FEDERAL GOVERNMENT OF NIGERIA

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

INTEGRATING PRIMARY HEALTH CARE GOVERNANCE IN NIGERIA

(PHC Under One Roof)

IMPLEMENTATION

PRRINN-MNCH

June 2013

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National Primary Health Care Development Agency (NPHCDA)
INTEGRATING PRIMARY HEALTH CARE GOVERNANCE (PHC Under one Roof) – IMPLEMENTATION MANUAL
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ACRONYMS

ANC	Antenatal Care
CBO	Community Based Organisation
CSO	Civil Society Organisation
CSC	Civil Service Commission
EOC	Emergency Obstetric Care
FMOH	Federal Ministry of Health
FP	Family Planning
HMIS	Health Management Information System
HR	Human Resource
HRIS	HR Information System
IMCI	Integrated Management of Childhood Illnesses
LGA	Local Government Authority
LGSC	Local Government Service Commission
MCH	Mother and Child Health
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOJ	Ministry of Justice
MOLG	Ministry of Local Government
MOWA	Ministry of Woman's Affairs
MSP	Minimum Service Package
NPHCDA	National Primary Health Care Development Agency
PHC	Primary Health Care
PHCUOR	PHC under one roof
SCM	Supply Chain Management
SDSS	Sustainable Drug Supply System
SHC	Secondary Health Care
SMOH	State Ministry of Health
SPHCDA	State PHC Development Agency
SPHCDB	State PHC Development Board
WHO	World Health Authority

FOREWORD

Primary Health Care made its entry into the national political agenda in Nigeria between 1986 to 1993 with a lot of progress in the expansion of health infrastructure to rural communities, establishment of Schools of Health Technologies and turn out of large number of Community Health Workers, the attainment of Universal Childhood Immunization target and the recommendation of the country's model by the WHO Review Team for other countries to replicate.

Over the years the health system has been structurally fragmented, especially at the sub-national level and largely characterized with vertical delivery of programmes. These vertical programmes contributed much less to the attainment of outcome and impact targets due to the inefficiency of service delivery. In recognition of this challenge, stakeholders at the national and state levels, during the first national meeting in Abuja in 2010, agreed on the strategy shift to an Integrated Primary Healthcare Governance (PHC Under One Roof), in order to bring managerial, planning, implementation and Monitoring/Evaluation under a single authority at the state level under the platform of the State Primary Health Care Development Board or Agency, which will ensure the implementation of integrated PHC services. The Policy and Guidelines were approved at the 54th National Council on Health in 2011.

A 2nd National Stakeholders' Meeting was convened in Abuja in September 2012 to consider the progress made, challenges and lessons learnt as well as to share inter-state experiences and agree on ways to improve effectiveness of implementation and comprehensive scale up. Twenty one states were found to have established the State Primary Health Care Boards, or equivalent agencies, in compliance with NCH approval. However, the degree of effectiveness of implementation varied. Consequently, it was agreed that the implementation guidelines be revised and circulated to stakeholders.

It is our hope that this Implementation Manual will bridge the gaps in the implementation of this national policy. The outcome will be an improved PHC system which is universally accessible to all Nigerians with the cardinal goal of making Nigerians healthy.

DR. ADO J. G. MUHAMMAD
Executive Director/ Chief Executive Officer

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DR M. J. ABDULLAHI
Director, Planning Research And Statistics

1. INTRODUCTION

At the 54th National Council on Health (NCH) Meeting in May 2011, resolution number 29 states:

> ***"Council noted the thrust of the National Health Bill in strengthening Primary Health Care (PHC) through the creation of PHC Boards/Agencies and the PHC Development Fund. Council noted efforts in "Bringing PHC under one roof" in line with the provisions of the National Health Bill. Council also noted the importance of enacting relevant state legislation and regulations that will facilitate the implementation of National Health Bill. Council therefore approved the implementation Guide on Bringing PHC under one roof (PHCUOR) as a working document to be used by the three tiers of government and approved that all states establish Primary Health Care Boards."***

Over the last several years, the National PHC Development Agency (NPHCDA) has introduced a process ("Bringing PHC under one roof") to strengthen PHC services through reducing the fragmentation of PHC service management. NPHCDA has hosted several workshops to support this.

In anticipation of the passage of the new Health Bill, many states have proceeded to establish State PHC Development Boards or Agencies (SPHCDB or SPHCDA). Many States have encountered several challenges in establishing SPHCDB or SPHCDA resulting in the establishment of institutions that do not meet the national policy). This manual has been developed by the NPHCDA to aid this process.

During 2012, the NPHCDA developed a checklist for monitoring progress (see below) which was shared at the national workshop in September. This was then used to assess progress in all states (see below).

This manual is developed along the themes of the checklist and each theme is explained in more detail. For each, requisite actions at Federal, state and LGA levels (as applicable) are discussed. Options adopted by the different states are presented following the "not-one-size-fits-all" principle. Potential indicators and targets are presented and steps to address the likely challenges explored.

It must be remembered that extensive health sector reform requires a sustained effort over considerable lengths of time. For example, the health sector reform process in Jigawa started in 2003 and started to bear fruit around five years later. Still today there are tasks that need to be completed. Thus, states need to be wary of quick fix solutions and need to be prepared for a lengthy period for the transformation to take shape and develop roots. Focus must be on improving the quality and coverage of health service delivery and promoting a culture of transparency, accountability and participation by all stakeholders.

a) Principles

"Bringing PHC Under One Roof" is modelled on WHO's guidelines for integrated district-based service delivery and is based on the following key elements:

- Integration of all PHC services delivered under one authority - at a minimum consisting of health education and promotion, MCH/FP, immunisation, disease control, essential drugs, nutrition and treatment of common ailments.
- A single management body with adequate capacity that has control over services and resources (especially human and financial). As this is implemented this will require repositioning of existing bodies.
- Decentralized authority, responsibility and accountability with an appropriate "span of control" at all levels. Roles and responsibilities of the different levels will need to be clearly defined.
- Principle of "three ones" (one management, one plan and one M&E system).
- An integrated supportive supervisory system managed from a single source.
- An effective referral system between/across the different levels of care.
- Enabling legislation and concomitant regulations (inclusive of the key elements).

- Integration of all PHC services delivered under one authority - at a minimum consisting of health education and promotion, MCH/FP, immunisation, disease control, essential drugs, nutrition and treatment of common ailments.
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- An integrated supportive supervisory system managed from a single source.
- An effective referral system between/across the different levels of care.
- Enabling legislation and concomitant regulations (inclusive of the key elements).

2. LEGISLATION

Key questions

- Has your State drafted a PHC Bill and Regulations?
- Has a PHC Bill and Regulations been passed by the State House of Assembly?
- Has a PHC Bill and Regulations been assented to by the Governor?
- Has a PHC Law and Regulations been gazetted?

a) Overview

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

There is a need for both legislation and regulations. Legislation (in the form of a Bill) is usually a more general document and provides the long term view. It is anticipated that legislation will be valid for 20 to 30 years. Legislation needs to pass through the whole legislative process and should be approved by both houses of the legislature (including passing through the Health Committee and possibly including public hearings). It then goes to the Governor for final assent. All these steps allow for alterations to the draft Bill and also can be bottlenecks (e.g. the passage of the National Health Bill).

Regulations on the other hand are more specific and map out the details and actions that need to be taken to realise the promise of the Bill. Regulations are usually signed off by the Commissioner for Health (this is normally provided for in the Bill). In addition, this means that it is easier to amend Regulations as and when changes occur. In a sense, Regulations are more sensitive to changing conditions. Regulations need to be aligned to the Bill and any State Bill needs to be harmonised with a National Bill.

It is critical that there is wide consultation over the development and passage of any Bill (to a lesser extent this is true for Regulations as they are more technical and fulfil the vision contained in the Bill). Leaders (political, religious and traditional), professional associations in the health sector and communities need to be consulted in developing the Bill. The Bill should reflect the aspirations of all the people of the state. It is also critical that the processing of the Bill (through the State Houses and by the Governor) is monitored so that key aspects are not watered down or removed.

The other reasons for wide consultation is to enrich the options proposed in the Bill, improve understanding of what the Bill entails, and thus what the health sector plans to do, and to ensure wide ownership of the final product. All this will enhance implementation.

There is no time limit for consultation and depending on the level of acceptance, the process can take from a few months to one year. This time is not wasted time as once most stakeholders buy in, the next

steps could move very fast. It also essential to note that consultation is an ongoing process that continues even after the bill has been passed and the PHC Board established.

b) Options

Most states have opted for "Bringing PHC under one roof". PHC services are delivered and managed by a multiplicity of role-players (SMoH, LGAs, NPHCDA, LGSCetc). States have thus drafted legislation to create one body (SPHCDA or SPHCDB) that will manage all PHC services in the state.

However, some states (e.g. Jigawa) have created a single body (in Jigawa this is called the Gunduma Health Services Board) that manages both PHC and SHC services. In some states, the process has started with PHC but there are plans to further the integration by including SHC services at a later stage.

In creating a single system for the management of PHC services (and in Jigawa's case both PHC and SHC services) states have created different management structures below the state level. These include:

- in Jigawa, the Bill has created 9 Gunduma Councils each responsible for health services in 2 to 4 LGAs;
- in some states, a zonal structure has been created or strengthened (if pre-existing) to manage the PHC services in 2 to 3 LGAs; and
- in some states the SPHCDA/B deals directly with the LGAs who provide the PHC services.

It is important to note that the alignment of the management structures below the state level must follow, to some extent, the existing geopolitical, traditional or cultural boundaries to ensure harmony and ease of administration. The population coverage should be of reasonable size (usually defined as serving between 50,000 and 500,000 people) to reduce administrative costs that would increase with too many smaller units.

Creating the different management structures highlighted above is in alignment with three of the key principles of "Bringing PHC under one roof" as agreed to by the NCH.

- Integration of all PHC services delivered under one authority - at a minimum consisting of health education and promotion, MCH/FP, immunisation, disease control, essential drugs, nutrition and treatment of common ailments.
- A single management body with adequate capacity that has control over services and resources (especially human and financial). As this is implemented this will require repositioning of existing bodies.
- Decentralized authority, responsibility and accountability with an appropriate "span of control" at all levels. Roles and responsibilities of the different levels willneed to be clearly defined.

The different structures reinforce the principle of not-one-size-fits all and the need for states to tailor their approach and their legislation to fit their state context and needs.

c) Challenges

There are five key challenges that states need to keep in mind as they move forward in "Bringing PHC under one roof".

Time

Many people want legislation to be developed as soon as possible. This contradicts the need for adequate consultation, for developing a full understanding and creating ownership of the process and the product. All this takes time. It is important for key stakeholders to discuss and understand the implications of what is a transformational shift in how health services are delivered and managed. This might need exposure to states in Nigeria who have already embarked on the process and possibly to countries (e.g. Ghana) who followed this route two decades ago. Thus there is a need to balance out the requirement of change and it not taking too long with the need for adequate time to ensure that the resulting system is adequately thought through, planned and implemented without challenges down the road.

Process

Similar to the need for adequate time, there is a need to ensure that all stakeholders are adequately consulted and that all understand the proposed changes and have bought into the process. Too many shortcuts with the process will most likely cause problems and challenges as the new system is implemented.

Stakeholders include politicians (both state and LGA), leaders (traditional and religious), current health managers (at state and LGA levels), bureaucrats in the public service at state and local government, health workers and professionals, professional associations and labour unions, and communities.

Budget implications

It is important for the budget implications to be worked out. This needs to be an estimate and there will be both savings and increased costs. It is critical for the politicians to understand the budget implications of what is being proposed. A good economic analysis is therefore useful and can be used to engage the health ministry, finance ministry, other policy makers and development partners in realignment of resources.

Integration of all PHC services delivered under one authority - at a minimum consisting of health education and promotion, MCH/FP, immunisation, disease control, essential drugs, nutrition and treatment of common ailments. A single management body with adequate capacity that has control over services and resources (especially human and financial). As this is implemented this will require repositioning of existing bodies. Decentralized authority, responsibility and accountability with an appropriate "span of control" at all levels. Roles and responsibilities of the different levels will need to be clearly defined.

Bill and Regulations

As discussed earlier, there needs to be both a Bill and Regulations. The Bill won't provide enough details for the health managers to implement all that is required. Far too often, the focus is on the Bill and the Regulations are only developed after the Bill has been approved. It is suggested that both are

developed at the same time and as soon as the Bill is assented to by the Governor, the Regulations are then signed, usually by the Commissioner for Health.

Altering the Bill

One of the common problems experienced is that the draft Bill is substantially revised in the passage through the legislative process. Of course, some alterations can be expected. But, if substantive changes are made this could impact on the suitability of the final version. For example, the Enugu Bill (assented to in 2005) was altered at the last minute to allow for the creation of 56 local management areas (in addition to the districts and the LGAs). This created an unwieldy and expensive management structure. Only now is the Bill being reviewed to resolve the issue. It is recommended that a committee be formed to shepherd and monitor the Bill through the legislative process. The committee should be senior enough to advise politicians of the implications (and costs) of any substantive changes.

d) Necessary steps

STEP 1: Build strong consensus among all stakeholders including government structures (e.g. SMoH, MOLG, LGSC, MOF, MOJ, State CSC, MOWA); legislators; LGA council chairmen, council and management; partners, CBOs, professional groups; traditional and religious leaders; private health professionals.

STEP 2: Involvement of LGA chairmen and PHC co-ordinators (and teams). It is critical that local government politicians and health service providers are included in the discussions to build the necessary consensus for the envisaged changes. Representatives from local government need to be included in the technical committee. Because some of the expected changes will affect how local government personnel and finances are managed, it is key that they are part and parcel of the planned changes.

STEP 3: Establish a technical committee to facilitate the process and drafting of a law utilising clear guidelines from FMOH/NPHCDA and based on the National Health Bill. The committee should comprise representatives from line ministries and relevant stakeholders. Different states have adopted different approaches to the committee step. In Jigawa, one committee drove the process from beginning to end. In other states, there have been several committees – for example, one committee to draft the proposal, another to oversee the implementation and the repositioning.

STEP 4: Strengthen advocacy initiatives around bringing "PHC Under one roof". For the initiative to move forward and for the PHC system to be unified and decentralised, many stakeholders need to be informed and involved in the discussion and development of reforms, so they can come to realise the advantages, the challenges and the pitfalls. This includes politicians from federal to LGA levels, health workers and health managers at all levels, traditional and religious leaders and the community at large. In addition, the process does require strong, skilled and influential leadership at a high level, as well as considerable advocacy, communication and coalition building to achieve a critical mass of change agents that are required for this transformation. Thus, a carefully-planned advocacy campaign needs to be developed and implemented.

It is critical that enough time is spent on the first four steps. Restructuring services is a major task and will take at least five to ten years to complete. It is important that all stakeholders understand the implications, the challenges and the benefits of the proposed changes.

There will be those who are reluctant to change for a variety of reasons. However, through structured workshops and retreats, possible study tours to areas where such changes have occurred and an ongoing advocacy and information campaign, most of these concerns can be addressed. But, it is important that people are not hurried through these steps.

