NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

WARD HEALTH SYSTEM

Second Edition

AUGUST 2018

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Foreword

This is the second edition of the Ward Health System Manual which has been built on the first edition printed in 2006. The first edition was developed against a background of continuing efforts to reform the health sector in Nigeria, and the historical hindsight of two previous failed attempts at revitalizing primary health care in Nigeria which made the NPHCDA to develop a manual that would assist in attempt at revitalizing primary health care system through the Ward Health System.

The Ward Health System (WHS) represents the current national strategic thrust for delivery of quality PHC services in Nigeria for improved health outcomes and is the model of implementation for achieving Universal Health Coverage (UHC).

In line with the Primary Health Care Revitalization Agenda, the WHS has been reviewed to align with the Primary Health Care Under One Roof (PHCUOR) Initiative, the National Health Act of 2014 and other initiatives in the Ward Health System for efficient PHC service delivery.

The review carried out by NPHCDA and partners has produced an up-to-date operational WHS document for the implementation of PHC services at ward and village levels. The importance of the Ward Health System in the implementation of Primary Health Care to achieve Universal Health Coverage for all Nigerians must be emphasized.

This edition includes all the initiatives that have evolved in Primary Health Care implementation since the first edition was published over a decade ago. These initiatives include Primary Health Care Under One Roof (PHCUOR) Policy, PHC Revitalization (1 functional Primary Health Centre per ward), Community Health Influencers, Promoters and Services (CHIPS) Programme, Emergency Routine Immunisation Coordinating Centres, Reviewed Ward Minimum Health Care Package (WMHCP), Basic Health Care Provision Fund (BHCPF) and so on.

This second edition is comprehensive in content and will be very useful to both PHC managers and service providers at all levels of implementation. In addition, students in health institutions and in allied professions will find this document useful.

I wish to appreciate all NPHCDA staff, partners and stakeholders for the commitment and kind support to the review and its successful outcome.

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Our sister departments (Disease Control & Immunisation (DCI), Planning, Research & Statistics (PRS), Community Health Services (CHS) and Advocacy & Communication (A&C) supported our efforts to review the Ward Health System and bring it up to date.

The Department also appreciates the immense contributions of our partners on the PHCSD Top Management Team (FMoH, NHED, NGF, IVAC/DCL, MNCH2, CHAI and eHealth Africa) which ensured the success of the review.

Finally, we appreciate the dedication of all staff of the Department to the timely completion of the review.

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Acronyms

ANC	-	ANTE NATAL CARE
BMPHS	-	BASIC MINIMUM PACKAGE OF HEALTH SERVICES
CBO	-	COMMUNITY BASED DISTRIBUTOR
CHO	-	COMMUNITY HEALTH OFFICER
CSO	-	CIVIL SOCIETY ORGANISATION
CHEW	-	COMMUNITY HEALTH EXTENSION WORKER
CHIPS	-	COMMUNITY HEALTH INFLUENCERS, PROMOTERS & SERVICES
DRF	-	DRUG REVOLVING FUND
FMC	-	FACILITY MANAGEMENT COMMITTEE
HF	-	HEALTH FACILITY
IMCI	-	INTEGRATED MANAGEMENT OF CHILDHOOD ILLNESS
ISS	-	INTEGRATED SUPPORTIVE SUPERVISION
LERICC	-	LOCAL EMERGENCY ROUTINE IMMUNIZATION COORDINATING CENTRE
LGHA MT	-	LOCAL GOVERNMENT HEALTH AUTHORITY MANAGEMENT TEAM
MNCH	-	MATERNAL, NEWBORN AND CHILD HEALTH
MSP	-	MINIMUM SERVICE PACKAGE
NCDs	-	NON-COMMUNICABLE DISEASES
NERICC	-	NATIONAL EMERGENCY ROUTINE IMMUNIZATION COORDINATING CENTRE
NGOs	-	NON-GOVERNMENTAL ORGANISATIONS
NHA	-	NATIONAL HEALTH ACT
NHMIS	-	NATIONAL HEALTH MANAGEMENT INFORMATION SYSTEM
NTDs	-	NEGLECTED TROPICAL DISEASES
OIRIS	-	OPTIMIZED INTEGRATED ROUTINE IMMUNIZATION SESSIONS
PLA	-	PARTICIPATORY LEARNING AND ACTION
PHC	-	PRIMARY HEALTH CARE
PHCUOR	-	PRIMARY HEALTH CARE UNDER ONE ROOF
PHCMIS	-	PRIMARY HEALTH CARE MANAGEMENT INFORMATION SYSTEM
PPM	-	PLANNED PREVENTIVE MAINTENANCE
PNC	-	POST NATAL CARE

REW	-	REACH EVERY WARD
RI	-	ROUTINE IMMUNIZATION
SBA	-	SKILLED BIRTH ATTENDANT
SERICC	-	STATE EMERGENCY ROUTINE IMMUNISATION COORDINATING CENTRE
SPHCB	-	STATE PRIMARY HEALTH CARE BOARD
STIs/HIV/AIDS	-	SEXUALLY TRANSMITTED INFECTIONS/HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY VIRUS
ToR	-	TERMS OF REFERENCE
UHC	-	UNIVERSAL HEALTH COVERAGE
VDC	-	VILLAGE DEVELOPMENT COMMITTEE
VPD	-	VACCINE PREVENTABLE DISEASE
WDC	-	WARD DEVELOPMENT COMMITTEE
WHO	-	WORLD HEALTH ORGANISATION
WHS	-	WARD HEALTH SYSTEM
WMHCP	-	WARD MINIMUM HEALTH CARE PACKAGE

CHAPTER 1: INTRODUCTION TO THE WARD HEALTH SYSTEM (WHS)

1.1 Background

There have been several attempts in the past to provide effective and efficient health services with wide coverage in Nigeria. The first attempt was in 1976 when the Federal Government introduced the Basic Health Services Scheme (BHSS) as part of the 1975-1980 Development Plan. Many health facilities of different categories were constructed and equipped all over the country. In addition, new cadres of community health workers were introduced. These were the Community Health Officer (CHO), Community Health Supervisor (CHS), Community Health Assistant (CHA) and the Community Health Aide (CHAide). The cadres were later on streamlined into 3 cadres: the Community Health Officer (CHO), Community Health Extension Worker (CHEW) and Junior Community Health Extension Worker (JCHEW).

The second attempt was in 1986 when 52 pilot LGAs were chosen to be developed as model PHC LGAs. Rigorous activities were carried out, starting with baseline data survey and situation analysis. Project Formulation and Plan Implementation workshops were conducted to plan activities using collected data. The LGAs were granted a "seed package" comprising a motorcycle, drugs and consumables from an "Essential Drugs List" and five hundred thousand naira to implement their activities.

Nigeria started the field implementation of Bamako Initiative (BI) programme in 1989. It was adopted as a strategy to strengthen PHC in the same 52 LGAs that were supported with resources and guidelines for the managerial infrastructure. Community Development Committees operated a 'Drug Revolving Fund" and this worked well in some LGAs. However, the desired objectives were generally not achieved because the people were passive recipients in most places and had limited power.

Nigeria, however made tremendous progress in the LGA focused PHC initiative of 1986 - 1992, which culminated in the attainment of Universal Child Immunization (UCI) target of 80%, high rating of the country by the WHO Review Team and the creation of the National Primary Health Care Development Agency in 1992.

Unfortunately, the period from 1993 - 1999 witnessed a loss of the earlier gains as a result of instability in political governance, poor funding, lack of political support, low capacity of the local governments to manage PHC and withdrawal of donor supports.

The WHO Review Team in 1992 noted that "community mobilization would greatly be assisted if the boundaries of the then health district are the same as the electoral ward (20,000 to 30,000 people) which elects a councillor to the LGA".

Recognizing the serious deterioration in the nation's health system and the central role of Primary Health Care, the Federal Government in 2000 repositioned the National Primary Health Care Development Agency and mandated it to revitalize the nation's PHC system. It was in the light of the foregoing that the Agency introduced the Ward Health System in 2001 by adopting the **Political Wards** as the operational units for the implementation of the PHC programmes. The "LGA-District/Village" structure, therefore gave way to the "LGA-Ward-Community/Village" structure. The idea is to provide a nationally acceptable targeted area of operation with clearly

defined boundary, political representation and population.

