPHCB Operational Guidelines have not been developed.

Office Setup: 67%
- The SPHCB has a physical office without requisite amenities and equipment such as power, water, computers, furniture, internet access and printer

Required Actions

Governance & Ownership - 67%:
- Constitute and inaugurate governing board according to national guidelines

Legislation - 0%:
- Develop, pass and assent Law to legalize and empower the existence of the SPHCB The SPHCB Law should:
    - Delineate roles and responsibilities of governing board from that of management team
    - Reflect clear oversight function of the SMoH on the SPHCB
    - Make provision for the transfer of all PHC health facilities in the state to the SPHCB
    - Make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
    - Indicate the different sources of PHC funding and expected contributions from the State and LGAs
- Develop regulations for the operationalization of the SPHCB Law

MSP - 17%:
- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 56%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB

Systems Development– 38%:

- Develop PHC annual operational plan incorporating LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Develop ISS checklist, list of ISS team (including State and LGA members), and supervisory schedule
- Establish functional data quality assurance system and conduct periodic state-wide DQA

Human Resources - 50%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan
- Develop staff nominal roll

Funding Sources and Structure - 43%:

- Establish dedicated budget line for SPHCB
- Include staff on the SPHCB payroll
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and provide integrated service delivery

Office Setup – 67%

- Provide requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

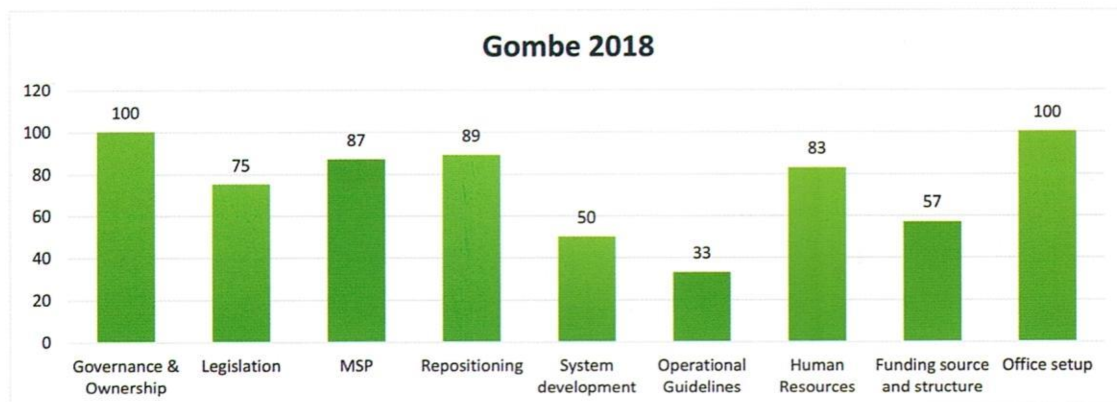
GOMBE STATE (Overall Score 76%)

Background

Gombe State was created in 1996 and its capital is Gombe. It has a land mass of 20,265 sq. km (NBS 2010) with 2016 projected population of 3,257,000 (NPopC 2006). It has 11 Local Government Areas (LGAs). There are 531 health facilities in the State. 508 (96%) are PHC facilities. 447 (88%) of the PHC facilities are public health facilities and 61 (12%) are private health facilities. Some of the State's health indices are IMR 90, U5MR 162, NMR 35 and U5 Stunting 54 (MICS 2016).

Main Findings

Gombe State scored 76% in the PHCUOR Scorecard 4 assessment placing it in the 1st position nationwide. Its best performing pillars include Governance and Ownership and Office Setup at 100% each, MSP 87%, Repositioning 89%, HR 83% and poor performing pillar is Operational Guidelines 33%.



Governance & Ownership: 100%

- Gombe SPHCB has a governing board and a management team.
- WDC are available.

Legislation: 75%

- Gombe SPHCB has a law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 87%

- Gombe SPHCB has a costed MSP document but it is unclear if the MSP is approved.
- There is no investment or service delivery plan. Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional maternal deaths, still births, neonatal deaths, U5 deaths and U5 stunting.

Repositioning: 89%

- PHC department, programmes (Malaria, HIV/AIDS, TBL, FP/MCH/Nutrition and Immunization) and staff in the SMoH have moved to the SPHCB. SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- LGA PHC departments have not transformed into LGHAs with definite reporting lines to the SPHCB.

Systems Development: 50%

- SPHCB has developed key strategic documents such as strategic health development plan, LGA PHC annual operational plan, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule.
- It has functional data quality assurance system, and has conducted a State-wide DQA in the previous year.
- SPHCB has no PHC annual operational plan, M&E /results/performance framework with clear milestones and targets. Performance review has not been conducted on SPHCB in the last one year.
- Its HMIS facility reporting rate for the last 12 months is <80%.

Operational Guidelines: 33%

- No SPHCB Operational Guidelines developed and SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate, vision and mission of the SPHCB.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have moved to the SPHCB and on-boarded. There are job descriptions for all SPHCB staff and positions. SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 53%

- SPHCB has a dedicated budget line and bank account. SPHCB staff are on the SPHCB payroll. Annual audit of the PHC income and expenditure for the preceding year was conducted.
- No PHC facility received regular operational funding in the last three months.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printe

Required Actions

Legislation - 75%:

- Amend SPHCB Law
    - To delineate roles and responsibilities of governing board from that of management team
    - To reflect clear oversight function of the SMoH on the SPHCB

MSP - 87%:

- Develop investment/service delivery plan and incorporate it in the state annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 89%:

- Transform LGA PHC departments into LGHAs with established reporting line to the SPHCB

Systems Development– 50%:

- Develop PHC annual operational plan incorporating LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Conduct periodic performance review of the SPHCB
- Improve HMIS monthly facility reporting rate to >80%

Human Resources - 83%:

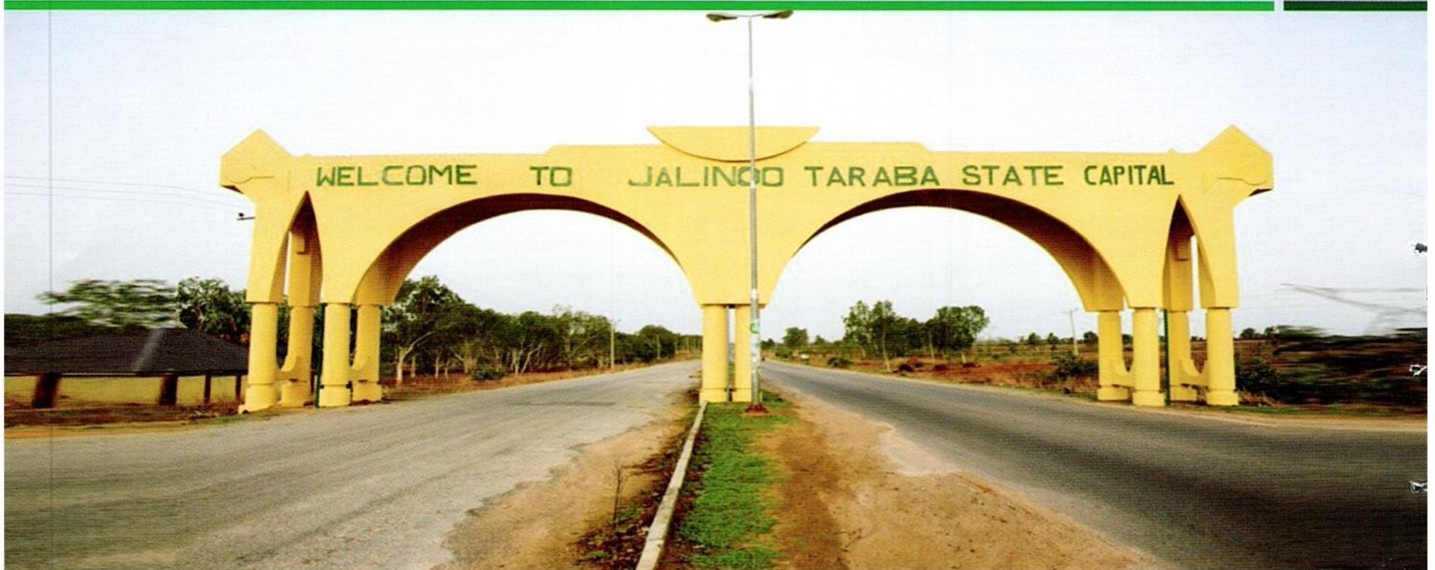
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to guide HRH strategic plan

Funding Sources and Structure - 57%:

- Support LGHAs when established to open dedicated bank accounts
- Provide regular funding for health facilities to cover operational expenses and uninterrupted service delivery
- Conduct periodic tracking of PHC budget performance

Operational Guidelines - 33%:

- Develop Operational Guidelines for all SPHCB staff and LGHAs
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB



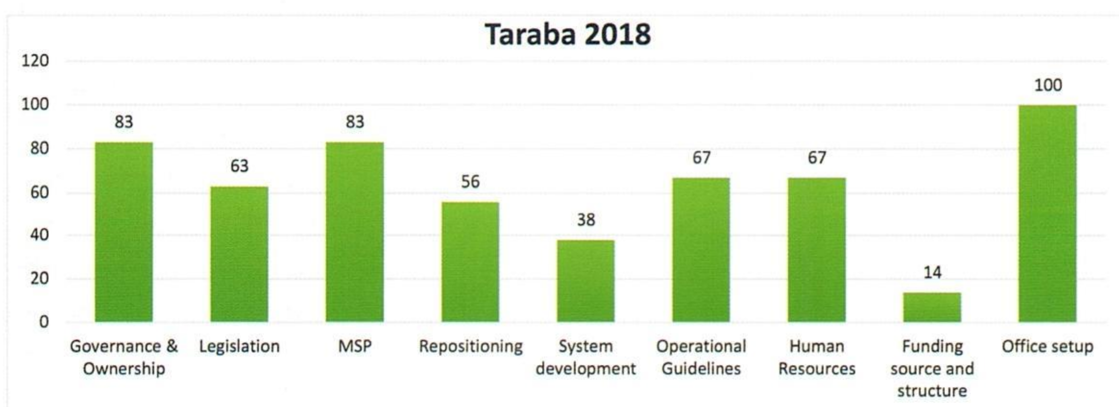
TARABA STATE (Overall Score 58%)

Background

Taraba State was created in 1991 and its capital is Jalingo. It has a land mass of 60,291 sq. km with 2016 projected population of 3,066,800 (NPopC 2006). It has 16 Local Government Areas (LGAs). There are 1,045 health facilities in the State. 1,030 (99%) are PHC facilities and 14 (1.3%) are SHC facilities. 895 (87%) of the PHC facilities are public health facilities while 135 (13%) are private health facilities. Some of the State's health indices are IMR 64, U5MR 105, NMR 22 and U5 Stunting 41 (MICS 2016).