STEP 5: Develop legislation and then regulations to support the establishment of a SPHC Board (SPHCDB) and relevant lower level health authorities and to address transitional measures e.g. staffing, financing and structures. This is a critical area and states will need to draw on people (both legal and health policy) well versed in these issues. These people should be both from within and without the state. Consider using international advisors, if necessary and if funds permit. Prior to this there will be a need for a concept paper based on a state situation analysis.

e) Indicators

- Technical committee comprised of senior government and stakeholder representatives established
- Bill assented to by Governor
- Regulations assented to by Commissioner for Health

3. SYSTEMS DEVELOPMENT

Key questions

- Has your State appointed a PHC Governing Board?
- Do Financial Management policies exist for the PHC Agency?
- Do Integrated Supportive Supervision policies and plans exist for the PHC Agency?
- Do Strategic and Annual planning policies, plans and budgets exist for the PHC Agency?
- Do Performance Management policies and plans exist for the PHC Agency?
- Do General Management and Administration policies exist for the PHC Agency?

a) Overview

The new structure (Gunduma Board, SPHCDA or SPHCDB) has a number of elements. At each level there is a governing body (usually called the board) and a management structure. At state level, the governing body is composed of respected leaders (both political, religious, traditional and technical). This body meets on a regular basis and oversees the functioning of the SPHCDB (or equivalent). The head of the management structure (Executive Secretary or equivalent) reports to the governing body. The governing body is usually responsible for the appointment of the executive secretary (in some cases the Governor will have the final say after the governing body has submitted a list of appropriate individuals). The governing body also approves the annual plan and budget and oversees the development of and monitors the implementation of policy. Policies will cover all systems areas (e.g. finance, human resource, performance management, supply chain management). These will be developed by the management team and need to be aligned to the policies of the state government. The management team consists of fulltime employees.

At sub-state levels, this structure can duplicate itself. There might be a governing structure. This can be called various names - LGA, the Gunduma Council, the Zonal Council or Area Health Committee. This governing body oversees the functioning of the fulltime management structure at this level but usually has no role in policy development. It also provides a link to the community that the health service covers.

Line function management resides with the fulltime management teams. At the sub-state level the management team oversees the functioning of the PHC facilities and hospitals (if the new structure integrates both PHC and SHC services) within its jurisdiction. In turn, this management body reports to and is managed by the state level management team.

It is key that the right people are found to populate these new structures, both the governing bodies and the management structures. There will be a lot of interest from a number of people in the state to ensure that they influence the selection. These are key positions and the appointment of poor or weak managers or individuals can impact on the functioning of the new structures. The committee tasked with overseeing the transformation needs to play a key role here and ensure that the Governor and other influential leaders are adequately briefed and appraised of the situation at regular intervals.

b) Options

The structures that can be created at state and sub-state level vary enormously across the states and again reflect on the not-one-size-fits-all principle. The structures should be catered for in the new Bill and Regulations and the line function management clearly spelt out.

Policy development needs to align with those adopted nationally and by the state and needs to follow the principles outlined in the resolution adopted by the NCH on "Bringing PHC under one roof", namely:

- Principle of "three ones" (one management, one plan and one M&E system).
- An integrated supportive supervisory system managed from a single source.
- An effective referral system between/across the different levels of care.

c) Challenges

There are three key challenges that states need to keep in mind as they move forward in "Bringing PHC under one roof".

Appointment of inappropriate people

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

Lack of clear distinction between governing body and management team

Inherent in the design, as encapsulated in the new Bill and Regulations, is the need to clearly define the role of the politicians and the administrators. This is played out in the respective roles and functions of the governing bodies and the management teams. For many years, this distinction has not been clear and has led to inappropriate interference in the functioning and management of the health services. Often this has had disastrous effects.

Thus, the new Bill and Regulations should clarify the roles and responsibilities of the politicians (e.g. the Governor is responsible for approving the appointment of the governingbody and the executive secretary of the Board, LGA chairmen are represented on the governing bodies), the governing body and the management structures. Line function management should rest with the fulltime management teams. Governing bodies are responsible for policy development and approval and oversight of the management teams. But, governing bodies are not entitled to indulge in the day-to-day management of the health service. That is entrusted to the management teams.

Gender imbalances in the governing bodies

Health services are provided to mothers and children who make up the bulk of the clients. However, governing bodies often have inadequate representation from women. This is an issue that needs to be

addressed in the new Bill and Regulations and must be considered by the transformation committee in assembling names for the governing body for the Governor to approve.

d) Necessary steps

STEP 1: Ensure that the transformation committee drives the process of establishing the SPHCDB (or equivalent) and management structures to manage the new system. It is key that the appointment of the governing bodies and the management teams follow a fair and transparent process and is consonant with the political aspirations of the state. The transformation committee, which is a senior committee usually appointed by the Governor, should oversee the process. In addition, the transformation committee needs to communicate progress regularly and to all stakeholders, but particularly to the Governor and the Commissioner for Health.

STEP 2: Establish the SPHCDB and management structures to manage the new system. An essential requirement for effective integration is that existing PHC staff (e.g. those currently employed by LGA, LGSC, SMoH) will all come under the management of the SPHCDB and the decentralised structures that are created. Payment of staff will be through the SPHCDB. Recruitment and equitable distribution of staff will be the responsibility of the SPHCDB. Similarly, finances will fall under the Board. This will entail consolidating health funds that currently fall under the LGAs, the SMoH, the SMoLG and any other bodies. At this stage, with managerial control over finances and human resources, the Board will be empowered to manage and provide health services. Usually, the health services provided will fall in line with a Minimum Service Package (MSP) which will be adapted from the federal level guidelines. Many states have developed a MSP that can be adapted and used.

STEP 3: Establishment of lower level health authorities. As stated before there is no-one-size-fits-all approach. For example, in Jigawa there is the Gunduma Board and nine Gunduma Councils (each covering two or three LGAs), in Enugu there is the State Health Board, seven District Health Boards (each comprising two or three LGAs), 17 districts and 56 Local Health Authorities. The key principles for establishing lower level structures are:

i. Single lines of accountability between each level and the authority above;

ii. Well-established accountability upwards at every level for finance, staff and service delivery

iii. Creation of structures of an appropriate size and span of control with borders that are coterminous with current political borders.

e) Indicators

- Governing body and management structure fully functional at all levels

4. HUMAN RESOURCES

Key questions

- Has your State developed a PHC Board and/or Agency Organogram?
- Has your State developed a staff profile for different facility types?
- Has your State developed Job Descriptions for PHC Agency Management and staff? Has your State developed staff affordability norms?
- Has your State interviewed and selected PHC Management personnel at all levels? Has your State developed a staff distribution plan?
- Has your State compiled an accurate staff database (HRIS set up)?
- Has your State identified and provided for working environment needs? Has your State fully deployed staff to facility postings?

a) Overview

Human resource management is one of the key challenges facing the new structures. There are three overriding issues that are also interlinked.

The first issue relates to the movement of staff from the existing bodies to the new structure. With the establishment of the SPHCDB (or equivalent), all health staff providing PHC services (in the case of the Gunduma, SHC services as well) need to now fall under the management of the new structure. In addition, they will be paid via the new structure. In effect, this means that staff previously employed by the SMoH or the LGAs (or other structures that exist) will now be employed by the SPHCDB (or equivalent). This can create problems in a number of areas: current employers may be reluctant to release staff, employees might not want to move and the new structure might not want to absorb some of the staff.

The second issue relates to the appointment of management staff at state and sub-state levels. Appointment of managers in the new state level structure is addressed under theme 2, with the centrality of the transformation committee in ensuring a fair and transparent process and that the right people are selected for the governing body and the management team. A similar approach needs to be followed for the selection and appointment of the governing body and the management team at the sub-state level.

The third issue relates to the inherited problems of maldistribution of staff, ghost workers and imbalance between professional and non-professional cadres. This is an issue that has political undertones and again highlights the delicate dance between governance and systems that the governing body and the management structure of the new SPHCDB need to embark on.

b) Options

In general, the best approach is to get a clear cut audit of existing staff, preferably using a HRIS database. This will form the basis for much of the work that will flow under this theme.

Movement of staff is a critical issue. Staff are accountable to those who manage and pay them. Thus, it is critical for the new SPHCDB to manage and remunerate all PHC staff (in the case of the Gunduma

system all PHC and SHC staff). The data in the HRIS will establish the numbers and the types of staff available. But, there are other issues to consider. Some of the health functions (often environmental health) will remain with LGAs and not be transferred to the new SPHCDB. In addition, there might be an excess of non-professional staff (e.g. security staff, cleaners). All these might not be needed in the new SPHCDB run facilities. They could be retained and redeployed by the LGAs. In addition, with the adoption of the MSP (see theme 9), the new SPHCDB should have a clearer idea of the number and type of staff needed at each facility. All these will inform the need for staff in the new SPHCDB run facilities. Thus, it is imperative for the new SPHCDB to do all the groundwork and then negotiate with the old employing structures for the staff they need to run their facilities.

For selecting/appointing sub-state governing bodies and management teams, the state level governing body and management team will oversee the process. As at state level, job descriptions need to be developed and selection processes that are fair and transparent adopted. It is critical for the health systems transformation initiative ("Bringing PHC under one roof") for the right people to be chosen to fill these positions. Thus care needs to be taken to ensure this. Communication with politicians at state and LGA level and with other community leaders and structures is vital.

Maldistribution, ghost workers and the balance between types of staff are all politically charged issues. The approach of developing the HRIS, using the MSP, classifying facilities correctly and determining the staff needs of each facility will assist the new SPHCDB in logically determining staff needs. However, to address the political dimension it is important for the high profile transformation committee (or a similar HR committee) to drive the process. This committee also needs to liaise and communicate with the relevant politicians (Governor, Commissioner for Health, LGA Chairmen) and communicate with other leaders and community structures.

Thus, the balance between the technical and the political is key to achieve the aims of staffing the new SPHCDB run facilities with the correct numbers and balance of staff.

c) Challenges

There are three key challenges that states need to keep in mind as they move forward in "Bringing PHC under one roof".

HR committee not senior enough

HR issues are both technical and political. Issues such as maldistribution of staff, incorrect mix of staff and ghost workers do not happen by chance. Thus, to address the issues needs a combination of political and technical acumen. The HR committee has to have enough seniority (inclusive of the ear of the Governor) to address these issues. Thus, it is important for the HR committee to be appointed by the Governor and have senior representation from the key Ministries so that progress can occur.

Technical steps not adequately followed

There will often be a tendency to fast track the process. However, the key steps (as outlined below) will need to be followed to ensure that the HR committee has all the requisite information to guide their deliberation and actions.

Resistance to change

There will be health workers who do not want to move, for a variety of reasons. There will be LGA chairmen who do not want to relinquish staff, again for a variety of reasons. As with other aspects of the

transformation, the key actors driving the different processes need to be aware of this and make provision for this. Communication and advocacy are key tools in their armamentarium.

d) Necessary steps

STEP 1: Establishing a HRIS database of existing staff. It is critical that the new SPHCDB (or equivalent) establish the current HR situation and then link this to HR needs based on a MSP approach. To do this effectively, the SPHCDB needs to utilize a HRIS. Currently, in some states HRPlanner is being used for this process. States most likely will need external consultant assistance to develop this database and then maintain it. Thus either fund needs to be sourced from government or from interested development partners.

STEP 2: Establishing a high profile HR committee. This is a key step. Most HR issues have a governance or political dimension. Just adopting a technical approach will not suffice. Thus, the HR committee needs to be sufficiently high profile with good links with the state political actors. Preferably, it should be linked or aligned with the transformation committee. This committee will need orientation and most likely training on such issues as the HRIS and the MSP. In addition, it will need ongoing technical support. Again this needs to be budgeted for and funds sourced.

STEP 3: Using the MSP to determine HR needs at all facilities. This is a key technical step. The MSP should be used to classify all facilities and thus determine the mix and numbers of staff required for each facility. This can then be loaded on the HRIS and used in negotiating for the transfer of current existing staff and also to recruit additional new staff. This will be further discussed in theme 9.

STEP 4: Negotiating with previous employers (particularly LGAs) re movement of staff. Once the numbers have been crunched, the HR committee can do the negotiations with the previous employees re the number and types of staff to transfer to the new SPHCDB run facilities. In the process, certain staff will remain with their previous employers and either be utilized to fulfil functions that are not transferred (e.g. environmental health) or redeployed within other departments. With the transfer of staff will come the transfer of funding to pay the staff.

STEP 5: Selecting/appointing sub-state governing bodies and management teams. As highlighted this will follow after the selection/appointment of the state level governing body and management team. The governing body and the management team of the state level SPHCDB will be responsible for managing the process according to the state recruitment processes. It is critical for the process to be fair and transparent and to be seen to be fair and transparent. Thus job descriptions and selection processes need to be drawn up and shared widely.

STEP 6: Communicating widely the processes, changes and outcomes. Any change creates uncertainty and fear of the unknown. It is vital that all aspects of the change are communicated widely to the different stakeholders in the state.

e) Indicators

- Staff paid by new management body
- HRIS fully established

5. FUNDING SOURCES AND STRUCTURE

Key questions

- Has your State released a PHC Board take-off grant?
- Has your State developed and/or produced PHC financial guidelines and/or manuals?
- Has your State established a dedicated budget process for planned PHC expenditure?
- Does your State have a system for tracking the release of budgeted funds?
- Has your State developed mechanisms for contributions from different role players?
- Has your State set up a pooled fund for services/operations?
- Has your State integrated pooled funding into the state budgeting system?

a) Overview

Financial resources are a key ingredient in ensuring the success of "Bringing PHC under one roof". All states are aware of the processes in ensuring that plans are developed and costed; that these costed plans are included in the state budget and that once approved that the funds are released timeously. This is not a smooth process.

It is critical that the SPHCDB develop systems and processes to ensure that plans are developed and costed, that these are included in the annual budgets of the SMoH and successfully defended and that budget release is tracked. It is also critical to develop an effective M&E system so that the SPHCDB can show the state government how the money has been spent and with what effect and impact.

b) Options

Some states have adopted pooled funding mechanisms. This allows the state, LGAs and development partners to contribute to the management and running of services provided by the SPHCDB. These funding mechanisms need adequate checks and balances to ensure that the money is spent according to the documented plan and budget.

In other states, the SPHCDB becomes a line in the government budgeting system and has to draft memorandums for Governor approval when it wants to draw down budgeted money.

Whatever the options chosen, it is critical that the SPHCDB develop appropriate financial processes and procedures to cost plans, budget for activities and ensure that the money allocated is spent wisely and that expenditure/releases from government is tracked. This needs to be encapsulated in a financial manual.

c) Challenges

There are three key challenges that states need to bear in mind as they deal with the financial issues:

Inadequate planning and budgeting processes

Most states have poor capacity when it comes to annual planning and budgeting. Plans are often rolled over from year to year. It is vital that the SPHCDB develop the capacity for annual planning and budgeting.

Lack of effective M&E systems

If policy makers and politicians are not made aware of how the money has been utilised and what differences it has made, they might not be prepared to be as generous in the future. The SPHCDB needs to develop an effective M&E system that has indicators showing outputs, outcomes and impact. This is a very powerful tool and one that is not utilised often.

Poor budget tracking

Little is done at state level to track budget releases and measure budget performance. The SPHCDB needs to develop the capacity to do this.

d) Necessary steps

STEP 1: develop the capacity to plan, budget and track release of funds. It is imperative for the SPHCDB management team to have the capacity to plan, budget and track budget release. This capacity will need to be built, most likely through external support and training. Funds for this need to be sourced from government or external development partners.