The third attempt at revamping the PHC system in Nigeria occurred in the year 2000 to 2005. The Federal Government provided funds to build model PHC Centres; 200 centres in 2001, 120 centres in 2004 and 61 centres in 2005. However, the Ward Health System was not effectively implemented and that necessitated the current review to include current strategies on how to make the ward health system more functional in line with the present administration's push for the concept of "one functional PHC centre per ward". Where there is no model health centre, existing health facility will be identified and upgraded to a Ward Model Health Centre.

The Ward Health System has remained the backbone for implementing primary health care programmes in Nigeria till date. Having one (1) functional primary health centre per ward will ensure increased access to the entire population. This will also enable integrated PHC service delivery with facilitated referrals, human resources for health (skilled, motivated, supervised), equipment, medicines and consumables, infrastructure upgrade, community engagement, demand creation through Ward and Village Development Committees, data management, supervision and strong collaboration (education, agriculture, environment and water resources).

1.2 Conceptual Framework

The Ward Health System (WHS) represents the current national strategic thrust for delivery of PHC services in Nigeria. It was designed to address the causes of previous failures in developing functional PHC system through building capacity of communities and harnessing grassroots political participation towards owning the health system that will be used to deliver services identified in the ward minimum health care package and developing effective systems of financing thus making it as community based as possible.

The Ward Health System (WHS) is based on the use of political wards as the catchment area to target PHC interventions. The Ward Health System requires at least one functional Primary Health Centre which will also serve as the upward referral facility in the ward. This Primary Health Centre in the ward may be referred to as the Ward Health Centre but for the sake of consistency, the term 'Primary Health Centre' is preferred. Other levels of PHC facilities are the health clinic and health post, the latter being the lowest level health facility in the ward. The Primary Health Centre is to coordinate and supervise all the health services within the ward both at the facility and community levels. The communities are actively involved right from the construction/rehabilitation stages of the health centres to handing over of the health centres to their Ward Development Committees (WDC) to ensure ownership and effective management of services. The Primary Health Centre is to be provided with appropriate number and mix of health personnel, equipment and drugs, and effectively linked with other health facilities in the ward.

Managerial support for the WHS is to be provided by the Ward Development Committees/Village Development Committees. Under the Ward Health System, the Primary Health Centre is the referral facility for all the other PHC facilities in a political ward. Each ward is subdivided into a maximum of six (6) health areas comprising of groups of villages/communities. Each health area has health facilities made up of health posts, clinics and outreaches all linked to the Primary Health Centre and are supervised by a resident JCHEW.

1.3 Goal & Objectives of the Ward Health System

Goal

The goal of WHS is to improve and ensure access to sustainable, quality, acceptable and affordable health services with full participation of people at the community level and thereby achieve Universal Health Coverage (UHC).

Objectives

- To promote full and active community participation and ownership of community health interventions in order to sustain an effective and efficient delivery of PHC services in the ward
- To improve access to quality health care and ensure equity
- To garner political commitment to Primary Health Care at the community and ward levels
- To reduce morbidity and mortality especially amongst the vulnerable groups - Women of Child Bearing Age, children under five years and the elderly

1.4 Benefits of the Ward Health System

The benefits of the Ward Health System include the following:

- The political ward is well defined and recognized by all tiers of government and therefore easier to administer
- The political ward enhances increased physical access to health services for the communities
- The Ward Supervisory Councilor is the elected representative of the ward and expectedly the political advocate of the people
- In urban LGAs where social integration diminishes the importance of their village settlements, the ward health system provides an acceptable alternative for subdividing the LGA
- The political ward promotes health as a social and political good
- The political ward enhances social inclusion and promotes resource mobilization for health

CHAPTER 2: ORGANIZATION AND MANAGEMENT OF WARD HEALTH SYSTEM

2.1 Organizational Structure

The Ward Health System (WHS) is designed to provide primary health care services to a political ward which is a constituency from where an elected councillor can represent the political and socio-economic aspirations of the ward in the local government council. It has a referral facility which is the Primary Health Centre which provides integrated services to cover all PHC components. The Primary Health Centre staffs coordinate and supervise all the health services within the ward. Each ward is subdivided into a maximum of six (6) health areas comprising of groups of villages in rural wards or neighbourhoods in urban wards based on population and landmass. Each health area has at least a fixed service delivery point, the health clinic and health posts in the villages and outreaches all linked to the Primary Health Centre and are supervised by a resident JCHEW.

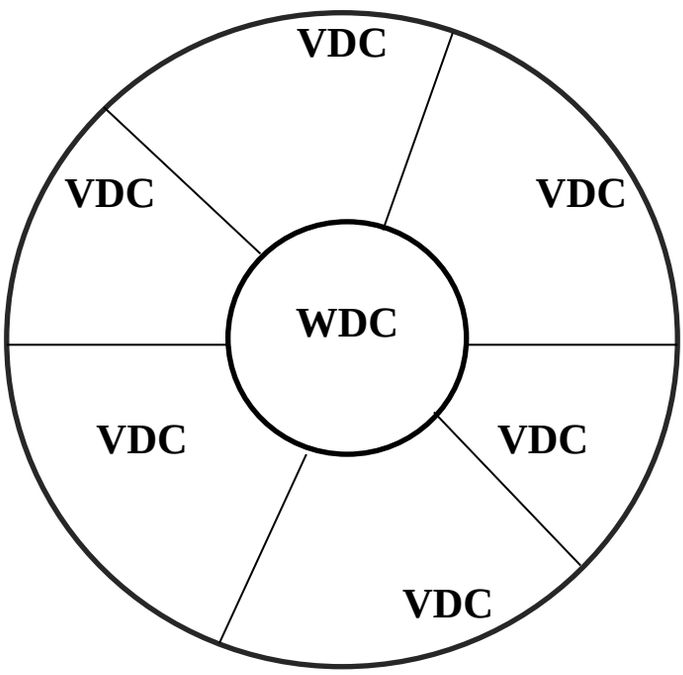

Figure 1: Sub-division of the Ward

2.2 Managerial Infrastructures

The management infrastructure of the ward health system is based mainly in the community. It consists of two committees: i) the Ward Development Committee (WDC) at the ward level and ii) the Village Development Committee (VDC) at both urban and rural settings. The WDC consists of Chairmen of each VDC in the ward, and serves as the apex body for the functions of the Primary Health Centre and other development activities carried out in the ward. It has a direct link with the LGHA through a representative of the WDC serving on the LG Advisory Committee.

All Primary Health Care facilities should have Facility Management Committees (FMCs) directly managing the health facilities. Each Facility Management Committee (FMC) for an individual

facility should report to the WDC or VDC as applicable for coordination and support. The chairmen of the VDCs in the ward are members of the WDC and represent their respective VDCs bringing health facility problems that are beyond the capacity of the health facility to the WDC. All identified problems at the ward level should be taken to the LG Health Authorities (LGHAs) for interventions and necessary actions. The members of the various committees are participating on a voluntary and merit basis and apart from transport and refreshment allowances are not entitled to further compensation.

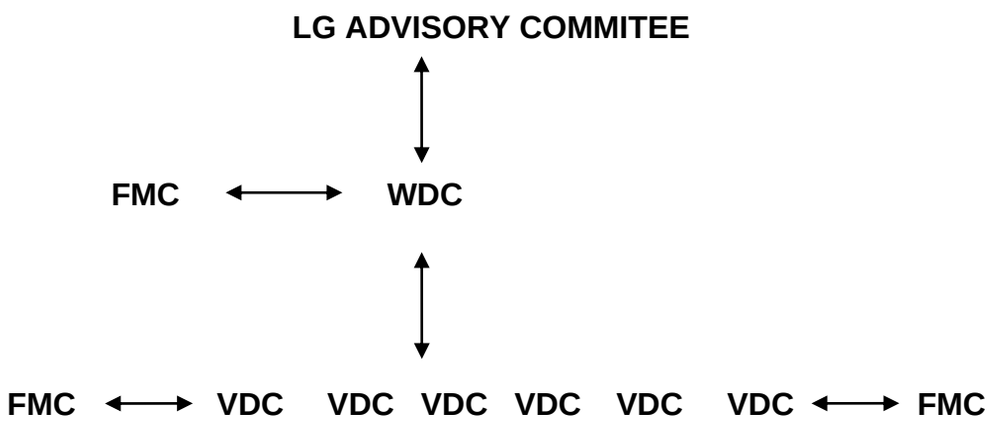

Figure 2: Managerial Infrastructures for the Ward Health System

Structurally, every ward has a Ward Development Committee. The recommended guidelines for the Composition, Functions and Terms of Reference (ToR) of the WDCs should be followed.