Main Findings

Taraba State scored 58% in the PHCUOR Scorecard 4 assessment placing it in the 11th position nationwide. Its best performing pillars include Governance & Ownership 83%, MSP 83% and Office Setup 100% and poor performing pillars are Systems Development 38% and Funding Sources and Structure 14%.



Governance & Ownership: 83%

- Taraba SPHCB has a governing board and a management team.
- LGA PHC departments have not transformed into LGHAs in the State.

Legislation: 63%

- Taraba SPHCB has a law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 83%

- The SPHCB has no costed and approved MSP document. There is no investment or service delivery plan. Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional maternal deaths, still births, neonatal deaths, U5 deaths and U5 stunting.

Repositioning: 56%

- PHC department, programmes including FP/MCH/Nutrition and Immunization and staff in the SMoH have moved to the SPHCB. SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.
- LGA PHC departments have not transformed into LGHAs with definite reporting lines to the SPHCB.

Systems Development: 38%

- SPHCB has strategic documents such as strategic health development plan and PHC annual operational plan.
- There is no LGA PHC annual operational plans, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has not been conducted on SPHCB in the last one year. State has no functional data quality assurance system, and has not conducted a State-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is <80%.

Human Resources: 67%

- Job descriptions are available for all SPHCB staff and positions.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure:

14% SPHCB has a bank account.

- No dedicated budget line for SPHCB.
- SPHCB staff are not on the SPHCB payroll.
- None of the PHC facilities received regular operational funding in the last three months.

Operational Guidelines: 67%

- A SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB.
- There is administrative manual to standardize the administrative processes in the SPHCB.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer

Required Actions

Governance & Ownership - 83%:

- Create LGHAs in all LGAs of the State.

Legislation - 63%:

- Amend SPHCB Law o To delineate roles and responsibilities of governing board from that of management team o To reflect clear oversight function of the SMoH on the SPHCB Develop regulations for the operationalization of the SPHCB Law

MSP - 83%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 56%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB

Systems Development – 38%:

- Develop PHC annual operational plan incorporating the LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Develop ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule
- Conduct periodic performance review of the SPHCB
- Establish functional PHC data quality assurance system, and conduct state-wide DQA
- Improve HMIS monthly facility reporting rate to >80%

Human Resources - 67%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to guide HRH strategic plan
- Develop staff nominal roll

Funding Sources and Structure - 14%:

- Establish dedicated budget line for PHC
- Include all PHC staff on the SPHCB payroll
- Support LGHAs when established to open dedicated bank accounts
- Conduct periodic tracking of PHC budget performance
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and uninterrupted service delivery

Operational Guidelines - 67%:

- Distribute PHCUOR manual to all staff at SPHCB and LGHAs

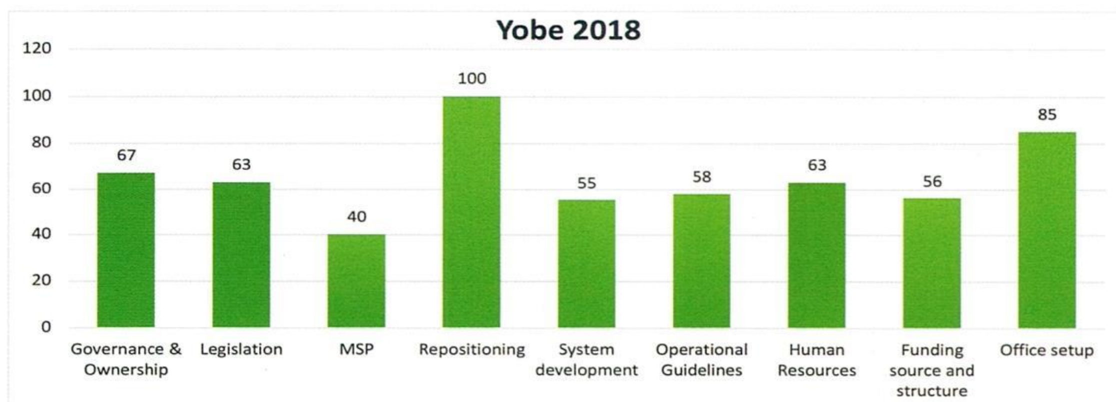
YOBE STATE (Overall Score 69%)

Background

Yobe State was created in 1991 out of Borno State and its capital is Damaturu. It has a land mass of 45,502 sq. km with 2016 projected population of 3,294,100 (NPC 2006). It has 17 Local Government Areas (LGAs). There are 517 health facilities in the State: 486 (94%) are PHC facilities, 30 (6%) are SHC facilities and one is a tertiary hospital. All PHC facilities are public health facilities (NPHCDA 2015). Some of the State's health indices are IMR 64, U5MR 102, NMR 44 and U5 Stunting 61 (MICS 2016).

Main Findings

Yobe State scored 69% in the PHCUOR Scorecard 4 assessment placing it in the 4th position nationwide. Its best performing pillars are Repositioning 100% and Office Setup 85% and poor performing pillar is MSP 40%.



Governance & Ownership: 67%

- Yobe SPHCB has a management team.
- LGA PHC departments have transformed into LGHAs.
- However, it does not have a governing board.

Legislation: 63%

- Yobe SPHCB Law is in place.
- Regulations have been developed for the operationalization of the SPHCB Law

MSP: 40%

- No costed and approved MSP document. Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional still births and U5 deaths but an increasing trend in the number of institutional maternal deaths, neonatal deaths and U5 stunting.

Repositioning: 100%

- All PHC staff and programmes in the SMoH have moved to the SPHCB.
- The LGA PHC departments have transformed into LGHAs with definite reporting lines to the SPHCB.
- SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.

Systems Development: 55%

- SPHCB has developed key strategic documents such as strategic health development plan, SPHCB and LGA PHC annual operational plans, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last one year. State has functional data quality assurance system and has conducted a State-wide DQA in the previous year.
- HMIS facility reporting rate for the last 12 months is <80%.

Human Resources: 63%

- All PHC staff in the LGAs, SMoLG and LGSC have moved to the SPHCB and on-

boarded. There are job descriptions for all SPHCB and LGHA staff and positions. The SPHCB has staff nominal roll.

- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 56%

- SPHCB has a dedicated budget line and bank account. All PHC staff are on the SPHCB payroll. The LGHAs have dedicated bank accounts. PHC budget performance is periodically tracked and annual audit of the PHC income and expenditure for the preceding year was conducted.
- No PHC facility received regular operational funding in the last three months.

Operational Guidelines: 58%

- The PHCUOR manual has been distributed to all staff and LGHAs and SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB. There is administrative/office manual to standardize the administrative processes in the SPHCB.

Office Setup: 85%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 67%:

- Constitute and inaugurate governing board for the SPHCB in line with national guidelines
- Constitute WDCs to strengthen health governance at ward level

Legislation - 63%:

- Amend SPHCB Law o To delineate roles and responsibilities of governing board from that of management team o To reflect clear oversight function of the SMoH on the SPHCB o To indicate the different sources of funding and expected contributions from the State and LGAs.

MSP - 40%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Systems Development– 55%:

- Improve HMIS facility monthly reporting rate to >80%

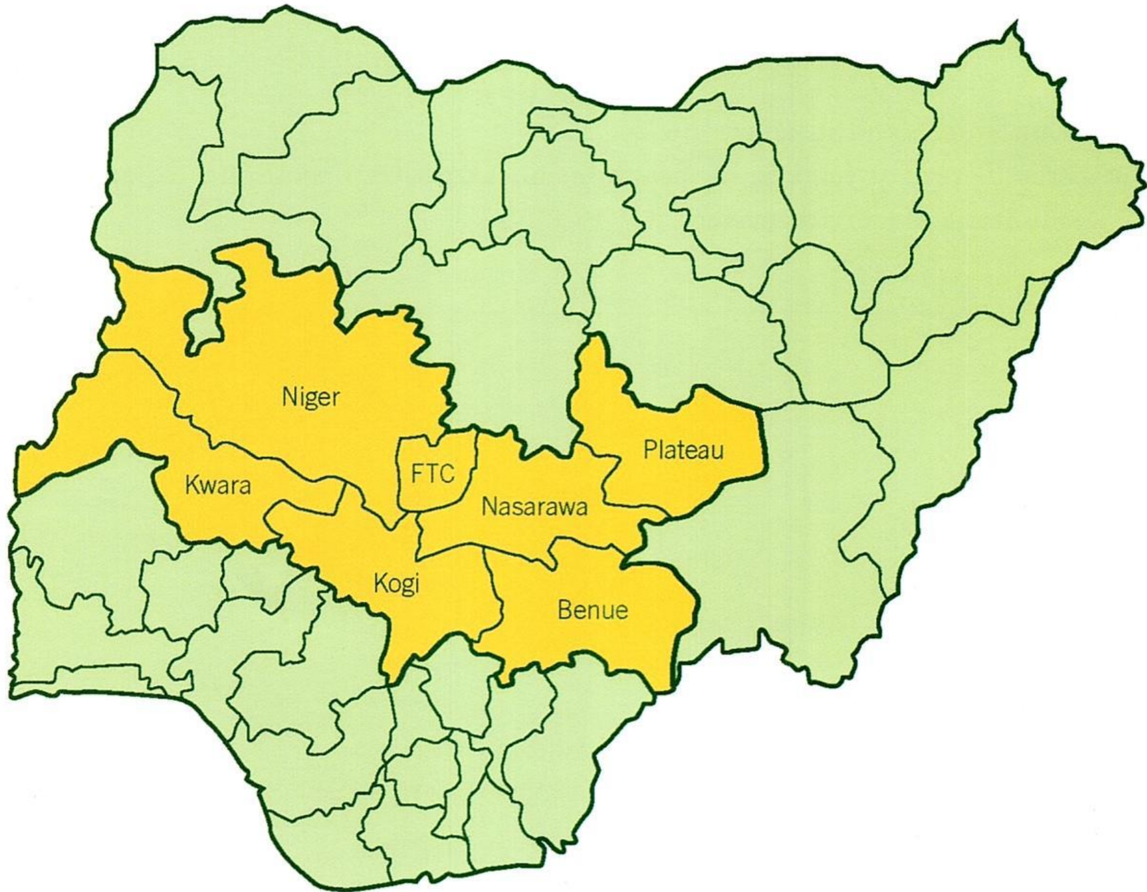
Human Resources - 63%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to guide HRH strategic plan