STEP 2: create a planning and budgeting committee. This should be the engine house for this area of activity in the SPHCDB. It is critical that competent and senior people are on this committee. The committee also needs to have connections to those in power (the Governor and the Commissioner for Health) so that their deliberations can be aired. Again, the capacity of this committee will need to be built.

STEP 3: explore options for creating pooled funds. This seems a good way forward as it allows for different groups (state, LGAs, development partners) to commit funds to a process that is transparent, that is controlled by the management team and that has sufficient checks and balances to satisfy all the contributors.

e) Indicators

- PHC take-off grant released
- Annual costed plan developed
- Budget performance over 90%

6. REPOSITIONING

Key questions Has your State defined new roles and responsibilities from the PHC Bill and Regulations? Has your State completed re-orientation of managers in new and old structures? Has your State built capacity of managers to undertake new tasks? Has your State established a mentoring and coaching system for all managers?

a) Overview

Once the new Bill and Regulations have been assented to, managers in the health sector face the difficult task of repositioning. There are four key areas for repositioning:

- Financial
- Human resource
- Services
- Management

The first three are dealt with in other themes (themes 3, 4 and 9). This theme deals with the management issues.

The Bill and Regulations should specify the functions, roles and responsibilities of the new bodies (whether Gunduma Board, SPHCA or SPHCDB). It should also specify what functions, roles and responsibilities will be transferred from existing bodies (e.g. SMoH,SMoLG). It might also specify that certain existing bodies will be closed down.

All this creates uncertainty and concern amongst existing and new management structures and personnel. It can also lead to resistance and blocking of changes. Thus, it is critical that all management is orientated to the provisions contained in the new Bill and Regulations and that they understand their functions, roles and responsibilities in the new dispensation.

The committee tasked with overseeing the transformation needs to take the lead in the re-orientation. They might need some external support from tertiary institutions or technical experts. Funding for this could be sourced from development partners. However, it is key that the state, either through the committee or the Ministry of Health, oversee the wholeprocess.

b) Options

Two key activities need to take place - re-orientation and capacity building. Re-orientation needs to occur for all staff at all levels. The Bill and Regulations need to be utilised to guide the re-orientation. Adequate time needs to be allocated to the process and the facilitators need to encourage frank and open discussion. Capacity building programmes need to focus on managers, especially those managers in the new structures.

c) Challenges

There are four key challenges that states need to bear in mind as they deal with the repositioning:

Involvement of all stakeholders

It is critical that all health workers are involved in the re-orientation. The process needs to be cascaded down from state to LGA levels. It is key that the MOLG is also involved and any other state level body that has previously been involved in health care delivery. Failure to re-orientate all health workers can lead to misunderstandings and resistance to change. This needs to be ameliorated as far as possible.

Funding

Re-orientation workshops and capacity building programmes for managers are expensive but necessary. It is important that this is budgeted for in the repositioning planning and that sources of funding are sought from both government and external funders (e.g. development partners).

Nature of CB programme

Many capacity building programmes for managers are theoretical in nature and remove the managers from their sites of work in order to train them. Managers need a work-based programme and need to be coached and mentored. These are all key elements in the design of a capacity building programme.

Resistance to change

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

d) Necessary steps

STEP 1: Repositioning of SMoH and SHMB for its new functions and roles. The passing of the legislation, the adoption of regulations and the creation of new structures with different arrangements especially for finance, human resource management and service provision

will indicate that the current roles and responsibilities of the different bodies will be altered. It is critical to understand this and create the space and time for the bodies to adapt to new situations. All the bodies (both old and new) will need support throughout this repositioning process.

STEP 2: Support the repositioning process at LGA level. Once the legislation has been passed and the regulations adopted, it is important that the LGAs and PHC departments support the restructuring process. The management of HR, finance and service delivery will all experience changes. The process will be far smoother if the LGAs have been part of the process from the beginning, if their concerns are understood and if they are allowed to play a full part in the repositioning activities.

STEP 3: Orientation and team building of staff for their new roles. With the changing environment and the movement of staff, it is vital that all staff are orientated on the new structural arrangements and the roles and responsibilities of the different bodies. LGA PHC health personnel will be key in all these processes. The Bill and the Regulations need to be used to guide the discussions.

STEP 4: Capacity building of managers in the new structures. It is also critical to build the capacity of the new managers of the system. A structured management capacity building programme needs to be developed. There are several models currently operational in Nigeria. It is proposed to use an on-the-job coaching and mentoring approach with minimal time away from work. The capacity building programme should be tailored to state specific circumstances that can be adjusted according to the budget available and could be linked to a certificated programme through a tertiary institution, if needed. Time on the programme could be structured in the following ways:

a. Time is made available for the participants to share challenges, successes and to discuss solutions.

b. The facilitators provide input in their area of expertise tailored to the specific context in the state – this might be on HR, HMIS, SDSS or other areas.

c. The facilitators work with the teams on developing an assignment/ project that can benefit their work context and the teams return to work on their 'project' or 'assignment'.

d. The facilitators mentor the teams during assignment/project implementation.

e. These are then discussed during the next session

e) Indicators

- Roles and responsibilities of all structures established
- Capacity building programme for managers functioning

7. OPERATIONAL GUIDELINES

Key questions

- Has your State drafted policies and procedures for the functioning of the PHC Agency?
- Has your State established HR, M&E, Accounting and other procedures/protocols?
- Has your State established a PHC Board Constitution and/or Rules?

a) Overview

States normally have well developed policies and procedures for HRM, procurement/SCM, accounting/financial management and M&E. In most, if not all, of the new Bills andRegulations the creation of the new SPHCDBs is accompanied by requirements for the development of SPHCDB specific policies, procedures and protocols related to these administrative areas. The Bill and/or regulations specifies who has to develop these and within what time frame. It is important for these to be developed in a written form and forthem to be aligned with similar policies, protocols and procedures extant in the state.

b) Options

One of the first tasks of the SPHCDB management team is to review the new Bill and the Regulations and to extract all the tasks that need to be done. Then, in conjunction with the governing body, the management team needs to embark on the development of the needed policies, protocols and procedures.

c) Challenges

There are two key challenges that states need to keep in mind as they move forward in "Bringing PHC under one roof".

Failure to determine tasks

Few states and the SPHCDB management teams in those states review the Bill and Regulations and extract the tasks that need to be done and then ensure that those tasks are completed within the prescribed time.

Failure to develop and assent to the Regulations

Several states have only developed the new Bill. There are no accompanying Regulations. In some cases the Regulations have been developed but not assented to. It is key that the Bill and Regulations be developed together and signed off in close proximity (time wise).

d) Necessary steps

STEP 1: review the new Bill and Regulations. It is important for the SPHCDB governing body and the management team to review the new Bill and Regulations and extract the key tasks that need to be completed. These need to be compiled into an action list, inclusive of timeline and who responsible.

The governing body and the management team should track progress at each management or board meeting to ensure that the timelines are adhered to.

STEP 2: finalise all the administrative procedures and share them with relevant personnel. The policies, protocols and procedures need to be finalised according to the timeline highlighted in step 1. These need to be aligned with similar policies, protocols and procedures adopted by the state. Once completed, they should be distributed to all relevant health workers falling under the management of the SPHCDB. In addition, training and orientation on these new administrative procedures needs to be undertaken. This should be budgeted for and funds sourced either from government or from development partners.

e) Indicators

- Policies and procedures for HRM, procurement/SCM, accounting/financial management and M&E established

8. COMMUNITY OWNERSHIP

Key questions

- Does your State that has Community Representation on the PHC Board?
- Does your State document shared PHC responsibilities with the community?
- Does your State have a community awareness plan for demand creation?
- Does your State allow Ward Development and/or Village Health Committees to contribute to PHC decision making?

a) Overview

One of the cornerstones of the PHC movement is the involvement of communities in all aspects of health care. Often this is partially or not attended to. It is important for communities to be involved in the governing structures of the SPHCDB at both state and sub-state levels. In addition, communities need to be engaged in health care activities at facility and community level.

Linked to community involvement and ownership is the need to ensure adequate representation from all components of the community. In particular, women, who are the prime users of health services, need to be represented in all structures and at all levels.

b) Options

The SPHCB needs to develop clear criteria for the representation of community members on the governing bodies at state and sub-state levels. In addition, community involvement needs to be sought for ward development, village health and facility health committees (the structures will differ across states).

It is imperative that documents are developed describing the criteria and the engagement expected from communities. These documents need to be developed in conjunction with community members and leaders and then widely disseminated to community leaders, groups and members.

c) Challenges

There are three key challenges that states need to keep in mind as they move forward in "Bringing PHC under one roof".

Lip service is paid to community engagement

Traditionally, health service providers and managers have not paid enough attention to community involvement in and ownership of health services. Thus, it requires a change in mindset to enable communities to fully participate.

Proceedings/processes do not allow for full participation

Timing of meetings, words used and other methods count against full community involvement, especially from grassroots community people. Care needs to be taken to ensure that all possible ways

are developed for communities to engage. Bottlenecks need to be identified and addressed.

Women are marginalised

For long, men have participated. Specific notes in documents and selection/appointment criteria need to emphasise the need for the involvement of women in structures at all levels.

d) Necessary steps

STEP 1: ensure documents are drawn up to encourage community involvement. Following the passage of the new Bill and Regulations, the governing body and the management structure needs to ensure that documents are drawn up highlighting the need for and explaining the process and mechanisms of community involvement. These documents need to be drawn up in conjunction with communities and not for or on behalf of communities.

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STEP 2: establish criteria for the selection of community members, including women, on governing structures. To ensure that women are adequately represented on the governing structures at state and sub-state levels and at facility level, clear criteria need to be drawn up on the membership and the selection process. This needs to be done in conjunction with community members, leaders and groups.

STEP 3: Widely explain and publicise the changes. As the proposed changes should produce a unified and decentralised PHC system (in some cases it could be both PHC and SHC), service delivery should improve because of clearer roles and responsibilities and the unification of the management of resources in the health system. It is important that LGA politicians and PHC service providers communicate these potential benefits to local traditional and religious leaders and to the community at large. Their support will greatly enhance the proposed changes and ensure a smooth transition.

e) Indicators

- Community representatives active members of the governing bodies

9. INFRASTRUCTURE AND FURNITURE

Key questions

- Has your State selected PHC Agency offices at State and Sub-State levels?
- Has your State renovated and/or furnished PHC Agency/Board office space?
- Has your State handed over the office space to PHC Agency Management?
- Has your State met work environment needs (vehicles, computers, internet, etc) ?

a) Overview

It is key that suitable offices are found for the state and sub-state level management teams. In addition, the tools of the trade (e.g. vehicles, computers) need to be made available to enable the SPHCDB management teams to perform their duties. Most states have allocated a start-up grant to fast track this process and then allowed for the inclusion of costed plans to be included in the state budget for the upcoming year.

b) Options

Because the SPHCDB was not budgeted for in the development of the plans and budgets for the current year, most states have allocated a start up grant to get the SPHCDB established and started. Usually, the transformation committee has driven this and consulted with the Governor on releasing adequate funding for the SPHCDB to start.

c) Challenges

There are three key challenges that states need to keep in mind as they move forward in "Bringing PHC under one roof".

Inadequate funding released/ poor budget determination

Although fundingcould be released, this might be inadequate for the needs of the SPHCDB. It is important that the transformation committee (or whoever is discussing with the Governor re the amount to be released) draws up a clear costed start up plan. This will help in the discussions with the Governor. Representatives from the SMoH need to be involved in this process.

Unsuitable offices selected

Selection of offices is key - both at state level and at sub-state level. It is important that the transformation committee draw up clear criteria to guide the selection process and that these are then used by the team looking for offices. If not, there is a worry that inappropriate (e.g. too small, inappropriate location) offices will be chosen. This will make it difficult for the SPHCDB and the sub-state management teams to function effectively.

Sub-state structures neglected

In many cases, the focus is on the state level office and its requirements while the sub-state level is neglected. It is vital that both levels are addressed in the selection of office space and the requirements needed to operationalize these offices. This all needs to be included in the start-up budget proposal and subsequent plans and budgets.

d) Necessary steps

STEP 1: Develop start up budget and plans. This is important before the Governor is approached for the release of a start-up budget. Ensure that office costs and equipment costs are budgeted for at both state and sub-state levels.

STEP 2: ensure that the transformation committee is driving the process. The transformation committee needs to oversee the process of discussing with the Governor the start-up funds needed and then working with the management team to ensure that the plans are implemented, office space is secured and the tools required purchased or transferred.

e) Indicators

- Offices at all levels established

10. MINIMUM SERVICE PACKAGE

Key questions

- Has your State adopted a Minimum Service Package for different facility types?
- Has your State instituted a facility assessment and investment plan?
- Has your State monitoring team regularly (at least yearly) evaluated MSP resource gaps?

a) Overview

The key objective for establishing the PHC Board is to ensure increase coverage and quality of health services as well as access to services at all levels. The adoption of the MSP approach will allow states to classify their facilities according to the adopted system and then determine resource needs for each and every facility. The FMoH and the NPHCDA have been advocating this approach for many years. However, in many states there is still a plethora of types of facilities, no uniformity in the naming of the different types of facilities and thus confusion around the resources (human, equipment, drugs and commodities, finances) needed for each facility.

The NPHCDA is currently reviewing a MSP tool that will allow states to classify their facilities. From this classification will flow standard resource packages that can then be tailored to the size and business of each facility. This will then assist states to determine and allocate resources more wisely. In addition, it will allow states to develop state-wide health facility investment plans that can be used to advocate to government and development partners for resources and the allocation of these resources.

b) Options

It is important that the new structure (SPHCDB or equivalent) adopt the MSP approach. This will allow the SPHCDB to develop a rational plan for the classification of facilities, for the allocation and distribution of resources (human, equipment, drugs and commodities, finances) and for the development of an investment plan that will guide resource allocation in the future.

Various tools exist but the NPHCDA is reviewing an excel linked spread sheet tool that can be used for this purpose. Whatever is used, SPHCB managers will need to be trained in the use of the tool and supported in their analysis and interpretation, at least initially. As before, this needs to be budgeted for and appropriate funds sourced from government or development partners.

As mentioned earlier, use of the MSP will assist in the discussions and negotiations around the transfer of staff and also in the development of appropriate budgets for the functioning of the new SPHCDB and the SPHCDB run health facilities.

c) Challenges

There are three key challenges that states need to keep in mind as they move forward in "Bringing PHC under one roof".

Challenges to classification of facilities

Classification of facilities has a strong political dimension. Communities and leaders often do not take kindly to facility classification being changed. While many understand the rationale and the fact that each community cannot have a hospital, there is reluctance to accept that this can happen in your own

community - the NIMBY or not-in-my-back-yard principle. Thus, this aspect of the MSP has to be dealt with in a politically sensitive manner. Ideally, the transformation committee should drive this process with full communication with and the support of the Governor and the Commissioner for Health. It is critical to understand that the classification is an extremely important step on which the rest of the MSP tool depends. Without classification, resource needs cannot be determined.