2.2.1 Ward Level

A. Composition of the Ward Development Committee (WDC)

- Ward head or the most respected village head so selected may serve as Patron
- One representative (the chairman) from every VDC in the ward
- The WDC Chairman shall be elected by members
- The WDC Secretary shall be elected by the members
- The Councilor representing the ward in the LG Council
- The officer-in-charge of the Primary Health Centre (Ward Focal Person/Supervisor)
- The CHIPS Community Engagement Persons
- The Ward Community Development Officer, if available
- The WDC should co-opt members of health-related sectors such as principals of secondary schools, primary school headmasters/headmistresses, Agriculture Extension Workers, Electricity personnel, Water and Works staff and NGOs
- At least 30% of membership shall be women and at least one woman should hold an elective post

B. Roles and Responsibilities of the WDC

The Ward Development Committee shall:

- Identify health and social needs of the ward and plan for them
- Supervise the implementation of ward work plans
- Identify local human and material resources to meet these needs
- Forward all health/community development plans (facility, village and wards levels) to LG Health Authority
- Mobilize and stimulate active involvement of prominent and other local people in the planning, implementation and evaluation of projects
- Take active role in the supervision and monitoring of the Drug Revolving Fund (DRF) in the ward
- Raise funds for community programmes when necessary at facility, village and ward levels
- Ensure accountability by providing regular feedback to the community on how funds raised are utilized
- Liaise with government and other voluntary agencies in finding solutions to health, social and other related problems in the wards
- Supervise the activities of the VDCs/FMCs/CHEWs/JCHEWs/CHIPS agents
- Oversee the functioning of the health facilities in the ward
- Provide necessary support to CHIPS agents
- Ensure that a WDC bank account is opened with a reliable commercial bank. The signatories shall be the Chairman, Secretary and Treasurer of the WDC
- Monitor equipment inventory and infrastructure at quarterly intervals
- Ensure the proper functioning of health facilities in the ward using a maintenance plan
- Ensure that NHMIS forms are correctly filled and submitted on time
- Give feedback of data collected to LGHA Management Team

C. Terms of Reference (ToR) for the WDC

The Committee shall:

- Meet monthly
- Record minutes of meetings
- Recommend that minutes of meetings be signed by the Chairman and Secretary after they are duly adopted at a follow-up meeting
- Comply with the quorum of members set to hold a meeting (at least two-thirds of members)
- Authorize the Treasurer to record and pay all monies into the appropriate bank account
- Authorize the Treasurer to spend money only after approval by the WDC
- Instruct the Treasurer to record all incomes and expenditures
- Use the Primary Health Centre as its meeting venue and secretariat of the WDC
- Advise, where there is a WDC bank account, signatories to be the Chairman, Secretary and Treasurer of the WDC
- Submit minutes of meetings to LG Advisory Committee

D. Accountability Framework for the WDC

The committee shall:

- Submit quarterly work plans in triplicates to the SPHCB through the LGHA; triplicates will be signed at state level and copies will be shared across the different levels: one copy will remain at SPHCB, one at LGHA and one with the WDC
- Submit quarterly report of work plan implementation progress to SPHCB detailing achievements, challenges(if any), areas of improvement
- Leverage on existing monthly town hall meetings in the ward to interact with community members on health-related issue (perception of health care delivery, health care needs, utilization of any funds raised for health care)
- Include health related insight from town hall meetings in monthly minutes of meeting
- Undergo quarterly performance review by the LGHA/SPHCB using quarterly reports, assessment scorecards and health facility spot checks

2.2.2 Village Level

A. Composition of the Village Development Committee (VDC)

- Village head to serve as Patron
- A respected person elected by the VDC members to serve as Chairman
- An elected literate member of the Village to serve as Secretary
- A representative of religious groups
- A representative of women's groups/associations
- A representative of occupational/professional groups
- A representative of NGOs
- Officer-in-charge of the health facility (JCHEW/CHEW)
- A representative of CHIPS agents
- A representative of persons living with disabilities
- A representative of youths
- A representative of traditional healers
- A representative of patent medicine vendors
- A trusted VDC member shall serve as Treasurer. The treasurer shall keep all the funds of the VDC and keep records of all transactions and present the financial reports at monthly meetings

B. Roles and responsibilities of the VDC

The committee shall:

- Identify health and health related needs in the village/community
- Plan for the health and welfare of the village/community
- Identify available resources (human and material) within the village/community and allocate as appropriate to PHC programmes
- Supervise the implementation of PHC work plan
- Monitor and evaluate the progress of the implementation of health activities
- Mobilize and stimulate active village/community involvement in the implementation of developed health plans
- Determine exemptions and deferments for drug payments but provide funds to pay for the exemptions/deferments

- Determine the pricing of drugs to allow for financing of other PHC activities
- Supervise all account books
- Supervise and monitor drug supply
- Select appropriate persons within the village/community to be trained for PHC and other programmes
- Establish a village health post where there is none already
- Liaise with other officials to provide health care and other development activities
- Forward village/community health plan to ward level

C. Terms of Reference (ToR) for the VDC

The VDC shall:

- Meet at least once every month
- Record minutes of meetings
- Minutes of meetings shall be signed by the Chairman and Secretary after adoption at subsequent meetings
- Comply with the quorum of members set to hold a meeting (at least two-thirds of members)
- The treasurer should record all incomes and keep all monies
- The treasurer should record all expenditures
- Where there is a VDC bank account signatories will be the Chairman, Secretary and Treasurer
- Receive regular reports from the Facility Management Committee where applicable
- Submit minutes of meetings to the Ward Development Committee

2.2.3 Facility Level

A. Composition of the Facility Management Committee (FMC)

A Facility Management Committee (FMC) will be established for individual Primary Health Care facility. The Facility Management Committee shall include:

- WDC (or VDC) Chairman or his or her representative as Chairman
- All unit heads in the facility (Maternity, pharmacy, laboratory, consultation, immunization etc)
- Account Officer of the facility
- Officer-in-charge of the facility as Secretary

B. Roles and Responsibilities of the FMC

Facility Management Committees have the following roles:

- Work with other health facility staff to promote improvements in health services and client satisfaction
- Ensure maintenance of the health facility infrastructure, equipment, vehicle etc
- Designate the Officer-in-charge of the facility to follow up on the Planned Preventive Maintenance requirements for the facility
- Identify resources from government and other stakeholders to improve services within the facility
- Monitor facility performance and progress in making service improvements
- Ensure the success of the Drug Revolving Fund (DRF)

- Open and operate a facility bank account in a reputable commercial bank. The signatories to the account shall be the Chairman and Secretary of the FMC
- Identify and address problems that discourage community members, particularly women and the poor, from using the health services provided in the facility
- Ensure CHIPS Community Engagement Persons submit monthly collated community data from CHIPS agents to the Primary Health Centre
- Discuss CHIPS personnel (CHIPS agents and CEPs) activities in the ward
- Make regular reports of its activities to the Ward Development Committee or Village Development Committee as applicable

C. Terms of Reference (ToR) of the FMC

The Committee shall:

- Meet once a week
- Meetings shall be held in the health facility
- The FMC Chairman or in his/her absence the Secretary, will call FMC meetings
- Two third of the FMC members must be present to form a quorum for the meeting to hold and decisions made by the Committee shall be valid
- Keep record of minutes of meetings
- Recommend that minutes of meetings be signed by the Chairman and Secretary after approval at the next meeting
- Any suspected financial mismanagement to be thoroughly investigated and appropriate sanctions shall be recommended (refund, suspension or dismissal) to higher authorities e.g. LGHA
- All misconducts in the health facility are to be thoroughly investigated and appropriate sanctions taken or recommended to higher authorities

2.3 Oversight Roles of SPHCB and LGHA

2.3.1 Roles and Responsibilities of SPHCB in WHS

The oversight roles and responsibilities of the State Primary Health Care Board (SPHCB) in the implementation of the WHS are as follows:

- Support the LG Health Authorities (LGHAs) in the provision and training of appropriate health manpower in the PHC facilities
- Setup the LG Advisory Committees for all LGAs in the state in line with national guidelines
- Provide technical assistance to the LG Health Authorities in the implementation of the Ward Health System
- Supervise the LG Health Authorities PHC programmes through the various State programme managers
- Collaborate with the LG Health Authorities to replicate the ward health system in all the wards of LGAs in the State
- Provide funding and material support e.g. vaccines, drugs and equipment to the LGAs for implementation of WHS
- Strengthen referral linkages between primary and secondary levels of health care in the state

- Supervise, monitor and evaluate the planning, budgeting and provision of PHC activities in the LGAs
- Ensure the availability of effective Management Teams for all LGHAs
- Provide all necessary support to schools of health technology, schools of nursing and midwifery and other PHC training institutions for training manpower
- Maintenance of major facility infrastructure and provision of major equipment
- Liaise with PHC stakeholders at the national, State and LGA levels to advocate and mobilise resources, technical assistance and political commitment to improve quality, coverage and efficiency of PHC system
- Allocate service delivery targets to LGHAs (based on respective LGA disease burden) and review implementation progress quarterly
- Develop assessment scorecard for WDCs using their key roles and responsibilities as metrics – this will be self-administered and also used for performance reviews
- Share scorecards quarterly with WDCs for self-evaluation and collate results
- Conduct periodic (quarterly/bi-annually) performance reviews of WDCs using signed work plans, assessment scorecards and self-evaluation results
- Share results and corrective actions with all WDCs

2.3.2 Roles and Responsibilities of LGHA in WHS

There are two key bodies that provide support for the implementation of the WHS. These are the LG Advisory Committee and the LGHA Management Team. Their composition, roles and responsibilities and terms of reference are as follows:

2.3.2.1 Local Government Advisory Committee

A. Composition of LG Advisory Committee

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

B. Roles of the LG Advisory Committee

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

Its tasks are to:

- Set the overall vision and mission of the LGHA
- Provide strategic direction to LGHA Management Team
- Advocate, mobilize and allocate resources for PHC activities
- Hold implementers to account for effective and efficient use of resources
- Accountable to State Primary Health Care Board (SPHCB)
- Develop effective working relationship with the management team and communities
- Receive and deliberate on health reports of LGA and advise LGHA MT on decisions to improve health outcomes
- Support LGHA MT on implementation of PHC in the LGA
- Identify and fund the PHC capital projects

C. Terms of Reference (ToR) of the LG Advisory Committee

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

- Meet quarterly
- Record minutes of meetings and review implementation of recommendations from previous minutes at the subsequent meeting
- Adopt minutes of meetings and ensure that the Chairman and Secretary sign them
- Comply with the quorum set to hold meetings
- Review reports on PHC activities and performance from LGHA MT and advise on measures to improve PHC outcomes
- Engage with opinion leaders especially at the LGA level to garner political commitment and ownership

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

2.3.2.2 Local Government Health Authority Management Team (LGHA MT)

The establishment of the LGHA MT is one of the key PHCUOR management reforms.

A. Composition of LGHA Management Team

The LGHA MT shall be composed of the following:

- Director PHC
- Two Deputy Directors
- Programme Officer, Planning, Research and M & E
- Programme Officer, Disease Control
- Programme Officer, Immunization
- Programme Officer, Essential Drugs and Logistics
- Programme Officer, Health Promotion

- Programme Officer, Nutrition
- Programme Officer, Reproductive, Maternal & Child Health
- Administrative Officer
- Finance and Accounts Officer

B. Roles and Responsibilities of LGHA Management Team

- LGHA MT is responsible for the day to day management of the LGHA
- The LGHA Management Team (LGHA MT) is the operational arm of the LGHA and is under the leadership of the Director PHC
- The team is responsible for overall planning, budgeting and management for LGHA resources for effective implementation, supervision, monitoring and coordination of PHC activities in the LGA

The LGHA MT will also perform the following duties:

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

C. Terms of Reference (ToR) for the LGHA MT

In carrying out the above functions, the LGHA MT shall:

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

- Ensure provision of appropriate human resources for health in the health facilities
- Ensure provision of basic amenities in the health facilities such as light, potable water, access road and staff quarters
- Ensure provision of funding and material support e.g. vaccines, essential medicines and equipment for implementation of WHS
- Provide technical support in the areas of capacity building: training of health workers, CHIPS agents and members of the development committees
- Ensure provision of kits for the CHIPS agents
- Supervise, monitor and evaluate health activities taking place in the ward
- Collaborate with the WDCs and VDCs to establish health facilities in the communities in the ward where there are none
- Coordinate the activities of other partners such as development agencies, NGOs and community-based civil society organizations
- Replicate the Ward Health System in all the wards in the LGA
- Prepare quarterly reports for presentation to the quarterly LG Advisory Committee meeting

2.4 Implementation Steps for the Ward Health System

To establish the Ward Health System, the following steps/activities must be followed:

- Awareness creation and community mobilization/sensitization for active participation, involvement and sustainability in the Ward Health System.
- Formation/Reactivation of Development Committees using Participatory Learning and Action (PLA) tools. Committees are formed at the following levels: Facility Level – Facility Management Committee (FMC), Village Level - Village Development Committee (VDC) and Ward Level - Ward Development Committee (WDC). Members of the committees are selected based on the national guidelines.
- Identification of a suitable health facility and upgrade of infrastructure and equipment where necessary to the status of a functional Primary Health Centre (where a Primary Health Centre does not already exist).
- Development of the Ward Health Plan (WHP).
- Mapping and division of the ward into a maximum of 6 health areas depending on population and landmass.
- Deployment of health workers to the primary health centre and other health facilities in the ward.
- Ensure the Primary Health Centre has a full complement of skilled staff including 1 medical officer where available to provide integrated PHC services.
- The Primary Health Centre will be supported by a minimum of ten (10) CHIPS agents to link it with the community members.
- Orientation of health workers on the Ward Health System and training on Integrated Ward Health Services delivery.
- Training/orientation of WDC and VDCs on their roles, responsibilities and operational guidelines in the ward health system.
- Establishment of PHC Management Information System: house numbering and placement of home-based and facility records and training on PHCMIS.
- Opening and operationalization of Drug Revolving Fund (DRF) accounts at LGA and facility levels.
- Establishment of a two-way referral system by identifying a suitable referral facility in the LGA.

- Establishment of an effective supervisory and feedback mechanism.

2.5 Opportunities Offered by the Ward Health System

- **Enhancement of local capacity** for community driven socio-economic development and poverty alleviation.
- **Improved investment** in health is good economics leading to increased productivity and socio-economic progress.
- **Health Sector Reform**. Community ownership and increased private sector involvement in health by international agencies, NGOs and civil society organizations, decentralization of management, efficient resource mobilization, utilization and accountability, equity and quality care.
- **Effective coordination through sound collaboration** with stakeholders in PHC for integrated PHC delivery.

CHAPTER 3: MINIMUM STANDARDS FOR THE WARD HEALTH SYSTEM (WHS)

3.1 Types of PHC Facilities

Health facilities are structures where different types of health services are provided by various categories of health workers. These health facilities are in different groups and called different names depending on the structure (building), staffing, equipment, services rendered and by ownership. Many terminologies have been used over the years including health posts, dispensaries, health clinics, maternities, primary health centres and comprehensive health centres.

However, based on the Ward Health System, the three recognized PHC health facility types are:

(1) Health Post to cover a population of 500 to 2,000 persons in a settlement or village.
(2) Primary Health Clinic to cover a population of 5,000 to 10,000 in a group of settlements/neighbourhood, villages (village areas) or communities.
(3) Primary Health Centre to cover a population of 10,000 to 30,000 in a political ward.

About 80% of the health conditions affecting Nigerians can be readily managed at the primary health care level. Primary Health Care facilities are best positioned to fast track the attainment of access to a minimum service package that guarantees the wellbeing of the majority of the people.

The emphasis of the Primary Health Care Revitalization Initiative of the NPHCDA is, therefore, to make at least one Primary Health Centre fully functional in each of the approximately 10,000 political wards in Nigeria to enhance achievement of the target for Universal Health Coverage. For this to be achieved, the primary health care facilities must conform to a minimum standard in all areas of resource provision for the services they can deliver.