Funding Sources and Structure - 56%:

- Provide regular funding for health facilities to cover operational expenses and uninterrupted service delivery

NORTH CENTRAL ZONE



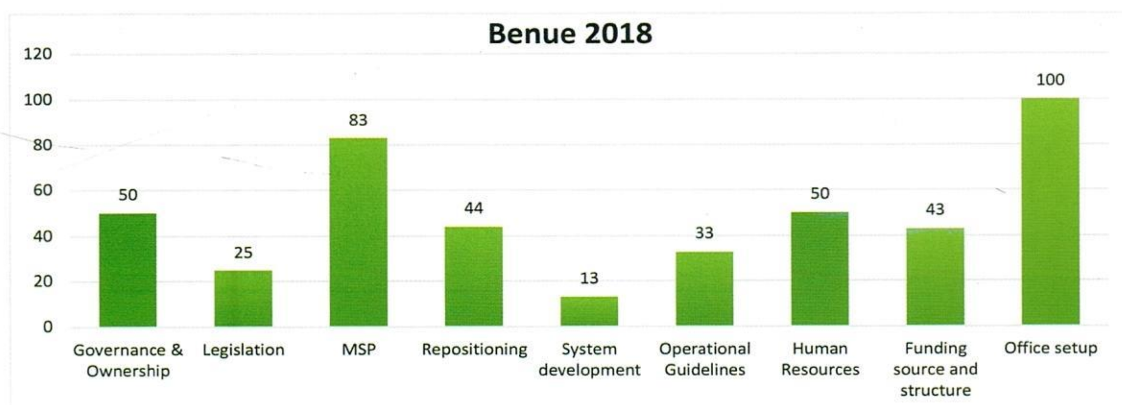
BENUE STATE (Overall Score 54%)

Background

Benue State was created in 1976 and its capital is Makurdi. It has a land mass of 33,955 sq. km with 2016 projected population of 5,741,800 (NPC 2006). It has 23 Local Government Areas (LGAs). There are 1,206 health facilities in the State: 1,111 (92%) are PHC facilities and 30 (6%) are SHC facilities. 771 (69%) of the PHC facilities are public health facilities and 340 (31%) are private health facilities. Some of the State's indices are IMR 70, U5MR 82, NMR 41 and U5 Stunting 29 (MICS 2016).

Main Findings

Benue State scored 54% in the PHCUOR Scorecard 4 assessment placing it in the 15th position nationwide. Its best performing pillars are MSP 83% and Office Setup 100% and poor performing pillars include Legislation 25%, Systems Development 13% and Operational Guidelines 33%.



Governance & Ownership: 50%

- Benue SPHCB has a governing board and a management team.
- There is no LGHA and WDCs are not functional in the State.

Legislation: 25%

- Benue SPHCB has a Law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 83%

- Benue SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan. Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional maternal deaths, still births, neonatal deaths, U5 deaths and U5 stunting.

Repositioning: 44%

- PHC department, programmes (FP/MCH/Nutrition, and Immunization) and staff and in the SMoH have moved to the SPHCB. SMoH has restructured its departments in line with the SPHCB reform.
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.
- LGA PHC departments have not transformed into LGHAs with definite reporting lines to the SPHCB.
- Orientation has not been conducted for the staff on the new roles and responsibilities of the SMoH.

Systems Development: 13%

- SPHCB has strategic health development plan
- SPHCB has no SPHCB or LGA PHC annual operational plans, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has not been conducted on the SPHCB in the last one year. State has no functional data quality assurance system, and has not conducted a State-wide DQA in the last year. Its HMIS facility reporting rate for the last 12 months is <80%.

Human Resources: 50%

- PHC staff in the LGAs, SMoLG and LGSC have moved to the SPHCB. There are job descriptions for all SPHCB staff and positions.
- SPHCB does not have staff nominal roll and HR plan for the strategic management of PHC HRH. Staff are yet to be on-boarded

Funding Sources and Structure: 43%

- SPHCB has a dedicated budget line and bank account.
- SPHCB staff are not on the SPHCB payroll. PHC budget performance is not periodically tracked and annual audit of the PHC income and expenditure for the preceding year was not conducted.
- No PHC facility received regular operational funding in the last three months.

Operational Guidelines: 33%

- There is administrative manual to standardize the administrative processes in the SPHCB.
- PHCUOR Implementation Guidelines is yet to be distributed to all staff and a SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 50%:

- Include women and key stakeholders in the governing board
- Reactivate WDCs to strengthen health governance at ward level

Legislation - 25%:

- Amend SPHCB Law
    - To delineate roles and responsibilities of governing board from that of management team
    - To reflect clear oversight function of the SMoH on the SPHCB
    - Make provision for the movement of PHC department, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB

- Indicate different sources of PHC funding and expected contributions from the State and LGAS Develop regulations for the operationalization of the SPHCB Law

MSP - 83%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address service delivery, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 44%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB
- Transform LGA PHC departments into LGHAs with definite reporting line to the SPHCB
- SMoH should conduct an orientation for the key staff on the new roles and responsibilities of the SMoH

Systems Development – 13%:

- Develop SPHCB annual operational plan incorporating the LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Develop ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule
- Conduct periodic performance review of the SPHCB
- Establish functional PHC data quality assurance system and conduct State-wide DQA Improve HMIS facility monthly reporting rate to >80%.

Human Resources - 50%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan
- Develop staff nominal roll
- Onboard all staff on the mandate, mission and vision of the SPHCB.

Funding Sources and Structure - 43%:

- Include all PHC staff on the SPHCB payroll
- Conduct periodic tracking of PHC budget performance
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and uninterrupted service delivery

Operational Guidelines - 33%:

- Distribute PHCUOR manual to all SPHCB and LGHA staff
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB

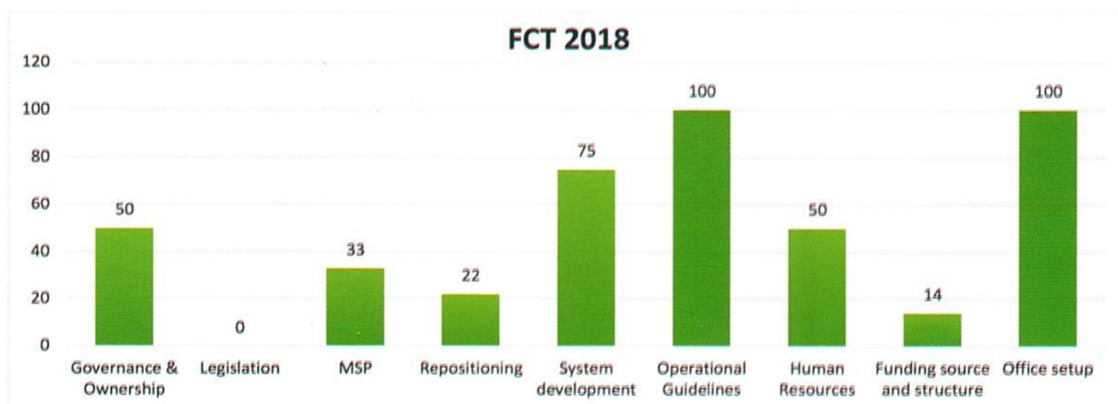
FCT ABUJA (Overall Score 33%)

Background

FCT was created in 1976 from parts of Niger, Nasarawa and Kogi States and its capital is Abuja. It has a land mass of 7,315 sq. km with 2016 projected population of 3,564,100 (NPC 2006). It has 6 Area Councils (ACs). There are 656 health facilities in the FCT: 559 (85%) are PHC facilities and 90 (14%) are SHC facilities. 179 (32%) of the PHC facilities are public health facilities and 380 (68%) are private health facilities. Some of the State's health indices are IMR 44, U5MR 71, NMR 27 and U5 Stunting 37 (MICS 2016).

Main Findings

FCT scored 33% in the PHCUOR Scorecard 4 assessment placing it in the 27th position nationwide. Its best performing pillars are Operational Guidelines and Office Setup at 100% each. Its poor performing pillars include Legislation 0%, MSP 33%, Repositioning 22% and Funding Source and Structure 14%.



Governance & Ownership: 50%

- FCT PHCB has a governing board.
- WDCs are available but not functional.
- FCT PHCB has no substantive Executive Secretary at the time of assessment.
- No LGHAs established in the FCT.

Legislation: 0%

- FCT PHCB has no law establishing it

MSP: 33%

- FCT PHCB has no approved and costed MSP policy document. There is no investment or service delivery plan. Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional maternal deaths and U5 with stunting but an increasing trend in the number of institutional still births, neonatal deaths and U5 deaths.

Repositioning: 22%

- FP/MCH/Nutrition and Immunization programmes have moved to the PHCB
- Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the PHCB.
- AC PHC departments have not transformed into ACHAs with definite reporting lines to the PHCB.

Systems Development: 75%

- The SPHCB has developed key strategic documents including strategic health development plan, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on SPHCB in the last one year. FCT has functional data quality assurance system and has conducted a FCT-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.
- FCT PHCB has no PHC annual operational plan and no M&E /results/performance framework with clear milestones and targets.

Human Resources: 50%

- There are job descriptions for all PHCB staff and positions. PHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 14%

- FCT PHCB has a dedicated budget line.
- PHCB staff are not on the PHCB payroll.
- No PHC facility received regular operational funding in the last three months.

Operational Guidelines: 100%

- The PHCUOR manual has been distributed to staff and SPHCB-wide orientation has been conducted to familiarize staff at all levels with the mandate of the SPHCB. There is administrative manual to standardize the administrative processes in the SPHCB.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 50%:

- Appoint substantive Executive Secretary for the PHCB
- Include women and key stakeholders in the governing board
- Establish ACHAs in the six Area Councils

Legislation - 0%:

- Develop, pass and assent law for establishing and empowering the FCT PHCB Law should: o Delineate roles and responsibilities of governing board from that of management team o Reflect clear oversight function of the Health & Human Services Department o Make provision for the transfer of all PHC health facilities in the FCT to the PHCB o Make provision for the movement of PHC staff in the FCT to the PHCB o Indicate different sources of PHC funding and expected contributions from the FCT and Acs.
- Develop regulations for the operationalization of the FCT PHCB law

MSP - 33%:

- Develop a costed and approved MSP document for PHC facilities in the FCT
- Incorporate investment plan in annual budget to address services, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 22%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the PHCB
- Transform AC PHC departments to ACHAs with established reporting line to the PHCB

Systems Development – 75%:

- Develop PHC annual operational plan incorporating the AC PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the PHCB

Human Resources - 50%:

- Transfer all PHC staff in the FCT to the PHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to guide HRH strategic plan
- Onboard all staff on the mandate, mission and vision of the PHCB.