Incorrect use of the MSP tool

Although the tool is not that complex, it is suggested that the SPHCDB management team undergo training in the use of the tool. If not, the use and interpretation of the results may be problematic.

Reluctance to introduce elements of free MCH services

Many Governors have declared free MCH services in their states. Although, the reality is that this might not be happening or not happening in the complete sense, politicians are often understandably reluctant to backtrack on their promises. Thus, this needs to be handled in a politically sensitive manner. It is advisable that the transformation committee or another such high level committee or person (e.g. the Commissioner for Health) drive this process. Exploring options of collaborating with the National Health Insurance Scheme is also critical to leverage resources and enhance a wider roll of free and quality MCH services.

d) Necessary steps

STEP 1: SPHCBD adopts the MSP approach. A key technical step is for the management team of the new SPHCDB to adopt the MSP approach. To do this the management team needs to review current available tools and adopt/adapt a tool to suit its purposes. As mentioned the NPHCDA is currently reviewing a tool (excel linked spread sheet) that statescan consider using. The SPHCDB will need training on the use of the tool and as before this needs to be budgeted for and funds sourced from government or development partners.

STEP 2: SPHCB utilizes the MSP approach to assist in the classification of facilities and the allocation of resources. Once the capacity has been built, the SPHCDB should use the tool in the classification of facilities and the allocation of current and future resources. As there is a political element in the classification of facilities, the SPHCDB needs to work closely with the transformation committee and the governing body of the SPHCDB. In addition, communication with other leaders and community structures is vital.

STEP 3: use of the MSP tool for developing free MCH services. Many state Governors have declared that MCH services are free at the point of service. However, this has not been costed in most states and the requisite resources are not necessarily available at facilities to provide free MCH services. The MSP tool allows for MCH services to be costed. Individual elements (e.g. ANC services, EOC services, IMCI services) can be costed and then combined to give a complete picture. This then allows states to introduce elements of the free MCH services in a sequential fashion dependent on budget availability. Eventually, the complete free MCH package can be provided.

e) Indicators

- MSP utilized to guide investment plan

11. SUPPORTIVE STEPS AT FEDERAL LEVEL

The whole process will require high level advocacy to state governors with clear messages on the need for and benefits of having PHC under one roof. In addition, throughout the process there needs to be an extensive communication and advocacy campaign to keep all stakeholders informed of progress and issues/challenges.

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

STEP 1: Define the framework for bringing "PHC Under one Roof". In the absence of legislation (and the draft Health Bill does not prescribe to state and LGA levels), it is critical that the NPHCDA produce policies and guides for the states to use. The concept note, the policy documentation, the implementation guide and the implementation manual (this document) will all assist states in developing legislation, regulations and implementation plans to bring "PHC Under one Roof". NPHCDA should take a lead in these activities.

STEP 2: Harmonise the activities of the different role players at federal level. As with the state level it is critical for the roles and functions of the different bodies that support PHC at federal level to be clarified and harmonised. This includes the support offered by the FMOH, the NPHCDA, the Sure-P office and the NHIS. All these bodies are fundamental in strengthening PHC service delivery, but they need to work synergistically. In essence, these bodies need to meet on a regular basis to track progress in "Bringing PHC under one roof".

STEP 3: Secure sufficient resources for strengthening PHC. Resources are potentially available in the draft Health Bill, the NHIS scheme, the Sure-P fund and through other multilateral and bilateral partnerships. It is imperative that the NPHCDA develop annually a clear plan and budget to harness and use these resources. Where necessary, guidelines need to be developed for accessing, utilising and retiring these funds (e.g. the proposed PHC Development Fund). The resources will be utilised to realise state developed service/facility plans based on the MSP. In addition, the key role of strengthening thecapacity of mid-level PHC managers has been realised by both the FMOH and the NPHCDA. Thus, adequate resources need to be made available for this key activity.

STEP 4: Strengthen advocacy initiatives around bringing "PHC Under one Roof". For the initiative to move forward and for the PHC system to be unified and decentralised, many stakeholders need to be informed and involved in the discussion and development of reforms, so they can come to realise the advantages, the challenges and the pitfalls. This includes politicians from federal to LGA levels, health workers and health managers at all levels, traditional and religious leaders and the community at large. In addition, the process does require strong, skilled and influential leadership at a high level, as well as considerable advocacy, communication and coalition building to achieve a critical mass of change agents that are required for this transformation. Thus, a carefully-planned advocacy campaign needs to be developed and implemented.

STEP 5: Strengthening the capacity of the NPHCDA to lead the process. The capacity of the NPHCDA at federal and lower levels needs to be strengthened in order for the agency to provide leadership and technical know-how in the restructuring process. Part of the NPHCDA planning needs to ensure that

the capacity is built both within the NPHCDA and the structures at state and LGA levels responsible for the restructuring. If necessary, a dedicated unit within the NPHCDA needs to be established.

STEP 6: Design and implement an M&E strategy. To track progress, measure success and identify challenges it is necessary for a simple M&E system to be designed. All three levels need to be responsible for collecting and analysing the indicators identified and then utilising the information generated to alter plans and activities.

STEP 7: hold regular dissemination workshops and meetings. It is proposed that the NPHCDA host annual national workshops to review progress on "Bringing PHC under one roof". In addition, the NPHCDA needs to facilitate zonal level workshops to ensure that the key messages are conveyed and understood.

12. INDICATORS/TARGETS

It is key that a small set of indicators is developed that cover each of the nine themes. For each indicator, targets can be established. Development of targets will be a state specific activity and indicative targets are given below - these should be adapted for each state. Targets are given for three years, but, if necessary, a longer timeframe can be envisioned and the targets adapted. Some themes are dependent on previous themes being completed (for example, it will be necessary for the Bill to be signed before money can be released or staff moved). This needs to be taken into consideration when developing state specific targets.

Indicator	Target Y1	Target Y2	Target Y3
Legislation			
Technical committee established	Committee established and comprised of senior government and stakeholder representatives	Committee functional and leading transformation	
Bill passed	Bill drafted	Bill approved by state Houses	Bill assented to by Governor
Regulations passed	Regulations drafted	Regulations approved by technical committee	Regulations assented to by Commissioner for Health
Systems Development			
Governing body and management structure fully functional at all levels	Governing body and management structure fully functional at all levels	Governing body and management structure fully functional at all levels	Governing body and management structure fully functional at all levels
Human Resources			
Staff paid by new management body	Staff paid by new management body	Negotiations with 'old' structures leading to transfer of all identified staff	Staff paid by new management structure
HRIS fully established	HRIS fully established	HRIS fully established	HRIS fully established
Funding Sources and Structure			
PHC take-off grant released	PHC take-off grant released	PHC take-off grant released	
Annual costed plan developed	Annual costed plan developed	Annual costed plan developed	Annual costed plan developed
Budget performance over 90%	Budget performance over 90%	Budget performance over 90%	Budget performance over 90%
Repositioning			
Roles and responsibilities of all structures established	Roles and responsibilities of all structures established	Roles and responsibilities of all structures established	Handover of roles and responsibilities complete
Capacity building programme for managers functioning	Capacity building programme for managers functioning	Capacity building programme for managers functioning	Capacity building programme for managers functioning
Operational Guidelines			
Policies and procedures for HRM, procurement/SCM, accounting/financial management and M&E established	Policies and procedures drafted	Policies and procedures approved by relevant person	Policies and procedures implemented
Community Ownership			
Community representatives active members of the governing bodies	Criteria for selection of community members agreed	Representative community members elected to all governing bodies	Community members trained on expected roles and responsibilities
Infrastructure and Furniture			
Offices at all levels established	Offices at all levels established	Offices at all levels established	Offices at all levels established
Minimum Service Package (MSP)			
MSP utilized to guide investment plan	MSP utilized to guide investment plan	MSP used to determine resource requirements for all facilities	MSP used to determine resource requirements for all facilities

Annex 1: Checklist for Monitoring Progress

Theme and Key Activities
LEGISLATION
Produce draft PHC Bill and Regulations
Refine, lobby for passage by state assembly
Gazette PHC Law and Regulations
SYSTEMS DEVELOPMENT
Financial management
Integrated support supervision
Strategic and Annual planning
Performance management
General management and administration
HUMAN RESOURCES
Staff affordability norms developed
Compile accurate staff database (HRIS set up)
Develop right-sizing plan for staffing
Develop PHC Board organogram and staff profile for facility types
Develop job descriptions: start with management level
Interview and selection of management teams at all levels
Working environment needs identified - office space, furniture, computers, HR tool kit
Deployment and staff movement completed: postings finalised
FUNDING STRUCTURE AND SOURCES OF FUND
Develop mechanisms for contribution from different role players
Set up pooled fund for services/operations
Release of take-off grant Develop and produce financial guidelines/manuals
Integrate funding into state budget system
Establish budget process
Track release
REPOSITIONING
Define new roles and responsibilities emanating from Bill and Regulations
Re-orientate managers in old and new structures
Build capacity of managers in all structures
Establish mentoring/coaching system for all managers
OPERATIONAL GUIDELINES
Pool together procedures and policies from all sources on different aspects of Board functioning
Establish job descriptions, funding mechanisms, M&E mechanisms, accounting procedures, protocols
Establish PHC Board procedures and rules
COMMUNITY OWNERSHIP
Capacity building of PHC Board teams and community members on roles and accountability to communities
Orientation of committees and staff on new roles
Awareness creation: radio programs, factsheets, materials, use of CSOs MINIMUM SERVICE PACKAGE (MSP)
INFRASTRUCTURE AND FURNITURE
Selection of PHC Board offices: State and sub-state , levels
Rehabilitation of offices
Furnishing and handover of offices
Transport requirements established and met
Computers and internetservices provided
Security services provided
MINIMUM SERVICE PACKAGE (MSP)
Adopt MSP of care for different levels of facilities
Institute facility investment planning: assess and select facilities for implementation
Identify resource gaps -additional resources needed (human and material) for implementing the MSP

Annex 2: Monitoring progress at state level

The checklist was utilised to do an assessment of the status of each state in late 2012 with respect to "Bringing PHC under one roof". Each component was colour coded:

- Green indicates compliance or task completed
- Yellow indicates task initiated and more than 50% complete
- amber indicates task initiated but less than 50% complete
- red indicates non-compliance or task not started

The detailed tool is shown below and this is followed by examples from the 2012 assessment. This provides a snapshot of where the different states are and can be used to track progress over time

ASSESSMENT TOOL

Status of PHC Bill	System Devt	HR	% of state budget allocated to Health	Funding Structure	Funding Source	Repositioning	Operational Guidelines	Community Ownership	Infrastructure & Furniture	MSP
Gazetted	Agency policies are developed	PHC staff deployed to HFs	15% or >	Pooled and integrated into state budget	State, LGs +Donors	Capacity of managers built for new tasks	Agency Procedures and protocols implemented	Community representation on Board	Equipped offices handed over to mgt	Facility assessment and investment for MSP
Passed	Board has set up Agency	Staff database developed	- -	Pooled funds from all sources	State and LGs	Managers re-oriented in new structures	Agency Procedures and Protocols drafted	Shared responsibilities for PHC	Office space furnished/ equipped	MSP resource gaps monitored
Drafted	PHC Board appointed	Staff distribution plan developed/costed	>5-10%	PHC budget line	State Only	New roles and responsibilities defined	Board Rules /constitution in place	Community PHC awareness	Space/offices identified	MSP articulated for different HF types
No Bill	No PHC Board appointed	No PHC HR Plan	5% or <	None of the above	No State Funding	No repositioning undertaken	No Board rules	No community involvement	No space identified	No MSP

SCORE CARD FOR IMPLEMENTATION OF "Bringing PHC Under One Roof" – Selected States

States	Entity Name	Status of PHC Bill	System Devt	HR	% of 2009 - 2011 state budget allocated to Health	Funding Structure	Funding Source	Repositioning	Operational Guidelines	Community Ownership	Infrastructure & Furniture	MSP	Comments
State 1	PHC Agency	2012											No PHC pooled fund, Law passed but Agency not yet functional
State 2	PHCD Agency	2005											No PHC pooled fund, Law passed but Agency not yet functional
State 3	District Health System	2009											No PHC pooled fund, Agency is functional but may be underfunded
State 4	District health System	2007											Basket fund for entire District Health System not PHC alone. Agency is functional
State 5													No PHC Bill drafted
State 6	PHCD Agency												No PHC pooled fund, Agency is functional State 7 PHCD Agency
State 7	PHCD Agency	2010											Has pooled fund and agency is fully functional

ANNEX 3:

DRAFT FRAMEWORK/GUIDELINE FOR THE ESTABLISHMENT OF STATE PRIMARY HEALTH CARE DEVELOPMENT AGENCY

JAN. 2010

..... STATE OF NIGERIA

PRIMARY HEALTH CARE DEVELOPMENT AGENCY

LAW 2010

A BILL FOR A LAW TO PROVIDE FOR THE ESTABLISHMENT OF PRIMARY HEALTH CARE DEVELOPMENT AGENCY AND OTHER MATTERS CONNECTED THEREWITH

BE IT ENACTED by the House of Assembly of ..... State of Nigeria as follows:

PART I

PRELIMINARY

Citation & Commencement **1.** This Law may be cited as ..... State Primary Health Care Development Agency Law 2010 and shall come into operation on the ..... day of..... 2010.

Interpretation **2.** In this Law, unless the context otherwise requires, the following expressions shall have the meanings hereby assigned to them respectively as follows:

"Agency" means the State Primary Health Care Development Agency established under Section 3 of this Law;

"Board" Means the State Primary Health Care Development Agency Governing Board established under Section 5 of this Law;

"Commissioner" means the Commissioner charged with the responsibility for matters relating to Health;

"Governor" means the Governor of the State;

Local Government" means the Local Government Areas in the State;

"Member" means Member of the Board and includes the Chairman;

"State" means the ..... State of Nigeria.

PART II

ESTABLISHEMENT OF THE AGENCY

Establishment of the Agency **3.** (1) There is hereby established for the State a body to be known as the ..... State Primary Health Care Development Agency.

(2) The Agency:
(a) shall be a body corporate with perpetual succession and a common seal;
(b) may sue and be sued in its corporate name;
(c) shall have power to acquire, hold or dispose of movable or immovable property.

PART III

POWERS AND FUNCTIONS OF THE AGENCY

Powers & Functions of the Agency **4.** The functions of the Agency shall be to:

(a) review the existing health policies particularly, with regards to their relevance in the development of primary health care and primary healthcare facilities and to propose changes where necessary;

(b) study health plans for primary health care at various levels under its supervisions to ensure their relevance to the primary health care delivery system of the State and to the National Health Policy;

(c) promote and monitor the implementation of health plans at various levels of the State Primary Health Care System;

(d) provide strategic technical support for the implementation of priority primary health care components as may be required or to introduce new components for integration;

(e) mobilize resources within the State, nationally and internationally for the development of primary health care in support of the programmes of the Agency;

(f) ensure effective implementation and supervision of all primary health care activities as well as monitoring for the maintenance of a minimum acceptable standard;

(g) ensure effective community involvement and participation in all primary health care activities from inception to implementation stage;

(h) strengthen referrals and linkages with other branches of the health sector especially, in the areas of maternal and child health, reproductive health care and other ailments with a view to significantly reduce morbidity and mortality;

(i) develop sound database for effective planning, implementation and supervision of all primary health care activities in the State;

(j) develop effective programme for training and re-training of all primary health care providers in the State;

(k) encourage effective collaboration with other sectors at all levels in the development and support of primary health care system to avoid duplication of efforts and waste of resources;

(l) take over and oversee the running of all primary health care facilities located in the State, except the local government dispensaries, which shall be managed by the Local Government Councils in the State;

(m) provide and maintain all infrastructure and equipment as well as employ and discipline staff of the facilities under its direct supervision;

(n) ensure the implementation of all relevant primary health care policies with regards to facilities, equipment and staff under its care;

(o) promote multi-sectoral and multi-disciplinary collaboration and encourage networking among the various stakeholders;

(p) do anything which in the opinion of the Governing Board is designed to facilitate the carrying out of the activities of the Agency.