3.2 Minimum Standard for Primary Health Care Facilities

3.2.1 HEALTH POST

Facility Type: Health Post
Catchment Area: Settlement or village level
Estimated Coverage Population: 500 to 2,000

Minimum Infrastructure
Building and Premises

- Two rooms with cross ventilation, walls and roof must be in good condition with functional doors and netted windows
- Functional separate male and female toilet facilities with water supply within the premises
- Availability of a clean water source, for example, motorized borehole, hand pump or protected well
- Be connected to the national grid and other regular alternative power source
- Have a sanitary waste collection point
- Have a waste disposal site
- Be clearly signposted – visible from both entry and exit points
- Be fenced with gate and generator house
- Appropriate staff accommodation provided within the facility premises

Personnel
The health post should be headed by at least a JCHEW who should spend at least 80% of his/her time in the community.

Services
- Health education and promotion
- Community mobilization for health
- Maintenance of PHC records
- Routine home visit
- Monitoring and supervision
- Treatment of minor ailments (all conditions as listed in the standing orders for JCHEWs)
- Two-way referrals

Hours of operation
Health posts can open at the convenience of the community members. It is expected that 20% of JCHEW time will be spent in the health post and 80% in the community.

Standing Orders
All health posts must have a copy of the current Standing Orders for JCHEWs.

Essential Medicines List (EML)
The Essential Medicines List for Health Posts is to be used at this level.

Essential Equipment List (EEL)
The Essential Equipment List for Health Posts is to be used at this level.

Other requirements
- Bicycle(1) or Motorcycle (1)
- Community assigned canoe (in riverine areas) (1)
- Mobile phone (1)

Managerial Support
Village Development Committee supporting the health worker(s) at the health post.

3.2.2 PRIMARY HEALTH CLINIC
Facility type: Primary Health Clinic
Catchment Area: Group of settlements/neighborhoods, villages (village areas) or Commnunities

Estimated Coverage Population: 5,000 to 10,000

Minimum infrastructure
Building and Premises

- A detached building with at least 5 rooms
- Walls and roof must be in good condition with functional doors and netted windows
- Functional separate male and female toilet facilities with water supply within the premises
- Availability of a clean water source e.g. motorized borehole, hand pump or protected well
- Be connected to the national grid and other regular alternative power source
- Have a sanitary waste collection point
- Have a waste disposal site
- Be clearly signposted – visible from both entry and exit points

- Be fenced with gate and generator house
- Appropriate staff accommodation provided within the facility premises

The building must have sufficient rooms and space to accommodate:

- Client observation area
- Consulting area
- Delivery room
- First stage room
- Injection and dressing area
- Lying-in ward (4 beds)
- Pharmacy section
- Record section
- Staff station
- Store
- Toilet facilities (separate for males and females)
- Waiting/reception area

Personnel

Clinical staff

- Midwife or Nurse/midwife 1
- CHEW 2
- JCHEW 1

Support staff

- Health attendants/assistants 2
- Security personnel 2
- Cleaners 1

Services

- Health education and promotion
- Routine home visits and community outreach services
- Community sensitization/mobilization
- Maternal newborn and child health care
- Family Planning
- Nutrition and food safety
- Immunization
- Treatment of all conditions as listed in the Standing Orders for CHEWs/JCHEWs
- Health Management Information System
- Provision of essential medicines and supplies
- Monitoring and supportive supervision
- Two-way referral services

Hours of operation
The facility should run at least 8 hours services
CHEWs/JCHEWs will distribute their working time as follows:
JCHEWs: 20% in the health facility and 80% in the communities

CHEWs: 40% in the facility and 60% in the communities

Standing Orders

All Primary Health Clinics must have a copy of the current Standing Orders for CHOs/CHEWs

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Essential Medicines List (EML)

The Essential Medicines List for Primary Health Clinics is to be used at this level.

Essential Equipment List (EEL)

The Essential Equipment List for Primary Health Clinics is to be used at this level.

Other Requirements

- Means of communication e.g. mobile phone (1)
- Motorcycle or tricycle (1)
- Bicycle(1)
- Small motor boat for riverine areas (1)

Managerial Support

Facility Management Committee (FMC) reporting to the Village Development Committee and upwards to the Ward Development Committee.

3.2.3 PRIMARY HEALTH CENTRES

Facility Type: Primary Health Centre
Catchment Area: Political ward
Estimated Coverage Population: 10,000 to 30,000

Minimum Infrastructure

Building and Premises

- A detached building having walls and roof in good condition with functional doors and netted windows.
- Have a clean water source within the premises e.g. motorized borehole, hand pump or protected well.
- Be connected to the national grid and other regular alternative power source.
- Have a sanitary waste collection point.
- Have a waste disposal site.
- Toilet facilities (separate for males and females)
- Be clearly signposted – visible from both entry and exit points.
- Be fenced with generator and gatehouse.
- Appropriate staff accommodation provided within the facility premises.

The building should have sufficient rooms and space to accommodate:

- Waiting/reception areas for Child Welfare, ANC, Health Education and ORT corner
- Staff station
- Consulting rooms
- Adolescent health service room
- Pharmacy & Dispensing unit
- Delivery rooms
- Maternity/lying-in ward

- In-patient ward
- Laboratory
- Medical records area
- Injection/Dressing area
- Minor procedures room
- Food demonstration area
- Kitchen
- Store
- Toilet facilities (Male and Female)

Personnel

Clinical staffs are encouraged to work with the current Standing Orders for CHOs/CHEWs to ensure that treatment is in line with minimum standard of care. There must be a full complement of PHC manpower/staff made up of clinical and support staff to provide the Minimum Service Package. These are:

Medical Officer (if available)	-	1
CHO	-	1
Nurse/midwives	-	4
CHEWs	-	3
Pharmacy Technician	-	1
Health Records Technician	-	1
Medical Laboratory Technician	-	1
JCHEWs	-	6

Support staff

Account Clerk	-	1
Driver	-	1
Health Attendant/Assistant	-	2
Security personnel	-	2
Cleaners	-	2
CHIPS Agents	-	10

Services

- Health education and promotion
- Routine home visits and community outreach services
- Community sensitization/mobilization
- Maternal newborn and child health care
- Family Planning
- Water Sanitation and Hygiene (WASH)
- Nutrition

- Immunization
- Control of non-communicable diseases (hypertension, asthma, epilepsy, diabetes etc)
- Treatment of communicable diseases (HIV/AIDS, TB, Malaria, STIs etc)
- Treatment of all conditions as listed in the Standing Orders for CHOs/CHEWs/JCHEWs
- Health Management Information System
- Oral health
- Eye care
- Community mental and psychosocial health
- Adolescent health
- Provision of essential medicines and supplies
- Monitoring and supportive supervision
- Care of the elderly
- Basic laboratory services
- Two-way referral services

Hours of operation
24hrs (Twenty-four hours) on every day of the week

Essential Medicines List (EML)
See Annex 1 for the minimum essential medicines and commodities for Primary Health Centres.

Essential Equipment List (EEL)
See Annex 2 for the minimum essential equipment for Primary Health Centres.

Other Requirements
- Ambulance (1)
- Mobile phone (1)
- Computer (2)
- Internet service
- Motorcycle (1)
- Small motor boat for riverine area (1)
- Stable source of electricity – generator/national grid/solar power

Managerial Support
Day to day management is by the Facility Management Committee (FMC) with the Ward Development Committee (WDC) providing oversight support and the LG Health Authority responsible for supervision, monitoring and linkages to the SPHCB.

3.3 Human Resources for the Ward Health System

One of the strategies evolved to improve coverage of PHC services at the rural and urban communities was the development of different cadres of health workers with training oriented towards provision of services in rural communities. Schools of Health Technology were established in every state with at least one such school per state to scale up the quantity and quality of the health workforce at the primary health care level. The cadres of health workers trained by the school are:

- Junior Community Health Extension Workers (JCHEWs)
- Community Health Extension Workers (CHEWs)
- Pharmacy Technicians
- Health Records Technicians

- Medical Laboratory Technicians

The Community Health Officers (CHOs) are trained at teaching hospitals under the Community Health Officers Training Programme (CHOTP). Other PHC workers include the nurse/midwife and medical doctors who receive their pre-service training in accredited schools of nursing/midwifery and medical schools respectively. The Medical Officer where available shall be the head of the health team in the facility or LGA. All PHC workers have administrative functions, community health functions, maternal and child health functions and clinical functions including referral to higher facilities where necessary. Environmental Health Officers where available are to be responsible for environmental sanitation and water issues only.