Funding Sources and Structure - 14%:

- Support ACHAs when established to open dedicated bank accounts
- Include all PHC staff on the PHCB payroll
- Conduct periodic tracking of PHC budget performance
- Conduct annual PHC income and expenditure audit
- Provide regular funding to health facilities for operational expenses and provision of PHC service delivery

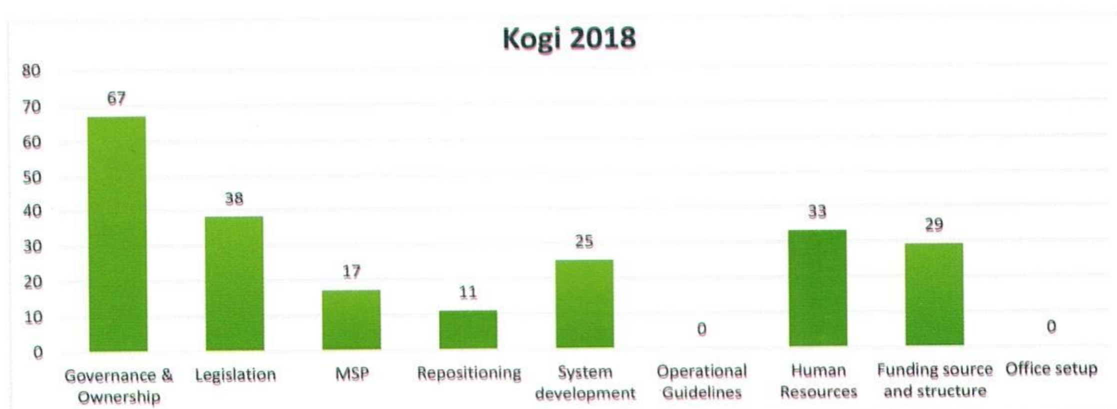
KOGI STATE (Overall Score 25%)

Background

Kogi State was created in 1991 from parts of Kwara and Benue States and its capital is Lokoja. It has a land mass of 29,833 sq. km with 2016 projected population of 4,473,500 (NPopC 2006). It has 21 Local Government Areas (LGAs). There are 1,077 health facilities in the State: 868 (81%) are PHC facilities and 28 (3%) are SHC facilities. 823 (95%) of the PHC facilities are public health facilities and 45 (5%) are private health facilities. Some of the State's health indices are IMR 49, U5MR 75, NMR 29 and U5 Stunting 27 (MICS 2016).

Main Findings

Kogi State scored 25% in the PHCUOR Scorecard 4 assessment placing it in the 28th position nationwide. Its best performing pillar is Governance and Ownership 67% and poor performing pillars include Operational Guidelines 0%, Funding Sources and Structure 29% and Office Setup 0%.



Governance & Ownership: 67%

- Kogi SPHCB has a governing board and a management team.
- LGHAs are not yet established in the state.

Legislation: 38%

- Kogi SPHCB has a Law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 17%

- Kogi SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan. Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional maternal deaths but an increasing trend in the number of institutional still births, neonatal deaths, U5 deaths, and U5 stunting.

Repositioning: 11%

- Only Immunization programme has moved to the SPHCB.
- FP/MCH/Nutrition, Malaria, HIV/AIDS and TBL programmes are yet to be transferred to the SPHCB.
- LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.
- SMoH has not conducted an orientation for the key staff on the new roles and responsibilities of the SMoH or restructured its departments in line with SPHCB reforms.

Systems Development: 25%

- SPHCB has strategic health development plan. State has functional data quality assurance system and has conducted a State-wide DQA in the previous year.
- SPHCB has no State or LGA PHC annual operational plans, M&E/results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has not been conducted on SPHCB in the last one year. There is no HMIS monthly facility report.

Human Resources: 33%

- There are job descriptions for all SPHCB staff and positions.

- PHC staff in the LGAs, SMoLG and LGSC have not moved to the SPHCB and staff are yet to be on-boarded. SPHCB has no staff nominal roll and no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 29%
- SPHCB has a dedicated budget line and bank account.
- SPHCB staff are not on the SPHCB payroll.
- No PHC facility received regular operational funding in the last three months.

Operational Guidelines: 0%
- SPHCB Operational Guidelines is not yet developed.

Office Setup: 0%
- SPHCB has a physical office without requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 67%:
- Include women and key stakeholders in the governing board in line with the national guidelines.

Legislation - 38%:
- Amend SPHCB Law
    - To reflect clear oversight function of the SMoH on the SPHCB
    - To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
    - To indicate different sources of PHC funding and expected contributions from the state and LGAs.
- Develop regulations for the operationalization of the SPHCB Law

MSP - 17%:
- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address services, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 11%:

- Transfer PHC programmes including FP/MCH/Nutrition, Malaria, HIV/AIDS and TBL to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB
- SMoH should conduct an orientation for the key staff on the new roles and responsibilities of the SMoH and restructure its departments in line with SPHCB reforms.

Systems Development– 25%:

- Develop PHC annual operational plan incorporating the LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Develop ISS checklist, list of ISS team (including State and LGA members), and supervisory schedule
- Conduct periodic performance review of the SPHCB
- Facilitate HMIS monthly reporting and improve HMIS facility monthly reporting rate to >80%

Human Resources - 33%:

- Transfer all PHC staff in LGA, SMoLG and LGSC to the SPHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan
- Develop staff nominal roll
- Onboard all staff on the mandate, mission and vision of the SPHCB.

Funding Sources and Structure - 29%:

- Include all PHC staff on the SPHCB payroll
- Support LGHAs when established to open dedicated bank accounts
- Conduct periodic tracking of PHC budget performance
- Conduct annual audit of PHC income and expenditure
- Provide regular funding for health facilities to cover operational expenses and provide integrated service delivery
- Operational Guidelines - 0%:

- Distribute SPHCB Operational Guidelines and distribute to all staff
- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the agency

Office Setup – 0%

- Provide requisite amenities and equipment such as power, water, computers, furniture, internet access and printer for the office building.

KWARA STATE

Its Good Here

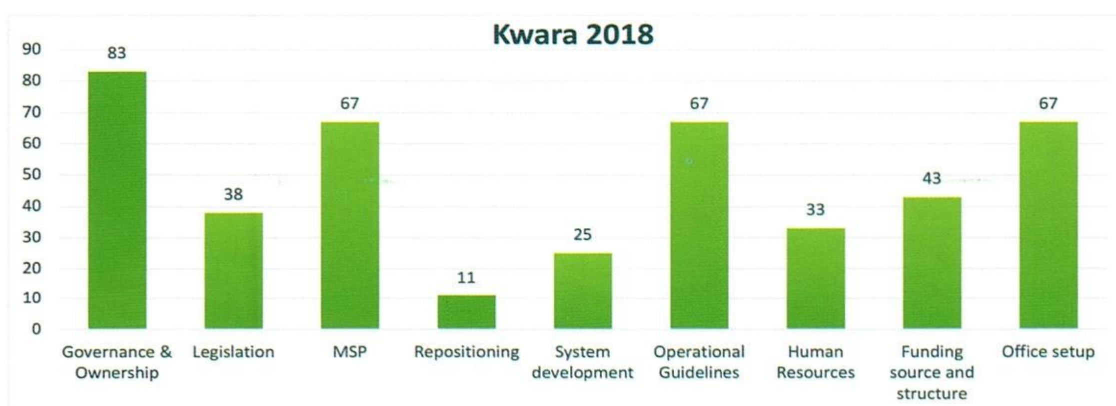
KWARA STATE (Overall Score 48%)

Background

Kwara State was created in 1967 and its capital is Ilorin. It has a land mass of 32,500 sq. km with 2016 projected population of 3,192,900 (NPC 2006). It has 16 Local Government Areas (LGAs). There are 740 health facilities in the State: 575 (78%) are PHC facilities and 164 (22%) are SHC facilities. 512 (89%) of the PHC facilities are public health facilities and 63 (11%) are private health facilities. Some of the State's health indices are IMR 40, U5MR 45, NMR 27 and U5 Stunting 32 (MICS 2016).

Main Findings

Kwara State scored 48% in the PHCUOR Scorecard 4 assessment placing it in the 18th position nationwide. Its best performing pillar is Governance and Ownership 83% and poor performing pillars include Legislation 38%, Repositioning 11% and Systems Development 25%.



Governance & Ownership: 83%

- Kwara SPHCB has a governing board and a management team. WDCs are available but not functional.
- LGHAs not yet established in the State.

Legislation: 38%

- Kwara SPHCB has a Law establishing it.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 67%

- Kwara SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.
- Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional still births, neonatal deaths, U5 deaths and U5 stunting but an increasing trend in the number of institutional maternal deaths.

Repositioning: 11%

- Immunization programme in the SMoH has moved to the SPHCB.
- Other PHC programmes including FP/MCH/Nutrition, Malaria, HIV/AIDS and TBL are yet to be transferred to the SPHCB. LGA PHC departments have not been transformed to LGHAs with definite reporting lines to the SPHCB. SMoH has not restructured its departments in line with the SPHCB reform and has not conducted an orientation for the staff on the new roles and responsibilities of the SMoH.

Systems Development: 25%

- SPHCB has developed key strategic documents inccluding strategic health development plan and PHC annual operational plan.
- SPHCB has no LGA PHC annual operational plans, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has not been conducted on SPHCB in the last one year. State has no functional data quality assurance system and did not conduct State-wide DQA in the previous year. There is no record on HMIS facility reporting.

Human Resources: 33%

- There are job descriptions for all SPHCB staff and positions.
- PHC staff in the LGAs, SMoLG and LGSC have not moved to the SPHCB, and staff are yet to be on-boarded. The SPHCB has no staff nominal roll and there is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 43%

- SPHCB has a dedicated budget line and bank account. An annual audit of the PHC income and expenditure for the preceding year was conducted.
- SPHCB staff are not on the SPHCB payroll.
- No PHC facility received regular operational funding in the last three months.