(q) take over and perform all functions relating to Primary Health Care services delivery hitherto performed by other Ministries, Agencies and Departments.

PART IV

ESTABLISHEMENT AND COMPOSITION OF THE GOVERNING BOARD

Establishment of the Board

5. (1) There is hereby established for the management of the affairs and implementation of policies of the Agency, a Board to be known as the ..... State Primary Health Care Development Agency Governing Board (in this law referred to as 'the Board');

Composition of the Board

(2) The Board shall consist of:

(i) Chairman - who shall be a highly respected healthcare practitioner
(ii) the Permanent Secretary or representative of Ministry of Health - Member
(iii) the Permanent Secretary or representative of Ministry for Local Government and Community Development - Member
(iv) the Permanent Secretary or representative of Ministry of Women Affairs - Member
(v) the Permanent Secretary or representative of Ministry of Information - Member
(vi) the Permanent Secretary or representative of Ministry of Environment - Member
(vii) the Director, Nursing Services - Member
(viii) the Director, School of Health Technology - Member
(ix) One person each to represent the following:
a. Community Health Practitioners Association of Nigeria - Member
b. Nigerian Medical Association - Member
(x) Three Local Government Councils' Chairmen, one from each Senatorial Zone representing all the Local Government Chairmen in the State - Members
(xi) the Executive Secretary of the Agency who shall be the Secretary to the Board.

Appointment of Chairman & Members of the Board

(3) The Chairman of the Board shall be appointed by the Governor who shall appoint the other members of the Board on the recommendation of the bodies concerned, if any.

(4) The Supplementary provisions set out in the schedule to this law shall have effect with respect to the proceedings of the Board and the other matters mentioned therein.

Functions and Powers of the Board

6. The Board shall be responsible for:

(a) determining the general policy for the administration of the Agency including the management of its property and finances;

(b) making regulations for the appointment, promotion, discipline and transfer of the staff of the Agency;

(c) the Board may appoint or constitute standing or ad hoc Committees as the case may be, to perform any of its functions on its behalf;

Establishment of Inter-Agency Technical Committee

7. (1) There shall be for the Agency an Inter-Agency Technical Committee which shall consist of:

i. Executive Secretary of the Agency - Chairman
ii. a representative of UNICEF - Member

iii.	a representative of WHO	-	Member
iv.	a representative of UNFPA	-	Member
v.	a representative of USAID	-	Member
vi.	a Director, Public Health/Medical Services, State Ministry of Health	-	Member
vii.	a represent of NPHCDA	-	Member
viii.	a representative of Ministry for Local Government	-	Member
ix.	a representative of Community Health Department of the Teaching Hospital in the State (or Federal Health Care Institution)	-	Member
x.	a representative of NHIS	-	Member
xi.	a representative of Health MGD	-	Member
xii.	a representative of PSN	-	Member
xiii.	a representative of Private Healthcare Providers	-	Member
xiv.	a representative of Traditional/Alternative Health Practitioners	-	Member
xv.	Director of Administration of the Agency	-	Secretary

Functions of the Inter-Agency Technical Committee

(2) It shall be the function of the Committee to:

i. Provide effective collaboration with other relevant stakeholders towards providing effective primary health care delivery services in the State;

ii. Initiate, organize and sponsor programmes for effective primary health care manpower development and creation of public awareness of the importance of primary health care;

iii. Supervise and monitor the day-to-day activities of the Agency especially, as it relate to the activities sponsored by the donor agencies;

PART V

STAFF OF THE AGENCY

Appointment of the Executive Secretary

8. (1) The Governor shall appoint a suitable person, preferably with good background in Public Sector Management as the Executive Secretary of the Agency.

(2) The Executive Secretary shall be:-

(a) the Chief Executive Officer of the Agency;
(b) responsible for the day-to-day administration of the Agency and for keeping the books and records of the Agency;
(c) subject to the general supervision of the Board and be answerable to it;
(d) on such terms and conditions as may be specified in his letter of appointment.

Tenure of Office

(3) The Executive Secretary and members of the board other than ex-officio shall hold office, in the first instance for a period of four (4) years and may be re-appointed for a further period of four (4) years and no more;

(4) Notwithstanding the provisions of subsection (3) of this section, the Executive Secretary may be removed from office for inability to discharge the functions of his office whether arising from infirmity of mind or body or for any other cause which is likely to prejudice the discharge of his functions or for gross misconduct.

Other Staff of the Agency

9. (1) The Board may from time to time appoint such other staff as it may deem necessary, to assist the Board in the performance of its functions under this Law.

(2) The Staff of the Agency may be drawn from within the service of the state through posting, transfer of service or secondment.

Discipline and conditions of service

10. (1) The Agency shall have power to exercise disciplinary control over its staff as it may deem necessary for the discharge of its functions under this Law and in accordance with the Civil Service Rules operating in the State.

(2) The terms and conditions of service of the employees of the Agency shall be as determined by the Board on recommendation of the Civil Service Commission.

Pension and Gratuity

(3) Service in the Agency shall be the approved service in the State for the purpose of the pension law. Accordingly, employees of the Agency, shall in respect of their service in the Agency, be entitled to pensions, gratuities and other retirement benefits as prescribed in the mainstream civil service.

(4) Notwithstanding the provisions of subsection (3) of this section, the Agency may appoint a person to any office on terms which preclude grant of a pension, gratuity or other retirement benefits.

PART VI

ESTABLISHMENT OF PRIMARY HEALTH CARE ZONES

Establishment of Zonal Offices

11. There is established for the Agency one zonal office in each Senatorial District in the State for effective discharge of its function as follows:

a) Zone 'A' with Headquarters at ....., comprising .....

b) Zone 'B' with Headquarters at .....comprising .....

c) Zone 'C' with Headquarters at ..... comprising .....

PART VII

FINANCIAL PROVISIONS

Source of Funds

12. (1) The Agency shall be jointly funded by the State and the Local Governments on a ratio of 40% to 60% respectively, with a contribution from the National Primary Health Care Fund when established.

(2) The Board shall have the right and power to source for funds from non-governmental organizations and other Donor Agencies

Account

13. (1) The Board shall keep proper record of Accounts in relation to all transactions of the Agency.

(2) The Board shall at the end of each year submit to the Governor through the Commissioner of Health an annual report of its activities for that financial year,

and shall include in such report a copy of the audited accounts of the Agency.

Credit Facility, Gift and Investment

14. (1) The Agency may seek for credit facility and accept gifts of land, money or other property on such terms and conditions, if any, as may be specified by the person or organization making the gift or donation.

(2) Notwithstanding the provisions of subsection (1) of this section, the Agency shall not accept any gift if the conditions attached by the person or organization making the gift are inconsistent with the functions of the Agency under this Law.

(3) The Agency may subject to the provisions of this Law and the condition of any trust created in respect of any property, invest all or any securities as may from time to time be approved by the Board.

PART VIII

PROCEEDINGS OF THE BOARD

Meetings

15. (1) The Board may meet at such time and place as the Chairman may direct. Provided that the Board shall meet, at least, three times in a year

(2) At any meeting of the Board, the Chairman shall preside and in his absence, the members present shall appoint one of their members to preside.

Standing Orders

(3) The Board may make standing orders for the proper conduct of its business and the regulation of its proceedings or any of those of its Committees.

Quorum

16. The quorum of the Board shall be the Chairman and four other members of the Board and the quorum of any Committee of the Board shall be as determined by the Board.

Power to Co-opt

17. Where the Board desires to obtain the advice of or information from any person on any particular matter, such person may be co-opted to the Board for such period as it deems fit save that the person so co-opted shall not be entitled to vote on any issue or count towards a quorum.

Power to Co-opt

18. (1) Every question at any meeting shall be determined by a simple majority of the members present at the meeting and each member shall have a single vote, but in the case of equality of votes, the Chairman shall have a casting vote.

(2) The Board may make standing orders not inconsistent with the provisions of this Law, governing its own procedure and in particular, with regards to the holding of meetings, the procedure and keeping of minutes thereof, the custody, production and inspection of such minutes, and the opening, keeping, closing and auditing of accounts.

Validity of Proceeding

19. No act or proceedings of the Board thereof shall be invalid by reason of defect in the appointment of a person purporting to be a member of the Board or any vacancy among its members.

Protection of Member of the board

20. A member shall not be personally liable for any act or omission or for any default

of the Board as long as such act, omission or default is in the course of operation of the Board and is done in good faith.

Common Seal

21. The common seal of the Agency shall be authenticated by the signature of the Executive Secretary or some other person as may be authorized by the Executive Secretary

PART IX

MISCELLANEOUS PROVISIONS

Structure of the Agency

22. (i) There shall be for the Agency the following Departments.

a. Community Health Services;
b. Diseases Control and Immunization;
c. Health Planning, Research and Statistics;
d. Monitoring and Inspection;
e. Admin and Finance;

(ii) The Agency shall have the following units:

a. Essential Drugs Unit;
b. Audit Unit;
c. Public Relations Unit
d. And such other departments and units as may be determined by the Board from time to time and approved by the Governor.

23. Subject to the approval of the Governor, the Board may make regulations for the purpose of carrying out the functions of the Agency.

24. From the commencement of this Law, the provisions of the local Government Service Commission Law shall not apply in relation to this Agency and accordingly:

(i) any matter concerning the appointment, promotion, discipline, transfer, retirement, of Local Government Primary Healthcare staff to the exclusion of local government dispensaries which was being dealt with by the Local Government Service Commission immediately before the commencement of this Law is hereby transferred to the Agency; and

(ii) Any person who immediately before the commencement of this Law was appointed by the local Government Service Commission to serve in any of the Local Government Primary Health Care Departments shall be deemed to have been appointed by the Agency pursuant to the provisions of this Law.

25. The functions and powers of the Agency under this Law shall be exercised to promote and provide for responsive, result oriented and effective primary health care services in the State pursuant to the provisions of paragraph 2(c) of the Fourth Schedule of the Constitution of the Federal Republic of Nigeria, 1999.

MADE at ..... State this .....day of 2010

ANNEX 4:

NATIONAL HEALTH BILL 2011

ARRANGEMENT OF CLAUSES

Clause

PART I - RESPONSIBILITY FOR HEALTH AND ELIGIBILITY FOR HEALTH SERVICES AND ESTABLISHMENT OF NATIONAL HEALTH SYSTEM

1 Establishment of the National Health System

2. Functions of the Federal Ministry of Health

3. Eligibility for exemption from payment for health services in public health establishments

4. Establishment and Composition of the National Council on Health

5. Functions of the National Council

6. Establishment and Composition of the Technical Committee of the National Council

7. Functions of the Technical Committee

8. Establishment of the National Tertiary Hospitals Commission

9. Functions of the Commission

10. Establishment of Primary Healthcare Development Fund

11. Establishment, Composition and Tenure of the Federal Capital Territory Primary Health Care Board

PART II - HEALTH ESTABLISHMENTS AND TECHNOLOGIES

12. Classification of Health Establishment and Technologies

13. Certificate of Standards

14. Offences and Penalties in respect of Certificate of Standards

15. Provision of Health Services at Public Health Establishments

16. Health Services at Non -Health Establishments and at Public Health Establishment other than Hospitals

17. Referral from one Public Health Establishment to another

18. Relationship between Public and Private Health Establishments

19. Evaluating Services of Health Establishments

PART III - RIGHTS AND DUTIES OF USERS AND HEALTH CARE PERSONNEL

20. Emergency treatment

21. Rights of Health Care Personnel

22. Indemnity of the HealthCare provider, Office or Employee of a HealthCare Establishment

23. User to have full knowledge

24. Duty to Disseminate Information

25. Obligation to Keep Record

26. Confidentiality

27. Access to Health Records

28. Access to Health Records Health Care by Provider

29. Protection of Health Records

30. Laying of Complaints

PART IV - NATIONAL HEALTH RESEARCH AND INFORMATION SYSTEM

31. Establishment, Composition and Tenure of National Health Research Committee
32. Research or Experimentation with Human subject
33. Establishment, Composition, Function and Tenure of National Health Research Ethics Committee
34. Establishment and functions of health research ethics committees
35. Coordination of National Health Information System
36. Duties of a FCT as regards Health Information
37. Duties of FCT Area Councils
38. Duties of Private HealthCare Providers
39. National Formulary Control of Safety of Drugs and Food Supply
40. National Health Insurance Scheme

PART V - HUMAN RESOURCES FOR HEALTH

41. Development and Provision of Human Resources in National Health System
42. Appropriate Distribution of Health Care Providers
43. Regulations relating to management of Human Resources in the Health System
44. Training Institutions
45. Industrial Health
46. Industrial Dispute
47. Medical Treatment Abroad

PART VI - CONTROL OF USE OF BLOOD, BLOOD PRODUCTS, TISSUE AND GAMETES IN HUMANS

48. Establishment of National Blood Transfusion Services

49. Removal of Tissue, Blood or Blood Products from Living persons

50. Use of Tissue, Blood or Blood Products removed or withdrawn from living persons

51. Prohibition of Reproductive, therapeutic Cloning of Human Kind

52. Removal and Transplantation of Human Tissue in Hospital

53. Removal, Use or Transplantation of Tissue and Administering of Blood and Blood Products by Medical Practitioner or Dentist

54. Payment in Connection with the Importation, Acq uisition or Supply of Tissue, Blood or Blood Product

55. Allocation and Use of Human Organs

56. Donation of Human Bodies and Tissue of Deceased Persons

57. Purposes of Donation of body, tissue etc

58. Procedure for revocation of any donation

PART VII – REGULATIONS AND MISCELLANEOUS PROVISIONS

59. Regulations

60. Powers of Minister to appoint Committees

61. Assignment of Duties and delegation of powers

62. Savings and transitional provisions

63. Interpretation

64. Short Title

A BILL

FOR

AN ACT TO PROVIDE A FRAMEWORK FOR THE REGULATION, DEVELOPMENT AND MANAGEMENT OF A NATIONAL HEALTH SYSTEM AND SET STANDARDS FOR RENDERING HEALTH SERVICES IN THE FEDERATION, AND OTHER MATTERS CONNECTED THEREWITH, 2011

[ ] Commencement

BE IT Enacted by the National Assembly of the Federal Republic of Nigeria as follows –

PART 1 - RESPONSIBILITY FOR HEALTH AND ELIGIBILITY FOR HEALTH SERVICES AND ESTABLISHMENT OF NATIONAL HEALTH SYSTEM

Establishment of the National Health System

(1) There is hereby established for the Federation the National Health System, which shall define and provide a framework for standards and regulation of health services, and which shall –

(a) encompass public and private providers of health services;

(b) promote a spirit of cooperation and shared responsibility among all providers of health services in the Federation and any part thereof;

(c) provide for persons living in Nigeria the best possible health services within the limits of available resources;

(d) set out the rights and duties of health care providers, health workers, health establishments and users; and

(e) protect, promote and fulfil the rights of the people of Nigeria to have access to health care services.