The pre-service training of CHEWs and JCHEWs in schools of health technology includes the use of "Standing Orders" for recognition and management of illnesses. The Standing Orders ensures uniformity in the quality of care and provides legal backing for the health workers. Medical doctors, dentists and dental assistants, and nurse/midwives working in primary health care facilities are encouraged to use the National Standard Treatment Guidelines. The most senior health worker in the ward will lead the Ward PHC Team as both the officer in charge of the Primary Health Centre and the Ward Focal Person/Supervisor.

In-service training of PHC workers is very important not just to ensure they have adequate and current skills and knowledge to provide high quality PHC services but to motivate them for greater performance. This can be carried out through workshops, short-term courses, ISS and mentoring. It must be planned and budgeted for to ensure it is carried out to achieve the desired health outcomes.

The facility-based health workers will be supported by a minimum of ten (10) trained and functional Community Health Influencers, Promoters and Services (CHIPS) agents per ward. The CHIPS agents are invaluable in linking the community and families to Primary Health Care facilities. Two (2) males will also be engaged to serve as Community Engagement Focal Persons.

3.3.1 Job Description for the PHC Workforce

1. Medical doctor to:
    a. Attend to all referrals from the ward.
    b. Attend to non-referral clients using the facility.
    c. Ensure that clients receive appropriate treatment necessary for their conditions.
    d. Ensure that essential medicines, vaccines, consumables and essential equipments are available in the facility at all times.
    e. Hold regular meetings with staff on the smooth running of the facility.
    f. Establish referral linkages with other facilities.

A medical doctor where available will be the head of the facility and the health team in the ward.

2. Community Health Officer (CHO) to:
    a. Assign responsibilities to other health workers.
    b. Supervise functions assigned to other health workers.
    c. Maintain discipline in the facility.
    d. Oversee the upkeep of the facility and its surroundings
    e. Develop ward action plans and draw up schedule of activities with the WDC.
    f. Supervise data collection, collation and analysis especially the NHMIS.
    g. Organize regular staff meeting and feedback on ongoing activities.
    h. Organize continuous education for the health team and the community.
    i. Conduct community diagnosis exercises.
    j. Plan for health interventions with other health workers and the community.
    k. Ensure community participation in health and health-related programmes.

l. Ensure all pregnant women are identified and have access to antenatal care services.
m. Establish a two-way referral for clients, appropriate links between facility staff and the CHIPS agents.
n. Ensure management of clients according to Standing Orders.
o. Maintain high quality of care.
p. Encourage the practice of rational drug use.
q. Provide services beyond the level of expertise of other staff according to Standing Orders.

3. Nurse/Midwife to:
   a. Provide maternal and child health services including antenatal care and conducting deliveries.
   b. Assess all pregnancy/labour cases with a view to referring complicated cases.
   c. Manage minor/common ailments using the National Standard Treatment Guidelines.
   d. Perform administrative functions where applicable.

4. Community Health Extension Worker (CHEW) to:
   a. Spend 60% of working time in the community.
   b. Perform administrative functions including attending WDC meetings.
   c. Visit communities regularly to assess community-based services.
   d. Ensure community participation in health and health-related activities.
   e. Ensure all pregnant women are identified and have access to antenatal care services.
   f. Establish a two-way referral for client.
   g. Manage clients according to Standing Orders.
   h. Maintain high quality of care.
   i. Practice rational drug use.

5. Pharmacy Technician to:
   a. Receive written prescription or refill requests and verify that information is complete and accurate.
   b. Maintain proper storage and security conditions for drugs.
   c. Fill bottles with prescribed medications and affix labels.
   d. Assist clients by answering simple questions, locating items or referring them to the appropriate health worker for medication information.
   e. Cost and file prescriptions that have been filled.
   f. Clean and help maintain equipment and work areas.
   g. Establish and maintain client profiles including lists of medications taken by individual client.
   h. Receive and store incoming supplies, verify quantities against invoices and inform head of facility of stock needs and shortages.
   i. Mix pharmaceutical preparations according to written prescriptions.
   j. Operate cash registers to accept payment from clients.

A Pharmacist where available will be in charge of both the pharmacy and store.

6. Health Records Technician to:
   a. Maintain client data.
   b. Fill completely and accurately all forms, cards and registers used in client management.
   c. Maintain and secure all written and electronic records of the facility.
   d. Ensure that information contained in the facility record is complete, accurate and only available to authorized personnel.

A Health Records Officer where available will be in charge of the medical records unit.

7. Medical Laboratory Technician to:
    a. Perform technical procedures ranging from collecting specimen from clients, specimen labelling, sorting specimens, checking labelling, logging specimens, arranging reports for delivery to appropriate officers.
    b. Maintain quality results by adhering to standards and controls and utilizing approved testing procedures.
    c. Provide confirmatory diagnosis to improve management of diseases.
    d. Ensure a safe and secure environment for clients and co-workers by following established standards and procedures and complying with legal regulations.
    e. Maintain patient confidence by keeping laboratory information confidential.

A Medical Laboratory Scientist or Technologist where available will be in charge of the laboratory.

8. Junior Community Health Worker (JCHEW) to:
    a. Provide basic and essential community services with guidance from the Standing Orders.
    b. Spend 80% of their working time in the community.
    c. Collect data; develop action plans and schedule of activities.
    d. Ensure community participation in health and health-related activities.
    e. Conduct home visits and follow-up clients.
    f. Manage clients according to Standing Orders.
    g. Promote two-way referral.

CHAPTER 4: DELIVERY OF INTEGRATED WARD HEALTH SERVICES

4.1 Background

The 16th WHO Regional Programme Meeting in Yaounde, Cameroon in February 1994 discussed issues relating to accelerating of the attainment of Health For All (HFA) through Primary Health Care. Arising from this, Nigeria developed a Minimum District Health Care Package for the acceleration of HFA through PHC. The package consisted of thirteen (13) components each with objectives and strategies to be implemented between 1995 and 2000.

In June 1998, a National Review Meeting to discuss progress resolved the number of components should be reduced from 13 to 4 namely:

1. Child Survival (IMCI and Routine Immunization)
2. Maternal and Newborn Care (ANC, Delivery, Postnatal care, FP)
3. Control of Communicable Diseases (Malaria, STI/HIV/AIDS, NTDs)
4. Health Education and Community Mobilization

At a national review meeting held in Port-Harcourt in 2001, an additional component, Nutrition, was added to the package. The reviewed package was renamed Ward Minimum Health Care Package (WMHCP) in line with the introduction of the Ward Health System (WHS) in 2001. In 2005, the NPHCDA in collaboration with the WHO convened a meeting and updated the WMHCP by adding the Control of Non-Communicable Diseases (NCDs) as the sixth component.

4.2 Ward Minimum Health Care Package (WMHCP)

The Ward Minimum Health Care Package includes health interventions and/or services that address health and health related problems that result in substantial health gains at low cost**.** In defining this package, a number of considerations were made: disease patterns, economic considerations (e.g. cost of services) and proportion of population affected/benefiting from health services. This package targets the grassroots through the delivery of a minimum set of interventions needed to meet the basic health requirements of the people hence contributing to achieving the national target of Universal Health Coverage and the attainment of the Sustainable Development Goals (SDGs). This package comprises cost-effective interventions known to promote health and development and reduce mortality and morbidity from common illnesses.

Below is the proposed Ward Minimum Health Care Package (2018) by the NPHCDA for the Ward Health System.