Operational Guidelines: 67%

- There is administrative manual to standardize the administrative processes in the SPHCB.
- SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Office Setup: 67%

- The SPHCB has a physical office without requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 83%:

- Include women and key stakeholders in the governing board in line with the national guidelines

Legislation - 38%:

- Amend SPHCB Law
  - To reflect clear oversight function of the SMoH on the SPHCB
  - To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
  - To indicate different sources of PHC funding and expected contributions from the State and LGAs.
- Develop regulations for the operationalization of the SPHCB Law

MSP - 67%:

- Develop a costed and approved MSP document for PHC facilities in the State
- Incorporate investment plan in annual budget to address services, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 11%:

- Transfer Malaria, HIV/AIDS, TBL and FP/MCH/Nutrition programmes to the SPHCB
- Transform LGA PHC departments into LGHAs with established reporting line to the SPHCB
- SMoH should restructure its departments in line with the SPHCB reforms
- SMoH should conduct orientation for staff on the new roles and responsibilities of the SMoH

Systems Development – 25%:

- Develop PHC annual operational plan and incorporate LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Develop ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule
- Conduct performance review of the SPHCB
- Establish functional data quality assurance system
- Conduct State-wide DQA
- Facilitate HMIS facility reporting and drive monthly reporting rate to >80%,

Human Resources - 33%:

- Transfer all PHC staff in LGAs to the SPHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition Develop functional HRIS to support HRH strategic plan
- Develop staff nominal roll
- Onboard all staff on the mandate, mission and vision of the SPHCB.

Funding Sources and Structure - 43%:

- Include SPHCB staff on the SPHCB payroll

- Support LGHAs when established to open dedicated bank accounts
- Conduct periodic tracking of PHC budget performance,
- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery

Operational Guidelines - 67%:

- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB

Office Setup – 67%

- Provide requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

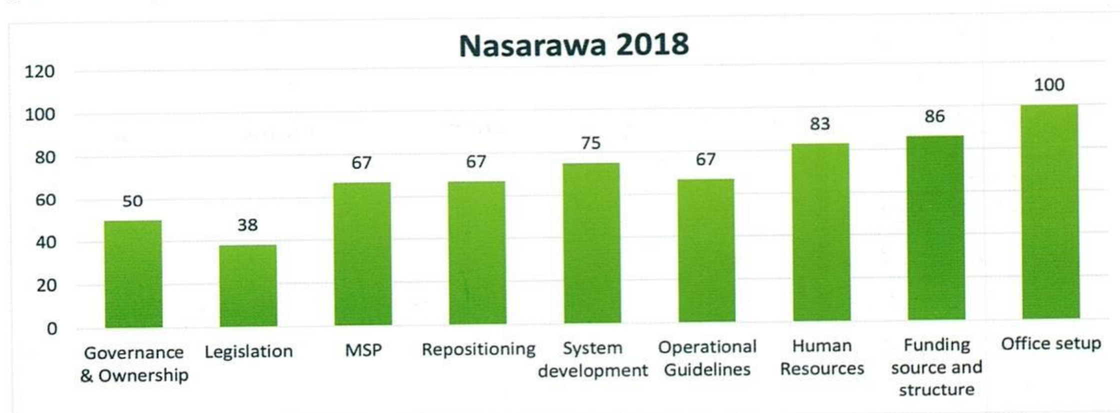
NASARAWA STATE (Overall Score 70%)

Background

Nasarawa State was created in 1996 and its capital is Lafia. It has a land mass of 28,735 sq. km with 2016 projected population of 2,523,400 (NPopC 2006). It has 13 Local Government Areas (LGAs). There are 1,070 health facilities in the State: 998 (93%) are PHC facilities, 17 (2%) are SHC facilities and 2 (0.1%) are tertiary health facilities. 756 (76%) of the PHC facilities are public health facilities and 242 (24%) are private health facilities (NAPHDA 2018). Some of the State's health indices are IMR 81, U5MR 121, NMR 47 and U5 Stunting 37 (MICS 2016).

Main Findings

Nasarawa State scored 70% in the PHCUOR Scorecard 4 assessment placing it in the 3rd position nationwide. Its best performing pillars include Human Resources 83%, Funding Sources and Structure 86%, Office Setup 100% and poor performing pillar is Legislation 38%.



Governance & Ownership: 50%

- Nasarawa SPHCB has a governing board and a management team.
- There are no LGHAs in the State.

Legislation: 38%

- The SPHCB has a Law establishing it. SPHCB Law does not make provision for some key requirements for the implementation of the PHCUOR policy.
- No regulations developed for the operationalization of the SPHCB Law.

MSP: 67%

- Nasarawa SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan.
- Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional still births, neonatal deaths, U5 deaths and U5 stunting but an increasing trend in the number of institutional maternal deaths.

Repositioning: 67%

- PHC department, staff and programmes including HIV/AIDS in the SMoH have moved to the SPHCB.
- SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- Malaria and TBL programmes are yet to be transferred to the SPHCB.
- LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.

Systems Development: 75%

- The SPHCB has developed key strategic documents such as strategic health development plan, SPHCB and LGA PHC annual operational plan, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. State has functional data quality assurance system and has conducted a State-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.
- SPHCB has no M&E/results/performance framework with clear milestones and targets. Performance review has not been conducted on SPHCB in the last one year.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have moved to the SPHCB and on-boarded. There are job descriptions for all SPHCB staff and positions. SPHCB has staff nominal roll.
- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 86%

- The SPHCB has a dedicated budget line and bank account. SPHCB staff are on the SPHCB payroll.
- PHC budget performance is periodically tracked and annual audit of the PHC income and expenditure for the preceding year was conducted.

Operational Guidelines: 67%

- SPHCB Operational Guidelines is not yet developed.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 50%:

- Include women and other stakeholders in the governing board
- Establish LGHAs in all LGAs in the State

Legislation - 38%:

- Amend SPHCB Law
    - To reflect clear oversight function of the SMoH on the SPHCB
    - To make provision for the movement of PHC departments, staff and health facilities in all LGAs to the SPHCB
    - To indicate different sources of PHC funding and expected contributions from the State and LGAs.
- Develop regulations for the operationalization of the SPHCB Law

MSP - 67%:

- Develop a costed and approved MSP document for PHC facilities in the State
- MSP should incorporate any free health services offered in the state

- MSP should be used to classify health facilities in the State and classification report should be documented for reference purposes
- Incorporate investment plan in annual budget to address services, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 67%:

- Transfer Malaria and TBL programmes to the SPHCB
- Transform LGA PHC departments into LGHAs with established reporting line to the SPHCB

Systems Development – 75%:

- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB
- Conduct periodic performance review of the SPHCB

Human Resources - 83%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to guide HRH strategic plan

Funding Sources and Structure - 86%:

- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery

Operational Guidelines - 67%:

- Develop Operational Guidelines to standardize administrative processes of the SPHCB

NIGER STATE (Overall Score 73%)

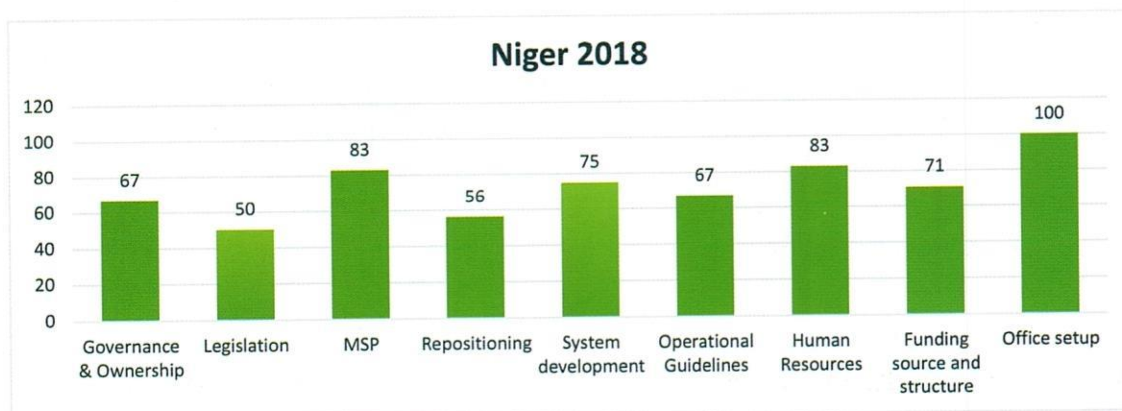
Background

Niger State was created in 1976 and its capital is Minna. It has a land mass of 76,363 sq. km with 2016 projected population of 5,556,900 (NPC 2006). It has 25 Local Government Areas (LGAs).

There are 1,335 health facilities in the State: 1,322 (99%) are PHC facilities. 1,095 (83%) of the PHC facilities are public health facilities and 227 (17%) are private health facilities. Some of the State's health indices are IMR 100, U5MR 149, NMR 59 and U5 Stunting 37 (MICS 2016).

Main Findings

Niger State scored 73% in the PHCUOR Scorecard 4 assessment placing it in the 2nd position nationwide. Its best performing pillars include MSP 83%, Human Resources 83% and Office Setup 100% with good performance in other pillars.



Governance & Ownership: 67%

- Niger SPHCB has a governing board and a management team.
- No LGHAs established in the 25 LGAs of the State.

Legislation: 50%

- Niger SPHCB has a Law establishing it.
- No regulations for the operationalization of the SPHCB Law.

MSP: 83%

- Niger SPHCB has no costed and approved MSP document.
- There is no investment or service delivery plan. Investment/service delivery plan is not captured in the annual budget.
- There is a decreasing trend in the number of institutional maternal deaths, still births, neonatal deaths, U5 deaths and U5 stunting.

Repositioning: 56%

- PHC department, programmes (FP/MCH/Nutrition and Immunization) and staff in the SMoH have moved to the SPHCB. The SMoH has restructured its departments in line with the SPHCB reform and has conducted an orientation for the staff on the new roles and responsibilities of the SMoH.
- Malaria, HIV/AIDS and TBL are yet to be transferred to the SPHCB.
- LGA PHC departments have not been transformed to LGHAs with definite reporting lines to the SPHCB.

Systems Development: 75%

- The SPHCB has developed key strategic documents including strategic health development plan, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has been conducted on the SPHCB in the last year. State has functional data quality assurance system and has conducted a State-wide DQA in the previous year. Its HMIS facility reporting rate for the last 12 months is >80%.
- SPHCB has no PHC annual operational plan and no M&E /results/performance framework with clear milestones and targets.

Human Resources: 83%

- PHC staff in the LGAs, SMoLG and LGSC have moved to the SPHCB and on-

boarded. There are job descriptions for all SPHCB staff and positions. SPHCB has staff nominal roll.