(2) The National Health System shall include

(a) the Federal Ministry of Health;

(b) the State Ministries of Health in every State and the Federal Capital Territory;

(c) parastatals under the federal and state ministries of health;

(d) all local government health authorities;

(e) the ward health committees;

(f) the village health committees;

(g) the private health care providers; and

(h) traditional and alternative health care providers

2. (1) The Federal Ministry of Health shall —

Functions of the Federal Ministry of Health

(a) ensure the development of national health policy and issue guidelines for its implementation;

(b) collaborate with the states and local governments to ensure that appropriate mechanisms are set up for the implementation of national health policy;

(c) collaborate with national health departments in other countries and international agencies;

(d) promote adherence to norms and standards for the training of human resources for health;

(e) ensure the continuous monitoring, evaluation and analysis of health status and performance of the functions of all aspects of the National Health System;

(f) co -ordinate health and medical services delivery during national disasters;

(g) participate in inter -sectoral and inter -ministerial collaboration;

(h) conduct and facilitate health systems research in the planning, evaluation and management of health services;

(i) ensure the provision of tertiary and specialized hospital services;

(j) ensure and promote the provision of Quarantine and Port Health Services;

(k) determine the minimum data required to monitor the status and use of resources;

(l) promote availability of good quality, safe and affordable essential drugs, medical commodities, hygienic food and water; and

(m) issue guidelines and ensure the continuous monitoring, analysis and good use of drugs and poisons including medicines and medical devices.

(2) Without prejudice to the foregoing functions, the Federal Ministry of Health shall: -

(a) prepare strategic, medium term health and human resources plans annually for the exercise of its powers and the performance of its duties under this Act;

(b) ensure that the national health plans referred to in paragraph (a) of this subsection shall form the basis of —

(i) the annual budget as required by the Federal Ministry of Finance; and

(ii) other governmental planning exercises as may be required by any other law; and

(c) ensure that the national health plans shall comply with national health policy.

(d) ensure the preparation and presentation of an annual report of the State of health of Nigerians and the National Health System to the President and the National Assembly.

(3) The Federal Ministr y of Health shall where necessary provide to State Ministries of Health —

(a) technical assistance in the development of state health policies and plans;

(b) commodities and technical materials, including methodologies, policies and standards for use in programme implementation including monitoring and evaluation; and

(c) other technical assistance as may be necessary.

(4) The Minister shall supervise the departments and parastatals of the Ministry to enable him carry out the functions assigned to the Ministry by this or any other Act.

3. (1) The Minister, in consultation with the National Council on Health may prescribe conditions subject to which categories of persons may be eligible for exemption from payment for health care services at pub lic health establishments.

Eligibility for exemption from payment for health services in public health establishments

(2) In prescribing any condition under subsection (1), the Minister shall have regard to: -

(a) the range of exempt health services currently available;

(b) the categories of persons already receiving exemption from payment f or health services;

(c) the impact of any such condition on access to health services; and

(d) the needs of vulnerable groups such as women, children, older persons and persons with disabilities.

(3) Without prejudice to the prescription by the Minister, all Nigerians shall be entitled to a guaranteed minimum package of services.

4. (1) There is hereby established the National Council on Health (in this Act refe rred to as "the National Council" or "Council") which shall consist of —

Establishment and Composi tion of the National Council on Health

(a) the Minister, who shall be the Chairman;

(b) the Commissioners responsible for matters relating to Health in the States of the Federation;

(c) the Secretary of Health and Human Services in the Federal Capital Territory, Abuja;

(d) Professional Association -

(i) Nigerian Medical Association.

(ii) Pharmaceutical Society of Nigeria.

(iii) National Association of Nurses and Midwives of Nigeria.

(2) The Permanent Secretar y of the Federal Ministry of Health shall be the Secretary to the National Council.

(3) The National Council shall meet not less than two times in a year.

(4) The National Council shall have powers to regulate its proceedings.

5. (1) The National Council which shall be the highest policy making body in Nigeria on matters relating to health, shall — Functions of the National Council

(a) have responsibility for the protection, promotion, improvement and maintenance of the health of the citizens of Nigeria, and the formulation of policies and prescription of measures necessary for achieving the responsibilities specified under this paragraph;

(b) offer advise to the Government of the Federation, through the Minister, on matters relating to the development of national guidelines on health and the implementation and administration of the National Health Policy;

(c) ensure the delivery of basic health services to the people of Nigeria and prioritize other health services that may be provided within available resources;

(d) advise the Government of the Federation on technical matters relating to the organization, delivery and distribution of health services;

(e) issue, and promote adherence to, norms and standards, and provide guidelines on health matters, and any other matter that affects the health status of people;

(f) identify health goals and priorities for the nation as a whole and monitor the progress of their implementation;

(g) promote health and healthy lifestyles;

(h) facilitate and promote the provision of health services for the management, prevention and control of communicable and non communicable diseases;

(i) ensure that children between the ages of zero and five years and pregnant women are immunized with vaccines against infectious diseases;

(j) coordinate health services rendered by the Federal Ministry with health services rendered by the States, Local Government, Wards, and private health care providers and provide such additional health services as may be necessary to establish a comprehensive national health system;

(k) integrate the health plan of the Federal Ministry of Health and State Ministries of Health annually; and

(l) perform such other duties as may be assigned to the Council by the Minister.

(2) The National Council shall determine the time frames, guidelines and format for the formulation of the National and State Health Plans.

(3) The National Council shall be advised by the Technical Committee established in terms of this Bill.

6. (1) There is hereby established a Technical Committee of the National Council on Health (in this Bill referred to as "the Technical Committee").

Establishment and Composition of the Technical Committe e of the National Council

(2) The Technical Committee shall comprise —

(a) the Permanent Secretary of the Federal Ministry of Health who shall be the Chairman;

(b) all Directors of the Federal Ministry of Health;

(c) the Legal Adviser of the Federal Ministry of Health;

(d) the Permanent Secretaries and any two Directors of all State Ministries of Health and FCT Department for Health and Human Services;

(e) one representative each of the Christian and Muslim umbrella health organizations;

(f) one representative each of the Armed Forces Medical Corps; that is, Army, Air Force and Navy;

(g) one representative of the Prisons Medical Services;

(h) one representative of the Police Medical Services;

(i) one representative each of the parastatal of the Federal Ministry of Health;

(j) one representative each of all statutory health regulatory agencies or councils;

(k) the Chairman of the Committee of Chief Executives of Teaching and Specialist Hospitals and Federal Medical Centres;

(l) one representative each of the registered health professional associations including trado-medical practitioners; and

(m) one representative of the private health providers.

(3) The Federal Ministry of Health shall provide the Secretariat for the administrative activ ities of the Technical Committee.

7. (1) The Technical Committee shall advise the National Council on its functions as contained in section 5(1) of this Act and any other matters that the council may refer to it.

Functions of the Technical Committee

(2) The Technical Committee shall strive to reach its decisions by consensus but where a decision cannot be reached by consensus; the decision of the majority of the members shall prevail and be regarded as the decision of the Technical Committee.

(3) The Technical Committee may create one or more ad hoc committees of experts in health matters to advise it on any matter with which it is concerned.

(4) The Technical Committee shall determine the proceedings for its meetings and the quorum for its meetings shall be not less than one third of its membership, including the person presiding at any such meeting.

8. (1) There is hereby established, a body to be known as the National Tertiary Hospitals Commission (in this Bill referred to as the Commission) which shall be a body Corporate, with perpetual succession and a common seal, and may sue and be sued in its corporate name.

Establishment of the National Tertiary Hospitals Commission

(2) The Commission shall consist of Executive Chairman, hwo shall be a Medical Director of the status of a Professor with a minimum of ten years working experience in a Teaching Hospital set up and the following members, that is -:

(a) the Permanent Secretary or his representative of the following Federal Ministries —

(i) Health;

(ii) Finance;

(iii) Establishment matters, office of the Head of Service of the Federation; and

(iv) Education

(b) the Chairman of the Committee of Chief Executives of Tertiary Hospitals;

(c) The Registrars of -

(i) Medical and Dental Council of Nigeria;

(ii) Nursing and Midwifery Council of Nigeria;

(iii) Medical Laboratory Science Council of Nigeria;

(iv) Pharmacists Council of Nigeria;

(v) Institute of Health Service Administrators;

(vi) Medical Rehabilitation Board;

(vii) Radiographers Registration Board of Nigeria;

(d) six persons appointed on merit, one from each geographical zone to represent the public interest, at least one of which must be a woman.

(e) one person to represent the organized private sector; and

(f) the Executive Secretary of the Commission, who shall be a member and Secretary of the Board.

9. (1) The functions of the Commission shall be to — Functions of the Commission

(a) advise the President through the Minister on matters affecting the establishment of tertiary hospitals in Nigeria;

(b) prepare periodic master plans for the balanced and coordinated development of hospitals in Nigeria;

(c) establish minimum standards to be attained by the various tertiary health facilities in the nation and also to inspect and accredit such facilities;

(d) make relevant investigations and recommendations to the Federal and State Governments on tertiary health care services in the national interest;

(e) advise the Federal Government on the financial needs, both recurrent and capital, of tertiary health services and in particular investigate and study the financial needs for training, research, and services and ensure that adequate provisions are made for these;

(f) set standards and criteria for allocation of funds from the Federal Government, monitor their utilization, source for grants as laid down by the Commission;

(g) collate, analyse and publish information in relation to tertiary health care services annually;

(h) lay down broad operational guidelines in all areas of management for use by the Hospital Management Board;

(i) monitor and evaluate all activities and receive annual reports

(j) carry out such other activities as are conducive for the discharge of its functions under this Act.

(2) The Minister may give the Commission directives of a general nature not relating to the particular matters with regard to the exercise by the Commission of its functions under this Act.

10. (1) There is hereby established a Fund to be known as the National Primary Health Care Development Fund (in this Act referred to as "the Fund").

Establishment of Primary Healthcare Development Fund

(2) The Fund shall be financed from —

(a) the consolidated fund of the Federation, an amount not less than two per cent of its value;

(b) grants by international donor partners; and

(c) funds from any other source.

(3) Money from the fund shall be used to finance the following: -

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

(b) 25 per cent of the fund shall be used to provide essential drugs for eligible primary healthcare facilities;

(c) 15 per cent of the fund shall be used for the provision and maintenance of facilities, equipment and transport for eligible primary healthcare facilities; and

(d) 10 per cent of the fund shall be used for the development of Human Resources for Primary Health Care.

(4) The National Primary Health Care Development Agency shall

(5) For any State or Local Government to qualify for Federal Government block grant pursuant to sub-section 1(1) of this section, such State or Local Government shall contribute -

(a) in the case of a State not less than 10 per cent of the total cost of projects; and

(b) in the case of a Local Government not less than five per cent of the total cost of projects

as their commitments in the execution of such projects.

(6) The National Primary Health Care Development Agency shall not disburse money to any -

(a) Local Government Health Authority if it is not satisfied that the money earlier disbursed was applied in accordance with the provisions of this Bill;

(b) State and Local Government that fails to contribute its counterpart funding and;

(c) States and local governments that fail to implement the national health policy, norms, standards and guidelines prescribed by the National Council on Health.

(7) The National Primary Health Care Development Agency shall develop appropriate guidelines for the administration, disbursement and monitoring of the fund.

11. (1) There is hereby established the Federal Capital Territory Primary Health Care Board (in this Bill referred to as "the Board")

Establishment, Composition and Tenure of the Federal Capital Territory Primary Health Care Board

(2) The Board s hall comprise –

(a) a part -time Chairman;

(b) an Executive Secretary with experience in health management who shall be the Chief Executive and Accounting Officer of the organisation;

(c) three other full -time members who shall have qualification and experience in human resources, financial management and administration;

(d) an Executive Secretary with experience in medical practice,who shall be the Chief Executive and Accounting Officer of the organization;

(e) one part -time member to represent each of the area councils;

(f) one representative of private healthcare providers in the Federal Capital Territory; and

(g) one representative of the Federal Capital Territory Hospital Management Board.

(3) The members of the Board shall be appointed by the Minister of the Federal Capital Territory on the recommendation of the Secretary of Health and Human Services.

(4) Members of the Board shall hold office for a term of four years in the first instance and may be reappointed for a further term of four years and no more on such terms and conditions as may be specified in their letters of appointment.

(5) The Board shall: -

(a) ensure coordination of planning, budgetary provision and monitoring of all primary healthcare services in the Federal Capital Territory;

(b) advice the Minister of Federal Capital Territory and Area Council health authorities in the Federal Capital Territory on any matter regardin g primary healthcare services in the Federal Capital Territory;

(c) recruit, promote, post, transfer, train and discipline staff on grade level 07 and above;

(d) pay salaries and allowances to primary healthcare staff;

(e) disburse funds provided to it by the National Primary Health Care Development Agency and other sources;

(f) undertake capital projects;

(g) ensure that annual reports are rendered by primary healthcare facilities in the area council health authorities;

(h) ensure annual auditing of accounts of primary healthcare facilities in the Area Council Authorities;

(i) consider applications for, and issue Certificate of Needs and Standards appropriate primary health care institution in its area of jurisdiction; and

(j) perform such functions as may be assigned to it by the Minister of the Federal Capital Territory or any other recognized authority.

(6) The Board shall establish and maintain a separate account into which shall be paid monies from the Government of the Federation or any other source.

PART II - HEALTH ESTABLISHMENTS AND TECHNOLOGIES

12. (1) The Minister -in-Council shall by regulation — Classification of Health Establishment and Technologies

(a) classify all health establishments and technologies into such categories as may be appropriate, based on:

(i) their role and function within the national health system;

(ii) the size and location of the communities they serve;

(iii) the nature and level of health services they are able to provide;

(iv) their geographical location and demographic reach;

(v) the need to structure the delivery of health services in accordance with national norms and standards within an integrated and coordinated national framework; and

(vi) in the case of private health establishments, whether the establishment is for profit or not; and

(b) in the case of federally owned tertiary hospitals, determine the establishment of the hospital board and the management system of such tertiary hospital.

(2) Nothing in the foregoing provision of this section shall preclude the House of Assembly of any State from making laws for that State for the regulation and inspection of private and non -governmental health facilities in that State.

Certificate of Standards

13. (1) Without being in possession of a Certificate of Standards, a person, entity, government or organization shall not : -

(a) establish, construct, modify or acquire a health establishment, health agency or health technology;

(b) increase the number of beds in, or acquire prescribed health technology at a health establishment or health agency;

(c) provide prescribed health services; or

(d) continue to operate a health establishment, health agency or health technology after the expiration of 24 months from the date this Bill took effect.

(2) The Certificate of Standards referred to in subsection (1) of this section may be obtained by application in prescribed manner from the appropriate body of government where the facility is located. In the case of tertiary institutions the appropriate authority shall be the National Tertiary Hospital Commission.