- Control of other Communicable Diseases (Malaria, Hepatitis, TB/Leprosy, Syphilis, NTDs, STIs/HIV/AIDS)
- Reproductive , Maternal, Newborn, Child and Adolescent Health Care
- Nutrition and Food Safety
- Water, Sanitation and Hygiene

- Non-communicable disease prevention (Cardiovascular disease, Diabetes, Cancers, Sickle Cell, Oral health, Eye health, Mental health, Care of the Elderly & Treatment of Minor Ailments/injuries)

- PHC Laboratory Services

- PHC Information System and Community Surveillance

- Environmental, Chemical products & Medical waste services

- Health Education, Promotion and Community Mobilization

- Resources to support services
  - ✓ Essential Medicines and Consumables for Primary Health Centres
  - ✓ Essential Equipment including Cold Chain for Primary Health Centres
  - ✓ Human Resources for Health for Primary Health Centres
  - ✓ Health Infrastructure development for Primary Health Centres
- Others
  - ✓ Emergency and Disaster preparedness
  - ✓ Coordination and collaboration
  - ✓ Monitoring and Evaluation
  - ✓ Administration and Finance

The Ward Minimum Health Care Package (2018) represents the Minimum Service Package (MSP) to be provided in the one functional Primary Health Centre (PHC) per ward. The standard requirement for each type of resource is contained in section 3.2 above.

4.3 Planned Preventive Maintenance (PPM)

The purpose of PPM is to ensure that buildings, equipment and utility services are always in a functional state so that the envisaged PHC service delivery is not interrupted at any time. The objective is to a establish Planned Preventive Maintenance (PPM) system that incorporate a culture of maintenance of PHC facilities into the planning, budgeting and implementation of PHC services. This enables early detection of faults/damages and provides for procurement of spares and routine and emergency maintenance services by qualified artisans or more highly specialised physical asset maintenance specialists.

It is important to emphasize the value of PPM because general maintenance is not adequately emphasized in PHC programmes. This is why infrastructure, equipment etc. degenerate, becomes unusable or unserviceable within a short period. This leads to wastage of huge resources and disruption of PHC service delivery.

At the PHC facility, the Officer-in-charge has overall responsibility for ensuring that all buildings and equipment are always in good condition. This responsibility is delegated to unit heads who are in turn responsible for the day to day use of these buildings and equipment. They must, therefore, report malfunctioning or breakdown of such equipment to the officer-in-charge. For minor repairs, for example, of plumbing, electrical, masonry and vehicle, the Facility Management Committee (FMC) should establish a partnership arrangement with local artisans. It is important for the SPHCB to put in place mechanisms for major repair and calibration of technical equipment; a similar mechanism should be established for major repair of buildings and utility services. The

responsibility and budget for repair should be clearly laid out and disseminated to all managers and staff to ensure that facility infrastructure, equipment and utility services are always in functional state.

Health workers must discuss Planned Preventive Maintenance with the FMC and WDC members and other stakeholders. The following steps must be established:

1. Maintaining databases of the current state of the infrastructure, equipment and vehicle in the facility.
2. Appropriate marking of all equipment with the facility name and maintaining an equipment asset register with all required technical details which are updated regularly.
3. Sufficient resources (funds, basic tools, materials etc) must be set aside for PPM in the facility.
4. There must be clear instructions regarding appropriate use and maintenance of newly acquired equipment by facility staff.
5. There must be a dedicated PPM Plan for the facility. The plan must indicate which sort of maintenance staff (artisans or specialists) can undertake which type of repairs.
6. A fault-reporting system must be put in place and all facility staff should be orientated to report faults and breakdowns promptly according to the fault-reporting system.
7. Facility Management Committee (FMC) to ensure response to maintenance requests is always prompt.
8. FMC must ensure that basic tools and materials required for planned preventive maintenance are available in the facility.
9. FMC should allocate repair jobs to suitable maintenance staff.
10. FMC should monitor the work done by maintenance staff to ensure effective and efficient repair of equipment according to specification.
11. FMC should provide feedback to the users on progress on preventive maintenance.
12. FMC through the Officer-in-charge should keep a record of their maintenance work in case a similar breakdown occurs again.
13. FMC should take responsibility for minor repairs in the facility and report any major repair jobs to the WDC and LGHA for necessary action.

4.4 **Outreach Services**

Primary Health Care services are delivered through a system of health care facilities within the communities. The communities that host these health facilities play a vital role in the planning, implementation, monitoring and evaluation of the activities. The health facilities provide services and serve the communities based on needs. Communities are mapped as catchment areas to which the health facilities can reach out to provide services. The services are usually based on needs which are derived from close collaboration between the health facility staff and the community represented by the Ward Development Committee (WDC). Some communities are far away from the health facility that serves the members of the communities. Communities at a distance greater than five (5) kilometres and above from the health facilities usually find it difficult to access health services in their community. This has far reaching effects on the health indices of the communities resulting in high disease burden and mortality rates.

These communities need health services to cater for the health needs of the members. Equity is the watch word and for services to be equitable, mechanisms must be put in place for communities in hard to reach, far to reach and disaster areas to access basic health care services.

Primary Health Care services are delivered in health facilities on a fixed basis with health workers attending to patients and clients on a daily basis with different health care packages. The need to ensure that all members of the community are catered for is paramount and requires taking services to those far to reach, hard to reach and special populations. Services for outreaches are:

- Immunization
- Nutrition and growth monitoring
- Ante Natal Care (ANC)
- Health Education to mention a few.

The services that are provided in a community are dependent on the needs of the community and the resources (human and financial) available.

The planning and provision of these services is carried out in collaboration with the community gate keepers for ownership and acceptability. Plans include which services should be rendered, where the services are rendered and the frequency of the service delivery sessions. The health services rendered outside the health facilities to bridge the access gap within communities are referred to as **Outreach services**.

The different models of outreaches include: (1) Single intervention outreaches which are focused on a single health service such as Routine Immunization, Nutrition etc and (2) Integrated Interventions Outreaches which are a combination of more than one intervention, for example, Immunization with Nutrition, vitamin A supplementation and de-worming of children.

The current policy states that all communities beyond two (2) kilometres from the health facility should be covered by an outreach service. The sessions are planned with the traditional leaders and a flexible date is fixed to provide the service. Ahead of the fixed date, continuous social mobilization activities are conducted; community dialogues and sensitization of community members on the benefits of such services like immunization are done. Community health workers conduct house to house mobilization and remind caregivers of the need to vaccinate their children and also remind them of the date for the session. Town announcers and public services announcements are made to sensitize the community members prior to this date.

On the stipulated date, health workers from the health facilities will come with all antigens and provide immunization services and with the community agree on the time for the next session depending on the vaccination schedule. This is a standard practice in Nigeria to bridge the gap in service delivery.

Outreach services have in no small measure increased coverage of the different interventions but have also contributed to increase in equitable access to health for the underserved population. It is recommended in communities with poor access especially due to distance. This strategy has improved health outcomes in middle and low income countries across the globe.

4.5 Use of Standing Orders

The Standing Orders are a set of specific guidelines arranged by age group, diseases conditions, findings, clinical judgment and actions, which define how clients should be cared for at the Primary Health Care Facilities. They are designed to be used by Community Health Workers but other health workers like medical doctors and nurse/midwives in PHC settings must also adhere to the Standing Orders unless there is a valid medical reason to deviate from them.

The objectives of the Standing Orders are to:

1. Give the health workers legal protection in their primary health care assignments.
2. Provide a systematic framework for history taking and physical examination.
3. Assist the health workers to manage less common, easily forgotten and more serious conditions.
4. Maintain a high and uniform standard of health care.
5. Minimize unnecessary, often-times expensive and time-consuming laboratory investigations and medications.
6. Provide a framework for evaluation of care and staff performance.

The Standing Orders, present as much as possible, the best treatment for each condition listed. As a result of many years of field testing, they are practical and relevant to the setting in which Community Health Workers operate.

1.6 Two-Way Referral System

A Two-Way referral system is an integral part of Primary Health Care services in the Ward Health System. It is called Two-Way Referral System as referral is to both the higher and lower levels of health care delivery. If a condition cannot be effectively managed at a level, the client is referred higher-up. The client having been treated successfully at the higher level is referred back to the lower level for continuity of care and follow-up. Also some clients whose first point of contact is a higher level may be referred to the appropriate level of care as necessary.

In the Ward Health System, a suitable facility is identified in the LGA for referral of serious cases from the apex Primary Health Centre.

For the Two-Way Referral System to be effective:

- Two-way referral forms must be printed and be readily available
- All health workers are adequately oriented on the system
- Officers-in-charge of facilities also need to be adequately oriented on the system and their expected roles

If the client is critically ill, the health worker should omit the normal paths of referral and refer the client immediately to the appropriate level.