- There is no HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 71%

- SPHCB has dedicated bank accounts. SPHCB staff are on the SPHCB payroll. PHC budget performance is periodically tracked and annual audit of the PHC income and expenditure for the preceding year was conducted.
- SPHCB has no dedicated budget line.
- None of the PHC facilities received regular operational funding in the last three months.

Operational Guidelines: 67%

- There is administrative manual to standardize the administrative processes in the SPHCB.
- SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Office Setup: 100%

- The SPHCB has a physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 67%:

- Include women and key stakeholders in the governing board as recommended in the national guidelines
- Establish LGHA in all 25 LGAs of the State

Legislation - 50%:

- Amend SPHCB Law o To reflect clear oversight function of the SMoH on the SPHCB
  - To make provision for the movement of PHC departments, programmes and staff in all LGAs to the SPHCB
- Develop regulations for the operationalization of the SPHCB Law

MSP - 83%:

- Develop a costed and approved MSP document for PHC facilities in the State
- MSP should incorporate any free health services offered in the State
- MSP should be used to classify health facilities in the State and classification report should be documented for reference purposes
- Incorporate investment plan in annual budget to address services, infrastructural and
- HRH gaps required to meet the MSP for PHC facilities

Repositioning - 56%:

- Transfer Malaria, HIV/AIDS and TBL programmes to the SPHCB
- Transform LGA PHC departments into LGHAs with established reporting line to the SPHCB

Systems Development – 75%:

- Develop PHC annual operational plan incorporating the LGA PHC annual plans
- Develop M&E /results/performance framework with clear milestones and targets for the SPHCB

Human Resources - 83%:

- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to guide HRH strategic plan Funding Sources and Structure - 71%:
- Establish dedicated budget line for PHC in the State annual budget
- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery

Operational Guidelines - 67%:

- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the
- SPHCB

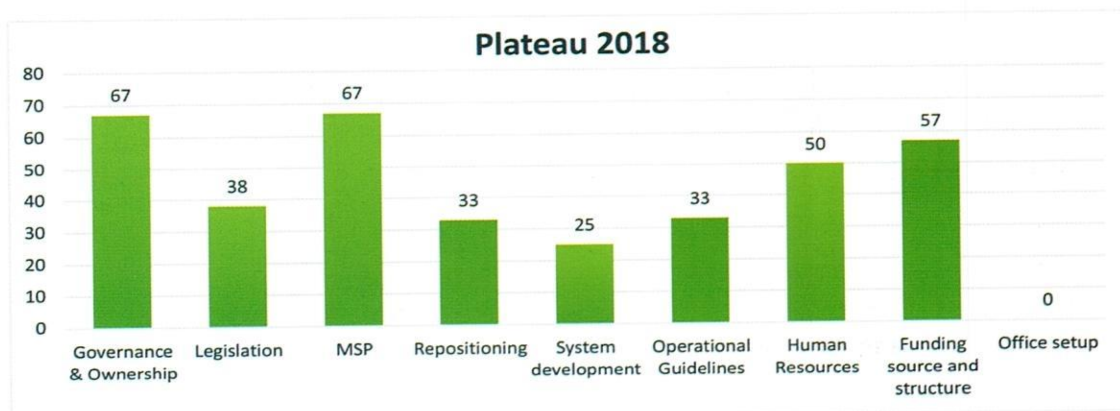
PLATEAU STATE (Overall Score 52%)

Background

Plateau State was created in 1976 and its capital is Jos. It has a land mass of 26,899 sq. km with 2016 projected population of 4,200,400 (NPopC 2006). It has 17 Local Government Areas (LGAs). There are 883 health facilities in the State: 833 (94%) are PHC facilities, 49 (6%) are SHC and one is a tertiary facility. 729 (87%) of the PHC facilities are public health facilities and 104 (12%) are private health facilities (NPHCDA 2015). Some of the State's health indices are IMR 55, U5MR 80, NMR 34 and U5 Stunting 40 (MICS 2016).

Main Findings

Plateau State scored 52% in the PHCUOR Scorecard 4 assessment placing it in the 16th position nationwide. Its best performing pillars are Governance & Ownership 67% and MSP 67% and poor performing pillars include Legislation 38%, Repositioning 33%, Systems Development 25% and Office Setup 0%.



Governance & Ownership: 67%

- Plateau SPHCB has a governing board and a management team.
- Both governing board and management team are headed by the Executive Secretary.

Legislation: 38%

- Plateau SPHCB has a Law establishing it.
- SPHCB Law does not separate the roles of the governing board from that of the management team.
- There is no clear oversight function of the SMoH on the SPHCB, no provision for the movement of PHC departments, programme and staff in the SMoH, SMoLG and all LGAs to the SPHCB.
- There is no regulations developed for the operationalization of the SPHCB Law.

MSP: 67%

- Plateau SPHCB has no costed and approved MSP document as at the time of the assessment.
- There is a decreasing trend in the number of institutional maternal deaths, still births, neonatal deaths, U5 deaths
- but an increasing trend in the number of U5 with stunting.

Repositioning: 33%

- Only Immunization programme in the SMoH has moved to the SPHCB.
- Other PHC programmes including FP/MCH/Nutrition, Malaria, HI/AIDS and TBL are yet to be transferred to the SPHCB. LGA PHC departments have not transformed to LGHAs with definite reporting lines to the SPHCB.

Systems Development: 25%

- SPHCB has strategic health development plan.
- SPHCB has no PHC annual operational plan incorporating all LGA PHC annual operational plans, M&E /results/performance framework with clear milestones and targets, ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule. Performance review has not been conducted on SPHCB in the last one year. State has no functional data quality assurance system, and has not conducted a state-wide DQA in the last one year. Its HMIS facility reporting rate for the last 12 months is <80%.

Human Resources: 50%

- PHC staff in the LGAs, SMoLG and LGSC have not moved to the SPHCB.
- There is no nominal roll and HR plan or HRIS for the strategic management of PHC HRH.

Funding Sources and Structure: 57%

- SPHCB has a dedicated budget line and bank account.
- SPHCB staff are on the SPHCB payroll.

Operational Guidelines: 33%

- SPHCB Operational Guidelines is yet to be developed and a SPHCB-wide orientation has not been conducted to familiarize staff at all levels with the mandate of the SPHCB.

Office Setup: 0%

- The SPHCB has no physical office with requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Required Actions

Governance & Ownership - 67%:

- Reconstitute SPHCB governing board in line with national guidelines
- Create LGHAs for all LGAs in the State

Legislation - 38%:

- Amend SPHCB Law
    - To delineate roles and responsibilities of governing board from that of management team
    - To reflect clear oversight function of the SMoH on the SPHCB
    - To make provision for the movement of PHC departments, programmes and staff in the SMoH, SMoLG and all LGAs to the SPHCB
- Develop regulations for the operationalization of the SPHCB Law

MSP - 67%:

- Develop a costed and approved MSP document for PHC facilities in the State
- MSP should incorporate any free health services offered in the State
- MSP should be used to classify health facilities in the state and classification report should be documented for reference purposes

- Incorporate investment plan in annual budget to address services, infrastructural and HRH gaps required to meet the MSP for PHC facilities

Repositioning - 33%:
- Transfer Malaria, HIV/AIDS, TBL, FP/MCH/Nutrition and remaining PHC programmes to the SPHCB
- Transform LGA PHC departments to LGHAs with established reporting line to the SPHCB

Systems Development – 25%:
- Develop PHC annual operational plan incorporating the LGA PHC annual plans
- Develop M&E/results/performance framework with clear milestones and targets for the SPHCB
- Develop ISS checklist, list of ISS team (including State and LGA members) and supervisory schedule
- Conduct performance review of the SPHCB
- Establish functional data quality assurance system
- Conduct State-wide DQA

Human Resources - 50%:
- Transfer all PHC staff in LGAs to the SPHCB
- Develop HRH strategic plan comprising of recruitment forecasting, redistribution, production, succession planning, capacity building, performance management including rewards and recognition
- Develop functional HRIS to guide HRH strategic plan
- Develop staff nominal roll

Funding Sources and Structure - 57%:
- Support LGHAs to open dedicated bank accounts
- Provide regular funding for health facilities to cover operational expenses and provide integrated PHC service delivery
- Conduct periodic tracking of PHC budget performance
- Conduct annual audit of PHC income and expenditure

Operational Guidelines - 33%:
- Develop SPHCB Operational Guidelines for all staff

- Conduct SPHCB-wide orientation to familiarize staff at all levels with the mandate of the SPHCB

Office Setup – 0%:

- Establish a permanent office building and provide requisite amenities and equipment such as power, water, computers, furniture, internet access and printer.

Conclusion and Recommendations

The PHCUOR Scorecard 4 is a veritable tool for high level advocacy to and for the states. It is also meant to guide States in focusing their interventions and inform the support to be provided to the States from the NPHCDA and the PHC TMT Partners to enhance State-level performance on the full implementation of the PHCUOR reform agenda. Based on the findings of the score card 4 assessemnt, the following recommendations were made:

- Validity of the Scorecard tool - Although the validity of the scorecard 4 tool overall is better than the previous tools especially in terms of correlation with the actual functionality of the boards, the inclusion of health outcomes under the MSP pillars resulted in some confusion in the scores for that pillar. For instance, states that have not implemented any of the MSP components but have improving health outcomes score high marks for the pillar even though no action has been taken under the MSP pillar. This needs to be corrected in future assessment to remove the health outputs component and to introduce a better measurement of health performance .