14. Any person, entity, government or organisation who performs any act stated under section 13(1) without a Certificate of Standards required by that section is guilty of an offence and shall be liable on conviction to a fine of N500,000.00 or to imprisonment for a period not exceeding two years or both.

Offences and Penalties in respect of Certificate of Standards

15. (1) The Federal Ministry of Health shall not operate or manage any establishment other than a tertiary establishment.

Provision of Health Services at Public Health Establishments

(2) The Minister, in respect of a tertiary hospital, and the Commissioner, in respect of all other public health establishments within the State in question, may: -

(a) determine the range of health services that may be provided at the relevant public health establishment; and

(b) in consultation with the relevant Treasury, determine the proportion of revenue generated by a particular public health establishment classified as a hospital that may be retained by that hospital, and how those funds may be used.

(3) The Minister, in consultation with the National Council may prescribe conditions subject to which categories of persons may be eligible for exemption from payment for health care services rendered by public health establishments.

(4) Without prejudice to any prescription made by the Minister, in terms of subsection (2) of this section, all citizens shall be entitled to a basic minimum pac kage of health services.

16. (1) The Minister in Council may prescribe: -

Health Services at Non-Health Establishments and at Public Health Establishment other than Hospitals

(a) minimum standards and requirements for the provision of health services in locations other than health establishments, including schools and other public places; and

(b) penalties for any contravention of or failure to comply with any such standards or requirements.

(2) The Minister may, subject to the provisions of any other law, prescribe conditions relating to traditional health practices to ensure the health and well -being of persons who are subject to such health practices

(3) Without prejudice to the above the House of Assembly in any State may make laws for the provision of health services at non health establishments in the state.

17. (1) Subject to this Act, a user may attend any public health establishment for the purposes of receiving health services.

Referral from one Public Health Establishment to another

(2) If a public health establishment is not capable of providing the necessary treatment or care, the public health establishment in question must transfer the user concerned to an appropriate public health establishment which is capable of providing the necessary treatment or care.

18. (1) The Minister shall prescribe mechanisms to ensure a co ordinated relationship between private and public health establishments in the delivery of health services.

- Relationship between Public and Private Health Establishments

(2) The Federal Ministry, any State Ministry or any Local Government may enter into an agreement with any private practitioner, private health establishment or non-governmental organisation in order to achieve any object of this Bill.

19. (1) All health establishments shall comply with the quality requirements and standards prescribed by the Minister after consultation with the National Council. — Evaluating Services of Health Establishments

(2) The quality requirements and standards stated in subsection (1) may relate to human resources, health technology, equipment, hygiene, premises, the delivery of health services, business practices, safety and the manner in which users are accommodated and treated.

(3) The National Tertiary Hospital Commission shall monitor and enforce compliance with the quality requirements and standards stated in subsection (1) as it relates to Tertiary Hospitals.

PART III - RIGHTS AND DUTIES OF USERS AND HEALTH CARE PERSONNEL

20. (1) A health care provider, health worker or health establishment shall not refuse a person emergency medical treatment for any reason. — Emergency treatment

(2) Any person who contravenes this section is guilty of an offence and is liable on conviction to a fine of N10,000.00 (ten thousand naira) or to imprisonment for a period not exceeding three months or to both fine and imprisonment.

21. (1) No health care personnel shall be discriminated against on account of his status and duties. — Rights of Health Care Personnel

(2) Subject to any applicable law, the head of the health establishment concerned may in accordance with any guideline determined by the Minister, Commissioner or any other appropriate authority impose conditions on the services that may be rendered by a health care provider or heal th worker on the basis of health status.

(3) Subject to any applicable law, every health establishment shall implement measures to minimise —

(a) injury or damage to the person and property of health care personnel working at that establishment; and

(b) disease transmission.

(4) Without prejudice to section 19(1) and except for Psychiatric patients, a health care provider may refuse to treat a user who is physically or verbally abusive or who sexually harasses him or her, and in such a case the health care provider should report the incident to the appropriate authority.

22. Subject to not being found negligent, a health care provider or other officers or employees of a health care establishment shall be indemnified out o f the assets of the health care establishment against any liability incurred by him in defending any proceeding, whether civil or criminal in which judgement is given in his favour or is acquitted, if any such proceeding is brought against him in his capac ity as a health care provider, an officer or employee of a health care establishment.

23. (1) Every health care provider shall give a user relevant information pertain ing to his state of health and necessary treatment relating thereto including: -

(a) the user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interests of the user;

(b) the range of diagnostic procedures and treatment options generally available to the user;

(c) the benefits, risks, costs and consequences generally associated with each option; and

(d) the user's right to refuse health services and explain the implications, risks, obligations of such refusal.

(2) The health care provider concerned shall, where possible, inform the user in a language that the user understands and in a manner which takes into account the user's level of literacy.

24. The Federal Ministry, every State Ministry of Health, every Local Government Health Authority and every private health care provider shall ensure that appropriate, adequate and comprehensive information is disseminated and displayed at facility level on the health services for which they are responsible, which shall include — Duty to Disseminate Information

(a) the types of health services available;

(b) the organisation of health services;

(c) operating schedules and timetables of visits;

(d) procedures fo r laying complaints; and

(e) the rights and duties of users and health care providers.

25. Subject to applicable archiving legislation, the person in charge of a health establishment shall ensure that a health record containing such information as may be prescribed is created and maintained at that health establishment for every user of health services. Obligation to Keep Record

26. (1) All information concerning a user, including information relating to his or her health status, treatment or stay in a health establishment is confidential. Confidentiality

(2) Subject to section 26, no person may disclose any information contemplated in subsection (1) unless —

(a) the user consents to that disclosure in writing;

(b) a court order or any law requires that disclosure; or

(c) non -disclosure of the information represents a serious threat to public health.

27. A health worker or any health care provider that has access to the health records of a user may disclose such personal information to any other person, health care provider or health establishment as is necessary for any legitimate purpose within the ordinary course and scope of his or her duties where such access or disclosure is in the interest of the user.

Access to Health Records

28. (1) A health care provider may examine a user's health records for the purposes of: -

(a) treatment with the authorisation of the user; and

(b) study, teaching or research with the authorisation of the user, head of the health establishment concerned and the relevant health research ethics committee.

(2) If the study, teaching or research under subsection (1)(b) of this section reflects or obtains no information as to the identity of the user concerned, it is not necessary to obtain the authorisations contemplated in that subsection.

Access to Health Records Health Care by Provider

29. (1) The person in charge of a health establishment who is in possession of a user's health records shall set up control measures to prevent unauthorised access to those records and to the storage facility in which, or system by which, records are kept.

(2) Any person who —

(a) fails to perform a duty imposed on them under subsection (1);

(b) falsifies any record by adding to or deleting or changing any information contained in that record;

(c) creates, changes or destroys a record without authority to do so;

Protection of Health Records

(d) fails to create or change a record when properly required to do so;

(e) provides false information with the intent that it be included in a record;

(f) without authority, copies any part of a record;

(g) without authority, connects the personal identification elements of a user's record with any element of that record that concerns the user's condition, treatment or history;

(h) gai ns unauthorised access to a record or record-keeping system, including intercepting information being transmitted from one person, or one part of a record -keeping system, to another;

(i) without authority, connects any part of a computer or other electronic system on which records are kept to—

(i) any other computer or other electronic system; or

(ii) any terminal or other installation connected to or forming part of any other computer or other electronic system; or

(j) without authority, modifies or impairs the operation of —

(i) any part of the operating system of a computer or other electronic system on which a user's records are kept; or

(ii) any part of the programme used to record, store, retrieve or display information on a computer or other electronic system on which a user's records are kept, commits an offence and is liable on conviction to imprisonment for a period not exceeding two years or to a fine of N250,000.00 or both a fine and such imprisonment.

30. (1) A ny person may lay a complaint about the manner in which he or she was treated at a health establishment and have the complaint investigated. Laying of Complaints

(2) The Minister, Commissioner or any other appropriate authority shall establish a procedure for the laying of complaints within the areas of the national health system for which the Federal or State Ministry is responsible.

(3) The procedures for laying complaints shall —

(a) be displayed by all health establishments in a manner that is visible for any person entering the establishment and the procedure shall be communicated to users on a regular basis;

(b) in the case of a private health establishment, allow for the laying of complaints with the head of the relevant establishment;

(c) include prov isions for the acceptance and acknowledgment of every complaint directed to a health establishment, whether or not it falls within the jurisdiction or authority of that establishment; and

(d) allow for the referral of any complaint that is not within the jurisdiction or authority of the health establishment to the appropriate body or authority.

(4) In laying a complaint, the person stated in subsection (1) shall follow the procedure established by the Minister or a Commissioner, as the case may be.

PART IV - NATIONAL HEALTH RESEARCH AND INFORMATION SYSTEM

31. (1) There shall be established by the Minister, a National Health Research Committee (in this Bill referred to as "the Research Committee").

Establishment, Composition and Tenure of National Health Research Committee

(2)(a) The membership of the Research Committee shall consist of not more than 15 members appointed by the Minister on the recommendation of the various research institutions and other related bodies in the Federation.

(b) the membership of this research committee established in terms of this section shall as much as possible reflect the federal character of Nigeria.

(3) There shall be for the committee -

(a) a Chairman who shall be an acknowledged health researcher and be accomplished and renowned in a health discipline.

(b) a secretary who shall be the Director of Health Planning and Research in the Federal Ministry of Health.

(4) A person appointed pursuant to subsection (2)(a) of this section shall —

(a) hold office for a term of three years in the first instance and may be re-appointed for another term of three years and no more, under such terms and conditions as may be specified in his letter of appointment; and

(b) vacate his office if he resigns through a letter written under his hand or is requested by the Minister to do so in the public interest.

(5) The Research Committee shall have the responsibility to

(a) determine the extent of health research to be carried out by public and private health authorities;

(b) ensure that health research agenda and research resources focus on priority health problems;

(c) develop and advise the Minister on the application and implementation of an integrated national strategy for health research; and

(d) coordinate the research activities of public and private health establishments.

(6) The Minister may prescribe the manner in which the Research Committee shall conduct its affairs and the procedure to be followed at its meeting, inclu ding the manner in which decisions are to be made and implemented.

(7) A member of the Research Committee who is not employed on full-time basis in the public service shall in respect of his service as member be paid such remuneration as may be determined by the Minister.

Research or Experimentation with Human subject

32. (1) Notwithstanding anything to the contrary in any other law, every research or experimentation on a living person shall only be conducted: -

(a) in the manner prescribed by the relevant authority; and

(b) with the w ritten consent of the person after he shall have been informed of the objects of the research or experimentation and any possible effect on his health.

(2) Where research or experimentation is to be conducted on a minor for a therapeutic purpose, the research or experimentation may only be conducted -

(a) if it is in the best interest of the minor;

(b) in such manner and on such conditions as may be prescribed; and

(c) with the informed written consent of the parent or guardian of the minor.

(3) Wher e research or experimentation is to be conducted on a minor for a non-therapeutic purpose, the research or experimentation may only be conducted —

(a) in such manner and on such conditions as may be prescribed by the research committee; and

(b) with the informed written consent of the parent or guardian of the minor.

33. (1) There shall be established by the Minister the National Health Research Ethics Committee (in this Bill referred to as "the National Ethics Committee").

Establishment, Composition, Function and Tenure of National Health Research Ethics Committee

(2) The membership of the Ethics Committee shall consist of not more than 15 persons which shall include -

(a) a Chairman;

(b) a medical doctor;

(c) a legal practitioner;

(d) a pharmacist;

(e) a nurse;

(f) not less than two religious leaders representing the Christian and Muslim religions;

(g) a community health worker;

(h) one researcher in the medical field;

(i) one researcher in the pharmaceutical field; and

(j) three other persons one of whom shall be a woman who in the opinion of the Minister are of unquestionable integrity.

(3) A member of the Ethics Committee shall be appointed for a term of three years in the first instance and may be reappointed for another term of three years and no more under such terms and conditions as may be specified in his letter of appointment.

(4) A member of the Ethics Committee shall vacate his office if he resigns or is reque sted in the public interest by the Minister to do so.

(5) If a member of the Ethics Committee vacates his office or dies, the Minister may fill the vacancy by appointing a person in accordance with subsection (2) for the unexpired term of office of his predecessor.

(6) The National Ethics Committee shall have power to determine the guidelines to be followed for the functioning of Institutional health research ethics committees, and for the avoidance of any doubt shall –

(a) set norms and standards for conducting research on humans and animals, including clinical trials;

(b) adjudicate in complaints about the functioning of health research ethics committees and hear any complaint by a researcher who believes that he has been discriminated against by any of the health research ethics committees;

(c) register and audit the activities of health research ethics Committees;

(d) refer to the relevant statutory health professional council, matters involving the violation or potential violation of an ethical or professional rule by a health care provider;

(e) recommend to the appropriate regulatory body such disciplinary action as may be prescribed or permissible by law against any person found to be in violation of any norms an standards, or guidelines, set for the conduct of research under this Bill; and

(f) advise the Federal Ministry of Health and State Ministries of Health on any ethical issues concerning research on health.

(7) For the purposes of subsection (6)(a), "clinical trials" means a systematic study, involving human subjects that aims to answer specific questions about the safety or efficacy of a medicine or method of prevention and treatment.

34. (1) Every institution, health agency and health establishment at which health research is conducted, shall establish or have access to a health research ethics committee, which is registered with the National Ethics Committee.

Establishment and functions of health research ethics committees

(2) A health research ethics committee shall: -

(a) review research proposals and protocols in order to ensure that research conducted by the relevant institution, agency or establishment will promote health, contribute to the prevention of communicable or non -communicable diseases or disability or result in cures for communicable or non-communicable diseases; and

(b) grant approval for research by the relevant institution, agency or establishment in instances where research proposals and protocol meet the ethical standards of that health research ethics committee.

(c) perform other functions that may be referred to it by the Minister.

35. (1) The Federal Ministry of Health shall facilitate and co-ordinate the establishment, implementation and maintenance by State Ministries, Local Government Health Authorities and the private health sector of the health information systems at national, state and local government levels in order to create a comprehensive National Health Management Information System.

Coordi nation of National Health Management Information System (NHMIS)

(2) The Minister may, for the purpose of creating, maintaining or adapting databases within the national health information system desired in subsection (1), of this section prescribe categories or kinds of data for submission and collection and the manner and format in which and by whom the data is to be compiled or collated and shall be submitted to the Federal Ministry of Health.

(3) The Minister and Commissioners shall publish annual reports on the state of health of the citizenry and the health system of Nigeria including the States thereof.

36. The Secretary of Health and Human Services shall by this Bill establish a committee for FCT to maintain, facilitate and implement the health information systems under section 34(1) of this Bill, at FCT and area council levels.

Duties of a FCT as regards Health Information

37. Each Area Council, which provides health services shall establish and maintain a health information system as part of the national health information system as specified under section 34(1) of this Bill.

Duties of FCT Area Councils

38. (1) All private health care providers shall: -

Duties of Private HealthCare Providers

(a) establish and maintain a health information system as part of the national health information system as specified under section 34(1) of this Bill; and

(b) ensure compliance with the provision of sub-section (1)(a) as a condition necessary for the grant or renewal of the Certificate of Standards.

(2) Any private health care provider that neglects or fails to comply with the pr ovision of subsection(1) of this section shall be guilty of an offence and on conviction shall be liable to imprisonment for a term of six months or a fine of N50,000.00.

(3) Nothing in the foregoing precludes a State Assembly from making laws with regards to health information system for that State and the Local Government Areas and the private health sector within that State.

National Formulary Control of Safety of Drugs and Food Supply

39. (1) There shall be a compendium of drugs approved for use in health facilities throughout the Federation - (in this Bill referred to as the "National Formulary") which shall be under the dynamic periodic review of the National Council.

(2) Indigenous and local manufacture and production of as many items in the formulary as practicable shall be encouraged.

(3) The National Agency for Food and Drugs Administration and Control (NAFDAC) shall exercise its functions as provided in the enabling Act, Cap. N1, LFN 2004.

40. (1) The National Health Insurance Scheme (NHIS) shall exercise its functions as provided in the enabling Act, Cap. N42, LFN 2004.

Nationa l Health Insurance

(2) It shall be the responsibility of the Council to ensure the widest possible catchments for the scheme throughout the Federation or any part thereof.

(3) The Minister may, subject to conditions as may be reviewed from time to time, give direction and determine persons eligible for exemption form payment of health services at public health establishment.

(4) Nothing in this section of the Bill shall be prejudicial to the powers of the House of Assembly of a State to make laws for that State to regulate the implementation of the scheme, as well as exemptions for payment of health services in that State.

PART V - HUMAN RESOURCES FOR HEALTH

41. (1) The National Council shall develop policy and guidelines for, and monitor the provision, distribution, development, management and utilisation of, human resources within the national health system.

Development and Provision of Human Resources in National Health System

(2) The policy and guidelines stated in subsection (1) shall amongst other things facilitate and advance —

(a) the adequate distribution of human resources;

(b) the provision of appropriately trained staff at all levels of the national health system to meet the population's health care needs; and

(c) the effective and efficient utilisation, functioning, management and support of human resources within the national health system.

42. The Minister, with the concurrence of the National Council shall determine guidelines that will enable the State Ministries and Local Governments to implement programmes for the appropriate distribution of health care providers and health workers.

Appropriate Distribution of Health Care Providers

43. The Minister shall make regulations with regard to human resources management within the national health system in order to: -

Regulations Relating to management of Human Resources in the Health System

(a) ensure that adequate resources are available for the education and training of health care personnel to meet the human resources requirements of the national health system;

(b) ensure the education and training of health care personnel to meet the requirements of the national health system, including the prescription of a re-certification programme through a system of continuing professional development;

(c) create new categories of health care personnel to be educated or trained;

(d) identify shortages of key skills, expertise and competences within th e national health system, and prescribe strategies which are not in conflict with any other existing legislation, for the: -

(i) education and training of health care providers or health workers in the Federation, to make up for any shortfall in respect of any skills, expertise and competences; and

(ii) recruitment of health care personnel from other countries,

(e) prescribe strategies for the recruitment and retention of health care personnel within the national health system and from anywhere outside Nigeria;

(e) prescribe strategies for the recruitment and retention of health care personnel within the national health system and from anywhere outside Nigeria;

(f) ensure the existence of adequate structures for human resources planning, development and management at national, state and local government levels of the national health system;

(g) ensure the availability of institutional capacity at state and local governments levels of the national health system to plan for, develop and manage human resources;

(h) ensure the definition and clarification of the roles and functions of the Federal Ministry of Health, state ministries of health and local government health authorities with regard to the planning, production and management of human resources; and

(i) prescribe circumstances under which health care personnel may be recruited from other countries to provide health services in the Federation.

Training Institutions

44. (1) The National Assembly may make laws in respect of the establishment and management of Health Training Institutions as well as the prescription of a minimum standard of quality and content of training and teaching in such institutions for personnel in all cadres in the health services of the Federation.

(2) The National Council shall ensure that there is adequate plan for manpo wer development throughout the federation or any part thereof to keep pace with evolving trends of expansion and improvement in health care delivery.

(3) Without prejudice to the provisions of subsections (1) and (2) of this section, the House of Assembly of any State may make laws for the establishment of any institution for training and teaching of Health personnel in cadres as may be determined by the National Council.

Industrial Health

45. (1) The National Assembly may make laws for the Federation or any part thereof with respect to the health, safety and welfare of persons employed to work in factories, and industrial and commercial outfits.

(2) The National Council shall ensure that the provisions made for industrial health and safety pursuant to subsection (1) of this section are complied with throughout the federation or any part thereof.

(3) The House of Assembly of any State shall have powers to make laws to enforce compliance with the provisions of this section in that State.

46. (1) Without prejudice to the right of all cadres and all groups of Health Professionals to demand for better conditions of service, health services shall be classified as Essential Service, and subject to the provisions of the relevant law. — Industrial Dispute

(2) Pursuant to subsection (1) of this section, industrial disputes in the public sector of Health shall be treated seriously and shall on no account cause the total disruption of health services delivery in public institutions of health in the federation or in any part thereof.

(3) Where the disruption of health services has occurred in any sector of National Health System, the Minister—in—Council shall apply all reasonable measures to ensure a return to normalcy of any such disruption within fourteen days of the occurrence thereof.

47. Without prejudice to the right of any Nigerian to seek investigation and treatment anywhere within and outside Nigeria, no public officer of the government of the federation or any part thereof shal l be sponsored for medical investigation or treatment abroad at public expense except in exceptional cases on the recommendation and referral by relevant expertise in respect of the investigation in Nigeria, and which recommendation or referral shall be d uly approved by the Minister or the Commissioner of Health of the State as the case may be. — Medical Treatment Abroad

51. (1) A person shall not without the prior written approval of the Minister: -

Prohibition of Reproductive, therapeutic Cloning of Human Kind

(a) manipulate any genetic material, including genetic material of human gametes, zygotes or embryos; or

(b) engage in any activity, including nuclear transfer or embryo splitting, for the purpose of the reproductive cloning of a human being.

(2) No person shall import or export human zygotes or embryos without the prior written approval of the Minister on the recommendation of National Ethics Research Committee.

(3) Any person who contravenes a provision of this section or who fails to comply therewith is guilty of an offence and is liable on conviction to imprisonment for a minimum of five years with no option of fine

(4) For the purpose of this section: -

(a) "reproductive cloning of a human being" means the manipulation of genetic material in order to achieve the reproduction of a human being and includes nuclear transfer or embryo splitting for such purpose; and

(b "therapeutic cloning" means the manipulation of genetic material from adult, zygotic or embryonic cells in order to alter, for therapeutic purposes, the function of cells or tissues.

52. (1) A person shall not remove tissue from a living person for transplantation in another living person or carry out the transplantation of such tissue except: -

Removal and Transplantation of Human Tissue in Hospital

(a) in a hospital authorised for that purpose; and

(b) on the written authority of: -

(i) the medical practitioner in charge of clinical services in that hospital or any other medical practitioner authorised by him or her; or

(ii) in the case where there is no medical practitioner in charge of the clinical services at that hospital a medical practitioner authorised thereto by the person in charge of the hospital.

(2) The medical practitioner stated in subsection (1)(b) shall not be the lead participant in a transplant for which he has granted authorisation under that subsection.

53. (1) Only a registered medical practitioner or dentist may remove any tissue from a living person, use tissue so removed for any of the purposes stated in this Bill or transplant tissue so removed into another living person.

Removal, Use or Transplantation of Tissue and Administering of Blood and Blood Products by Medical Practitioner or Dentist

(2) Only a registered medical practitioner or dentist, or a person acting under the supervision or on the instructions of a medical practitioner or dentist, may administer blood or a blood product to, or prescribe blood or a blood product for, a living person.

54. (1) It is an offence for a person: -

Payment in Connection with the Importation, Acquisition or Supply of Tissue, Blood or Blood Product

(a) who has donated tissue, blood or a blood product to receive any form of financial or other reward for such donation, except for the reimbursement of reasonable costs incurred by him or her to provide such donation; and

(b) to sell or trade in tissue, blood or blood products, except as provided for in this Bill.

(2) Any person found guilty of an offence under subsection (1) is liable on conviction to a fine of N100,000 (one hundred thousand naira) or to imprisonment for a period not exceeding one year or to both fine and imprisonment.

55. (1) Human organs obtained from deceased persons for the purpose of transpla ntation or treatment, or medical or dental training or researeh, shall only be used in the prescribed manner.

Allocation and Use of Human Organs

(2) Human organs obtained under subsection (1) shall be allocated in accordance with the prescribed procedures.

(3) The National Tertiary H ospital Commission shall prescribe: -

(a) criteria for the approval of organ transplant facilities; and

(b) procedural measures to be applied for such approval.

(4) A person who contravenes a provision of this section or fails to comply therewith or who charges a fee for a human organ is guilty of an offence and shall be liable to imprisonment for a minimum of five years without option of fine.

56. (a) A person who is competent to make a will may: -

Donation of Human Bodies and Tissue of Deceased Persons

(i) in the will; or

(ii) in a document signed by him and at least two competent witnesses; or

(iii) in a written statement made in the presence of at least two competent witnesses,

donate his or her body or any specified tissue thereof to be used after his or her death, or give consent to the post mortem examination of his or her body, for any purpose provided for in this Bill.

(b) A person who makes a donation as stated in paragraph (a) above may nominate an institution or a person as donee.

57. (1) A donation under section 55 may only be made for the purposes of:-

Purposes of Donation o f body, tissue etc

(a) training of students in health sciences;

(b) health research;

(c) advancement of health sciences;

(d) therapy including the use of tissue in any living person; or

(e) production of a therapeutic, diagnostic or prophylactic substance.

(2) This Bill does not apply to the preparation of the body of a deceased person for the purposes of embalming it, whether or not such preparation involves the: -

(a) making of incisions in the body for the withdrawal of blood and the replacement thereof by a preservative; or

(b) restoration of any disfigurement or mutilation of the body before its burial.

58. A donor may, prior to the removal for transplantation of the relevant organ into the donee, revoke a donation in the same way in which it was made or, in the case of a donation by way of a will or other document, also by the intentional destruction of that will or document. Procedure for revocation of any donation

PART VII – REGULATIONS AND MISCELLANEOUS PROVISIONS

59. The Minister, in consultation with the National Council, may make regulations with regard to any other matter which is reasonably necessary or expedient to prescribe in the implementation of this Bill. Regulations

60. (1) The Minister may, after consultation with the National Council, establish such number of advisory and technical committees as may be necessary to achieve the objects of this Bill. Powers of Minister to appoint Committees

(2) When establishing an advisory or technical committee, the Minister may determine by notice or circular: -

(a) its composition, functions and working procedure; and

(b) any incidental matters relating to that advisory or technical committee.

61. (1) The Minister may assign any duty and delegate any power imposed or conferred upon him by this Bill, except the power to make regulations to:

Assignment of Duties and delegation of powers

(a) any person in the employ of the Federal Government; or

(b) any council, board or committee established in terms of this Bill.

(2) A Commissioner may assign any duty and delegate any power imposed or conferred upon him or her by this Bill, except the power to make regula tions to any officer in the relevant State Ministry or any Council, Board or Committee established in terms of this Bill.

(3) The Permanent Secretary of the Federal Ministry may assign any duty and delegate any power imposed or conferred upon him or her by this Bill to any official in the Federal Ministry.

(4) The Permanent Secretary of a State Ministry may assign any duty and delegate any power imposed or conferred upon him or her in terms of this Bill to any official of that State Ministry of Health.

62. (1) Anything done before the commencement of this Bill under a provision of any other relevant Act or regulation which could have been done under a provision of this Bill shall be regarded as having been do ne under the corresponding provision of this Bill.

Savings and transitional provisions

(2) The Minister may prescribe such further transitional arrangements as may be necessary in the circumstance.

63. In this Bill, unless the context otherwise requires :- Interpretation

"appropriate authority" means any other authority apart from the Minister, Commissioner, Executive Secretary, Chairmen of Boards or Chairman of Agency;

''basic minimum package" means the set of health services as may be prescribed from time to time by the Minister after consultation with the National Council on Health;

"blood product" means any product derived or produced from blood, including circulating progenitor cells, bone marrow progenitor cells and umbilical cord progenitor cells;

"certifi cate of standards" means a certificate under section 14;

"Commissioner" means the Commissioner of a State responsible for health;

"communicable disease" means a disease resulting from an infection due to pathogenic agents or toxins generated by the infection, following the direct or indirect transmission of the agents from the source to the host;

"Constitution" means the Constitution of the Federal Republic of Nigeria, 1999;

"death" means brain death;

"embryo" means a human offspring in the first eight weeks from conception;

"gamete" means either of the two generative cells essential for human reproduction;

"gonad" means a human testis or human ovary;

"health agency" means any person other than a health establishment:

(a) whose business involves the supply of health care personnel to users or health establishments;

(b) who employs health care personnel for the purpose of providing health services; or

(c) w ho procures health care personnel or health services for the benefit of a user, and includes a temporary employment service involving health workers or health care providers;

''health care personnel'' means health care providers and health workers;

''hea lth care provider'' means a person providing health services under Act of Law;

''health establishment'' means the whole or part of a public or private institution, facility, building or place, whether for profit or not, that is operated or designed to provide inpatient or outpatient treatment, diagnostic or therapeutic interventions, nursing, rehabilitative, palliative, convalescent, preventative or other health service under section 13;

''health research'' includes any research which contributes to knowledge of: -

(a) the biological, clinical, psychological or social processes in human beings;

(b) improved methods for the provision of health services;

(c) human pathology;

(d) the causes of disease;

(e) the effects of the environment on the human body;

(f) the development or new application of pharmaceuticals, medicines and related substances; and

(g) the development of new applications of health technology;

"health research ethics committee" means any committee established under section 35;

"health services" means health care services that are preventive, protective, promotive, curative and rehabilitative in respect of physical mental and social well being;

"health technology" means machinery or equipment that is used in the provision of health services, but does not include medicine as defined in the Drugs and Related Products Registration etc Act, No. 19 of 1993;

"health worker" means any person who is involved in the provision of health services to a user, but does not include a heal th care provider;

"hospital" means a health establishment which is classified as a hospital by the Minister under section 13;

"Minister" means the Minister charged with responsibility for matters relating to health;

"National Council on Health" means the Council established by section 5:

"national health policy" means all policies relating to issues of national health as approved by the Federal Executive Council on the advice of the National Council on Health through the Minister;

"National Health Research Committee" means the Committee established under section 34;

"National Health Research Ethics Committee" means the Committee established under section 35;

"National health system" means the system within the Federal Republic of Nigeria, whether in the public or private sector, concerned with the financing, provision or delivery and regulation of health services;

"non -communicable disease" means a disease or health condition that cannot be contracted from another person, an animal or directly from the environment;

"norm" means a statistical normative rate of provision or measurable target outcome over a specified period of time;

"NPHCDA" means the National Primary Health Care Development Agency established under section 11;

"Office of Standards Compliance" means the Office established under this Bill;

"oocyte" means a developing human egg cell;

"organ" means any part of the human body adapted by its structure to perform any particular vital function, including the eye and its accessories, but does not include skin and appendages, flesh, bone, bone marrow, body fluid, blood or a gamete;

"Permanent Secretary" means the administrative head of the Federal Ministry of Health or a State Ministry of Health;

Partnership for Service