- Correlation with Health Outcomes: Even though some institutional (facility-based) health outcomes were included under the MSP pillar, the overall score measures more of PHC governance and less of health outcomes. The correlation between health governance and health outcome is a not linear because of the complexity of factors relating to health outcomes. Future scorecards therefore need to be reviewed to ensure that the focus on measurement of health sector i.e. how it is organized and managed. The introduction of the global PHC Performance Initiative Vital Sign Profile is recommended to compliment PHCUOR score card as they can both be used to reinforce the strengthening of the PHC system, the first focusing on overall governance while the latter focuses on the greater details of health system

ANNEX 1: SCORECARD 4 ASSESSMENT TOOL

SCORECARD FOR ASSESSMENT OF ESTABLISHMEN T AND FUNCTIONALITY OF STATE PRIMARY HEALTH CARE BOARDS (SPHCBs)

Instruction:

State Being Assessed: ____________________ **Dates of Assessment** ____________________

Assessors

1) Name ____________________ **Organization** ____________________

2) Name ____________________ **Organization** ____________________

3) Name ____________________ **Organization** ____________________

SN	Questions	*Notes*	Responses		
			YES	NO	DON'T KNOW
1	**GOVERNANCE AND OWNERSHIP**				
1.1	Is there a management team in place (headed by a substantive Executive Secretary) for the SPHCB	*Tick YES if there are directors and an ES for the SPHCB. No if either the directors or the ES are not in place*			
1.2	Is there a Governing Board for the SPHCB with clear roles and responsibilities separate from that of the management team?	*Tick YES if there is a Governing Board with an appointed chairman and members with defined roles and responsibilities*			
1.3	Does the Governing Board include representatives from at least all of the following: SMoH, SMoLG, ALGON and Women Group?	*Tick YES if the Governing Board has representatives from ALL of the institutions/groups.*			
1.4	Is there a LG Health Authority in every LGA reporting to the SPHCB?	*Tick YES if there exists LGHAs with defined roles and responsibilities*			
1.5	Is there a management team in each of the LG health authorities?	*Tick YES is there is a PHC Management team made up of the DPHC and deputy/assistant directors*			
1.6	Does the SPHCB have Ward Development Committees (WDCs) in all the wards in the state?	*Tick YES if there is a List of WDC chairmen and members for all the wards in the state*			
2	**LEGISLATION**				
2.1	Is there a Law (i.e. bill passed by the legislature and signed by the Governor) for the SPHCB?	*Tick YES if there is a copy of the signed SPHCB Law*			
2.2	Does the Law have provision that clearly seperates the roles of the Governing Board from that of the management team?	*Tick YES if there is a section in the Law that covers this provision*			

2.3	Does the Law have a clear provision on the oversight role of the SMoH including accountability lines?	*Tick YES if there is a section in the Law that covers this provision*			
2.4	Does the Law have provision for the transfer of all PHC health facilities in the state to the SPHCB?	*Tick YES if there is a section in the Law that covers this provision*			
2.5	Does the Law provide for the movement of PHC departments and PHC staff in the SMoH and SMoLG to the SPHCB?	*Tick YES if there is a section in the Law that covers this provision*			
2.6	Does the Law provide for the movement of PHC departments and PHC staff in all LGAs in the state to the SPHCB?	*Tick YES if there is a section in the Law that covers this provision*			
2.7	Does the law have clear provisions for the different sources of funding and expected contributions of the state and LGAs?	*Tick YES if there is a section in the Law that covers this provision*			
2.8	Is there a Regulation for operationalizing the SPHCB Law?	*Tick YES, if there is a copy of a Regulation and signed by the HCH or Governor*			
3	**MINIMUM SERVICE PACKAGE (MSP)**				
3.1	Is there an approved costed Minimum Service Package (MSP) policy in place in the state?	*Tick YES if there is an MSP document (approved by Government, defines health facility typology, minimum services expected at all levels, minimum HRH, Infrastructure, and costing*			
3.2	Does the MSP policy also incorporate services that are expected to be provided free such as free MNCH?	*Tick YES if there is a clear provision on free health care services*			
3.3	Has the SPHCB classified all the health facilities in the state in line with the typology outlined in the MSP?	*Tick YES if there is a list of all HFs in the state classified according to the MSP typology*			
3.4	Is there an Investment plan in place for the SPHCB, targeting one functional PHC per ward, to address the infrastructural and HRH gap required to meet the MSP for PHC facilities?	*Tick YES if there is an investment or service delivery plan*			
3.5	Is there provision in the current annual budget for the investment plan?	*Tick YES if there is a provision in the State annual budget for the preceeding year*			
3.6	Is there a decreasing trend in the number of institutional maternal deaths in the preceeding 12 months?	*Tick YES if there is a decreasing trend in facility maternal deaths based on DHIS2 data in the preceeding 12 months. Else tick No*			
3.7	Is there a decreasing trend in the number of institutional stillbirths in the preceeding 12 months?	*Tick YES if there is a decreasing trend in facility stillbirths based on DHIS2 data in the preceeding 12 months. Else tick No*			
3.8	Is there a decreasing trend in the number of institutional neonatal deaths in the preceeding 12 months?	*Tick YES if there is a decreasing trend in facility neonatal deaths based on DHIS2 data in the preceeding 12 months. Else tick No*			

3.9	Is there a decreasing trend in the number of institutional under five deaths in the preceeding 12 months?	*Tick YES if there is a dec reasing trend in facility under-five deaths based on DHIS2 data in the preceeding 12 months. Else tick No*			
3.10	Is there a decreasing trend in the number of institutional under fives who are underweight in the preceeding 12 months?	*Tick YES if there is a decreasing trend in facility maternal deaths based on DHIS2 data in the preceeding 12 months. Else tick No*			
4	**REPOSITIONING**				
4.1	Has the PHC department and all PHC staff in the SMoH been moved to the SPHCB?	*Tick YES if both the depart ment and staff have been moved to the Board.Tick No if there is still a PHC Department in the MoH*			
4.2	Have the LGA PHC departments been transformed into LGHAs with definite reporting line to the SPHCB?	*Tick YES if there are LGHA in each of the LGAs. Else tick No*			
4.3	Has the Malaria programme been moved to the SPHCB?	*Tick YES if the Malaria Programme has been moved to the SPHCB.*			
4.4	Has the HIV/AIDs programme been moved to the SPHCB?	*Tick YES if the HIV/AIDS Programme has been moved to the SPHCB.*			
4.5	Has the TBL programme been moved to the SPHCB?	*Tick YES if the TBL Programme has been moved to the SPHCB.*			
4.6	Have the FP/MCH/Nutrition programmes been moved to the SPHCB?	*Tick YES if the FP/MCH/Nutrition Programme has been moved to the SPHCB.*			
4.7	Has the Immunization programme been moved to the SPHCB?	*Tick YES if the Immunization Programme has been moved to the SPHCB.*			
4.8	Has the SMoH restructured the roles and responsibilities of its departments to align with the creation of the SPHCB?	*Tick YES if the SMoH has restructured its departments in line with the SPHCB reform*			
4.90	Has there being an orientation/briefing of the key staff of the SMoH on the new roles and responsibilities of the SMoH?	*Tick YES if the SMoH has conducted an orientation for the key staff on the new roles and responsibilities of the SMoH*			
5	**SYSTEMS DEVELOPMENT**				
5.1	Is there a Strategic Health Plan for PHC development in the state (linked to the overall State SHDP)?	*Tick YES if there is a current Strategic Health Plan in the state*			
5.2	Is there an Annual PHC Plan with Budget?	*Tick YES if there is a current Annual Health Plan in the state*			
5.3	Does each of the LGHAs have an annual PHC plan?	*Tick YES if EACH of the LGAs has a current Annual Health Plan*			
5.4	Is there an M&E/result/performance framework with clear milestones and targets for the SPHCB?	*Tick YES if there is a current result framework/log frame for the state*			
5.5	Is there a functional Integrated Supportive Supervision (ISS), quality assurance system and implementation plan for the SPHCB?	*Tick YES if there is a list of State ISS team, LGHA ISS team and Supervisory plan*			

5.6	Is there a functional performance review s ystem in place for the SPHCB?	*Tick YES if at least one performance review has been conducted in the past year with participants from the SPHCB and LGHAs*			
5.7	Is the monthly HMIS facility reporting rate more than 80%?	*Tick YES if the cumulative fac ility report for the last 12 months is greater than 80% on the DHIS2*			
5.8	Is there a functional data quality assurance system in place?	*Tick YES if the state conducted a state-wide DQA exercise in the preceeding year*			
6	**HUMAN RESOURCES**				
6.1	Have all PHC staff in the LGAs /SMoLG/LGSC been moved to the SPHCB or LGHAs	*Tick YES if all PHC staff in the LGAs have been moved to the SPHCB.*			
6.2	Is there a job description for each of the positions in the SPHCB?	*Tick YES if a job descripti on for each of the positions in the SPHCB is available*			
6.3	Is there a job description for each of the positions in the LGHA?	*Tick YES if a job description for each of the positions in the LGHA is available*			
6.4	Is there a functional Human Resources Information System for the SPHCB?	*Tick YES if there is a comprehensive and up to data database of HRH for the Board*			
6.5	Is there a process in place for onboarding new staff?	*Tick YES if all the SPHCB staff (engaged/posted) in the last twelve months havle been onboarded*			
6.6	Is there a HRH plan for the SPHCB?	*Tick YES if the HRH plan for the SPHCB identifies staffing gaps, the number and qualifications of staff required to fill the gaps*			
7	**FUNDING SOURCES & STRUCTURE**				
7.1	Is there a dedicated budget line for the SPHCB?	*Tick YES if there is a budget line for PHC activities excluding salaries*			
7.2	Is there a bank account for the SPHCB with all the signatories drawn from the management team of the SPHCB?	*Tick YES if there a bank account for the SPHCB*			
7.3	Are all PHC staff on the payroll of the SPHCB?	*Tick YES if all PHC staff are on the payroll of the SPHCB.*			
7.4	Does each LGHA have a dedicated account with signatories from within the LGHA management team?	*Tick YES if there a bank account for the LGHA. Else tick NO*			
7.5	Does each PHC facility receive regular funding (monthly/quarterly) to implement planned PHC activities e.g. outreach services, supervision, health education etc?	*Tick YES if a sample of atleast 3 HFs each in three LGAs received funding in the preceeding three months. Else tick NO*			
7.6	Is there a functional system for regular tracking of PHC expenditure?	*Tick YES if there is a document showing regular analysis of budget performance.*			
7.7	Is there a published consolidated audited report of PHC income and expenditure for the preceeding year?	*Tick YES if there is an auditted report for PHC for the preceeding year. ELSE tick NO*			

8	OPERATIONAL GUIDELINES				
8.1	Has the state disseminated the PHCUOR implementation guidelines to all staff at state and LGA levels?	*Tick YES if the PHCUOR manual has been distributed to at least ALL management staff in the SPHCB and LGHA. Else tick NO*			
8.2	Is there an admin/office manual for administrative procedures (HR, Admin, Logistics, Finance etc)	*Tick YES if there is an Admin/office manual. Else ick NO*			
8.3	Have key personnel (management team of SPHCB and LGHA) been trained on the mandate of the SPHCB using the policy guidelines?	*Tick YES if ALL members of the management team at State and LGA have been trained on the mandate of the SPHCB. Else tick NO*			
9	**Office Set-up**				
9.1	Does the SPHCB have an office building?	*Tick YES if the SPHCB has a building allocated to it as office. Else tick NO*			
9.2	Does the office building have at least Internet access, printer, water, power, power backup and for each of the management team - office space, basic furniture, and computer?	*Tick YES if the SPHCB offic e building has at least one of each of the materials listed. Else tick NO*			

ANNEX 2: ASSESSMENT PROTOCOL

METHODOLOGY FOR PHCUOR SCORECARD 4 ASSESSMENT

Day 1 Monday, 21/05/18 – National Assessor arrives the State capital.

Day 2 Tuesday, 22/05/18 – The assessment team members (National Assessor, NPHCDA State Coordinator and Partner) report in the office of the Executive Secretary for introduction and pay a courtesy call to the Hon. Commissioner of Health. We kindly request the SPHCB to facilitate the visit to the Hon. Commissioner of Health. The assessment tool for the State Ministry of Health will be applied during the visit. The National Assessor will train the team members and also be the person to apply the tools at all levels.

Day 3 Wednesday, 23/05/18 – The PHCUOR Scorecard 4 Assessment tool for the SPHCB will be applied on the Executive Secretary and the management team. We will appreciate if the Data Manager/Officer will be part of the exercise. The required documents will be provided by the SPHCB with copies for the assessment team to take away.

Day 4 Thursday, 24/05/18 – The assessment team accompanied by an officer of the SPHCB will visit an LGA outside the State capital and also visit a Primary Health Centre in a ward outside the LGA headquarters to apply the assessment tools for these levels. The SPHCB will be responsible for its officer going with the assessment team. The team will debrief the Executive Secretary and management team of SPHCB after concluding its assignment in the state. Day 5 Friday, 25/05/18 – Departure from the State.

The required documents to be provided by the SPHCB for the PHCUOR Scorecard 4 Assessment

1. The SPHCB Law as signed by the Governor and gazette
2. Regulations
3. List of members of the Governing Board and their operational guidelines
4. List of Local Government Health Authorities and members of the LG Advisory Committees

METHODOLOGY FOR PHCUOR SCORECARD 4 ASSESSMENT

Day 1 Monday, 21/05/18 – National Assessor arrives the State capital.

Day 2 Tuesday, 22/05/18 – The assessment team members (National Assessor, NPHCDA State Coordinator and Partner) report in the office of the Executive Secretary for introduction and pay a courtesy call to the Hon. Commissioner of Health. We kindly request the SPHCB to facilitate the visit to the Hon. Commissioner of Health. The assessment tool for the State Ministry of Health will be applied during the visit. The National Assessor will train the team members and also be the person to apply the tools at all levels.

Day 3 Wednesday, 23/05/18 – The PHCUOR Scorecard 4 Assessment tool for the SPHCB will be applied on the Executive Secretary and the management team. We will appreciate if the Data Manager/Officer will be part of the exercise. The required documents will be provided by the SPHCB with copies for the assessment team to take away.

Day 4 Thursday, 24/05/18 – The assessment team accompanied by an officer of the SPHCB will visit an LGA outside the State capital and also visit a Primary Health Centre in a ward outside the LGA headquarters to apply the assessment tools for these levels. The SPHCB will be responsible for its officer going with the assessment team. The team will debrief the Executive Secretary and management team of SPHCB after concluding its assignment in the state. Day 5 Friday, 25/05/18 – Departure from the State.

The required documents to be provided by the SPHCB for the PHCUOR Scorecard 4 Assessment

1. The SPHCB Law as signed by the Governor and gazette
2. Regulations
3. List of members of the Governing Board and their operational guidelines
4. List of Local Government Health Authorities and members of the LG Advisory Committees
5. Minimum Service Package (MSP) document
6. Investment or Service Delivery Plan
7. Annual Budget

ANNEX 3: LISTS OF ASSESSORS

SOUTHERN ZONES 21ST – 25TH MAY, 2018

S/N	STATE OF DEPLOYMENT	NAME OF NPHCDA ASSESSOR	NPHCDA STATE COORDINATOR	PARTNER
1	LAGOS	MRS CHITO NELSON	SC OGUN	CHAI
2	OGUN	MR SINA ADELAKUN	SC LAGOS	HERFON
3	OYO	MR ADENIYI EKISOLA	SC OSUN DR.M.O. OYESIJI	NGF
4	OSUN	MRS TOSIN DARE	SC OYO MR.S.A. AKINRINADE	NGF
5	ONDO	MRS SAKINA HAMZA	SC EKITI MRS. V.O. ADEBIYI	HERFON
6	EKITI	MRS KHADIJAH ISHOLA	SC ONDO MR A.A. ADEOYE	HERFON
7	EDO	DR. O. OGBE	SC DELTA DR OFONAKARA UZOCHUKWU	HERFON
8	DELTA	DR. IRENE ESU	SC EDO DR JOSEPHINE OBAYAGBONA	HERFON
9	BAYELSA	MR PETER OSIKWEMHE	SC RIVERS DR I. UKPANG	HERFON
10	RIVERS	DR. DANIEL OTOH	SC BAYELSA MR. M. O. AGBEDEYI	CHAI
11	CROSS RIVER	MRS SEMIRA WAKASO	SC AKWA IBOM MRS ANNE UMOH	NGF
12	AKWA IBOM	MR LANRE AJAYI	SC CROSS RIVER MR JULIUS IDOKO	NGF
13	ENUGU	DR NGOZI NWOSU	SC EBONYI MR E.A.NWACHUKWU	NGF
14	ANAMBRA	MR CHARLES IJEOMA	SC ENUGU MR. PHILLIP UGWUEZEH	HERFON
15	EBONYI	MRS IFY ONWUDINJO	SC ANAMBRA	HERFON
16	IMO	PHARM. AMAKA NWOHA	SC ABIA DR EJESIM-NWOSU	PACFaH@Scale
17	ABIA	DR. VAL OBIJEKWU	SC IMO MRS STELLA OKORO	HERFON

NORTHERN ZONES 29TH MAY – 2ND JUNE, 2018

S/N	STATE OF DEPLOYMENT	NAME OF NPHCDA ASSESSOR	NPHCDA STATE COORDINATOR	PARTNER
1	NIGER	TOSIN DARE	SC FCT MR. MUHAMMAD KAWU	NGF FIRO ELHASSAN KAKA HERFON ALH. AHMED USMAN
2	KANO	MRS KHADIJAH ISHOLA	SC JIGAWA MR. MOHAMMED MOHAMMED	HERFON DR. SHEHU USMAN ABDULLAHI
3	KATSINA	MR ADENIYI EKISOLA	SC KADUNA MRS. MARIYA NASIR	HERFON PHARM. A. GACHI

4	KADUNA	PHARM. AMAKA NWOHA	SC ZAMFARA MR.SALISU SANI	NHED DR. GRACE ONOTU
5	FCT	MRS. PRISCILLA IKPAREN	SC NIGER MRS. YEMI ADEOSUN	HP+ YOMI SULE
6	KEBBI	MR. AYENI DICKSON	SC SOKOTO MR. BALA USMAN DANGOGO	HERFON ABUBAKAR KOKO
7	ZAMFARA	MR. CHARLES IJEOMAH	SC KATSINA MR. MAIKUDI ABUBAKAR	NGF DR. AHMAD
8	SOKOTO	MR. MICHEAL AJAYI	SC KEBBI MR AKUSO YAHAYA	HERFON DR. UMAR
9	JIGAWA	DR. DANIEL OTOH	SC KANO MR.KABIRU YAKASAI	HERFON ADAMU BABALE
10	BENUE	MR. SINA ADELAKUN	SC PLATEAU MR. IFEANYI OHANU	NHED DR. EMMANUEL SOKPO
11	PLATEAU	DR. O. OGBE	SC NASARAWA MRS. GLADYS OKORO EKWUEME	HERFON PHARM. GONGYI
12	GOMBE	MRS. NELSON CHITO	SC BAUCHI MR. BASHIR MAIDABINO	HERFON ALIYU EL-NAFATY
13	ADAMAWA	MRS ADEOLA OHIFEME	SC TARABA MR. SULEIMAN YAKUBU	NGF MR. UBONG ESSIEN HERFON DR. PETER THOMAS
14	TARABA	HALIMA TAJO	SC ADAMAWA	HERFON MR. DAVID POLYCARP
15	BAUCHI	DR. NWOSU NGOZI	SC GOMBE MR. YAHAYA AHMAD	NHED AUWAL ZUBAIR
16	YOBE	MRS. SAKINATU HAMZA	SC BORNO MRS. FALMATA A. USMAN	NHED DR. SHEHU SULE
17	BORNO	MOHD SABO ADAMU	SC YOBE MR.HASSAN BELLO	NHED DR. SHEHU SULE
18	KWARA	MRS. IFEYINWA ONWUDINJO	SC KOGI MR. IDOWU FOLAYAN	NGF MR. EMEKA ANACHUSI HERFON MR. AMUDA OLAYINKA AZEEZ
19	KOGI	MRS. VICTORIA APOCHI	SC KWARA MRS. BOLATITO OLADIPO	NGF MRS. OLUBUNMI AKANBI HERFON COMRADE ANDREW ENEJINYON
20	NASARAWA	DR. VAL OBIJEKWU	SC BENUE MR. USMAN YAKUBU	NGF MRS. CHINEKWU OREH

ANNEX 4: EDITORIAL TEAM FOR PHCUOR SCORECARD 4 REPORT

1.	Dr. Oladimeji Olayinka	NPHCDA
2.	Dr. Shehu Sule	NHED
3.	Dr. Emmanuel Sokpo	NNHED
4.	Dr. Ahmad Abdulwahah	NGF Secretariat
5.	Pharm. Chinekwu Oreh	NGF Secretariat
6.	Ms. Uche Eberi	ACHF
7.	Ms. Kimberly Nnabue	IVAC/DCL
8.	Mr. Micah Oloche Anya	NPHCDA
9.	Mr. Adeniyi Ekisola	NPHCDA

References

MICS 2016. Abuja: National Bureau of Statistics.

NPopC 2006. 2006 Population and Housing Census of the Federal Republic of Nigeria: National and State Population and Housing Census Priority Tables. Abuja: National Population Commission

NPHCDA 2015. Primary Health Care Under One Roof PHCUOR Implementation Scorecard III Report. Abuja: National Primary Health Care Development Agency

Printed with the support of:

NIGERIA
GOVERNORS'
FORUM

The Secretariat
49/51, Lake Chad Crescent, Maitama, Abuja.