TWO – WAY REFERRAL SYSTEM

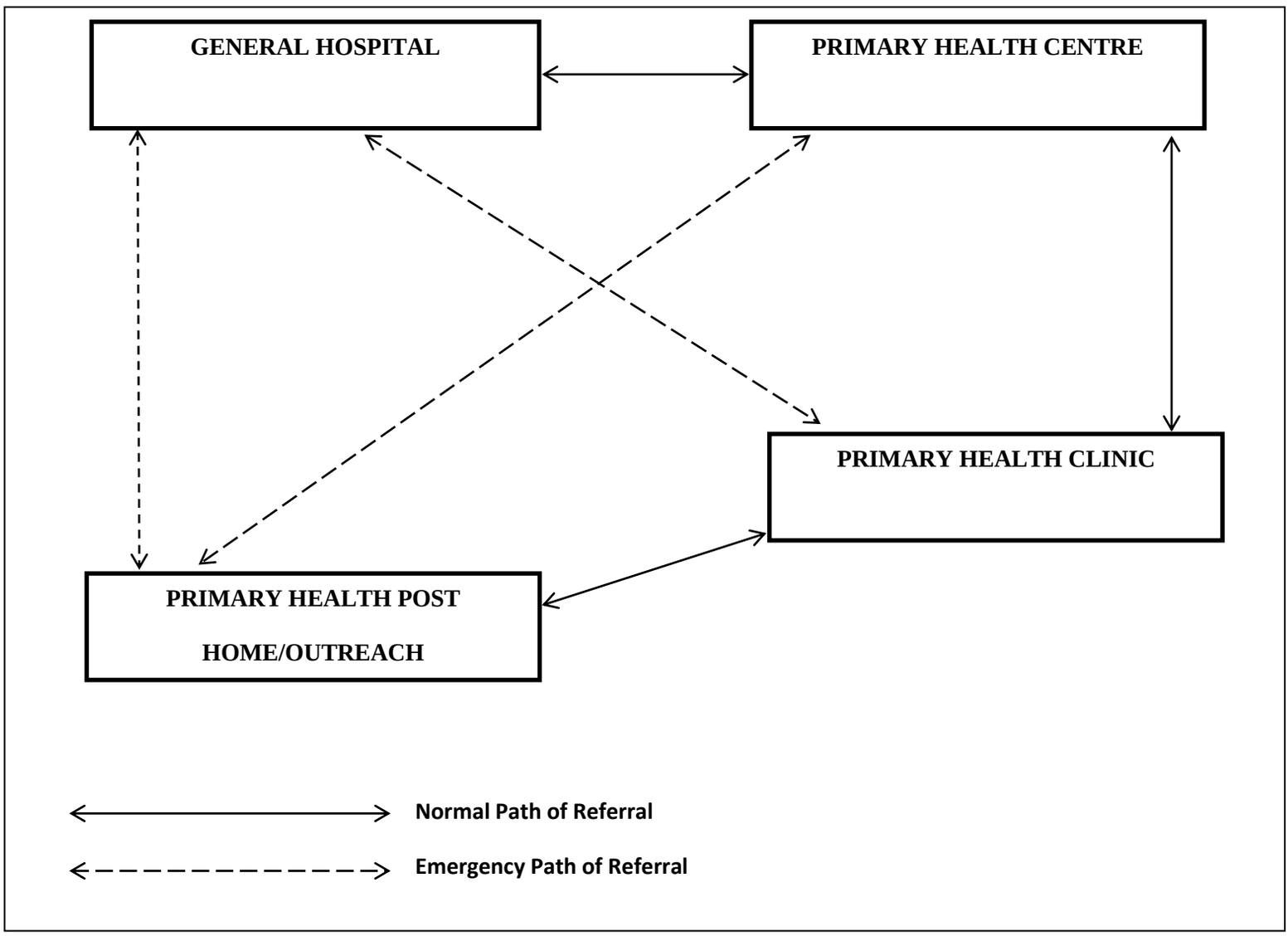


Figure 3: Two-Way Referral System showing both normal and emergency paths of referral

CHAPTER 5: MONITORING AND EVALUATION

5.1 Introduction

Monitoring and Evaluation of health programmes is crucial for the attainment of a sustainable health care system. Monitoring and evaluation are effective tools for enriching quality of interventions.

Monitoring is a systematic and continuous process of examining data, procedures and practices to identify problems, develop solutions and guide interventions. Monitoring is conducted regularly (daily, weekly, monthly, and quarterly). The information collected directs programme activities.

Evaluation is a periodic assessment of overall programme status: performance, effectiveness and efficiency. It is linked to policies, programme processes, systems under which the programme operates strategic choices, outcomes and impact. It assesses the relevance, performance and success of ongoing and completed programmes. It determines whether or not inputs into an operation were utilized effectively to produce results. It usually takes a certain amount of time before sufficient evidence of results can be observed or attributed to an intervention.

5.2 Health Management Information System (HMIS)

Effective Health Information System is equally essential for the sustenance of health care system.

- It promotes information for effective programme planning and implementation
- It allows for timely corrective measures to be taken in the event of programme encountering problems
- It encourages efficient use of resources and improves programme effectiveness
- It promotes feedback based on empirical facts that can be used for programme review and re-planning

In the past, the impact of health services on the population was hampered by the dearth of reliable data, weak and uncoordinated information support system. In 1995, the Federal Ministry of Health, its parastatals and agencies recognized the need to review the existing health system and the need for a co-coordinated health information system for the effective management of the health system. This led to the establishment of the National Health Management Information System.

5.2.1 Objectives

Objectives of the Health Management Information System consist of:

- provision of appropriate infrastructure
- establishment of mechanism and procedure for collecting and analyzing health data to provide needed information

- assessing the state of the health of the population
- identifying major health problems
- monitoring the progress towards PHC goals and targets of the health services
- providing indicators for evaluating the performance of the health services and their impacts on the health status of the population
- providing information to those who need to take action, those who supplied the data and the general public

5.2.2 Functions of Health Management Information System (HMIS)

- Collection, collation, analysis, utilization and dissemination of data in its jurisdiction
- Ensuring timely forwarding/sharing of data to relevant departments, agencies and programmes operating at the LGA
- Ensuring forwarding of aggregated data using prescribed forms to the State level.
- Training and supervision of health facilities
- Ensuring that the LGA M&E office is the management unit for HMIS at the LGA level

5.3 Levels of Reporting

For effective management of health services, the NHMIS monitoring forms for data generation are grouped according to level of use:

- Home.

  These are the home-based records which are of two (2) types.

  - Child Health Card for children under 5 years
  - Personal Health Card for those aged 5 years and above

  Information in both cards is transferred to the Family master card

- Community
  - Community register
  - Community summary form
  - Community Demographic Profile Sheet

- Health Facility

  The health facility based records are:

  - Family Master Card
  - Attendance registers e.g. antenatal care register, labour and delivery register, child welfare register, immunization register, OPD register etc
  - Monthly Summary Records of PHC Services

- Annual Records of PHC Services
- Other forms e.g. referral slips, discharge summary forms etc

- Ward

  Ward Focal Person/Supervisor will collate the data from all health facilities in the ward and forward to the M&E Officer at LGA level.

- LGA

  The LGHA MT will be responsible for collating data for all the wards in the LGA and reporting to the SPHCB. The LGHA ISS Team will conduct quarterly ISS visits to wards in the LGA to supervise facilities, outreach services, communities and development committees using national harmonized ISS checklists

- State

  Reports of the quarterly ISS visits and service data from all LGAs will be used at the state-level to develop both quarterly and annual progress reports.
  The SPHCB ISS Team supervises LGHA MT, Ward PHC team, facilities, outreach services, communities and development committees in the LGAs of the State at least twice annually. The SPHCB ISS Team may join the LGHA ISS Team periodically on the quarterly ISS visits.

- National

  Monitor overall trends from PHC service delivery.
  National PHC team is responsible for collation and maintenance of data from all states. Provide technical support to any state that experiences issues with data management.

5.4 Information Flow

All categories of PHC workers, CHIPS agents and members of the various committees should be trained on how to monitor their Ward programmes. There should be appropriate data collection tools (cards, profile sheets, summary forms, other forms e.g. referral slips and discharge summary forms, daily registers and monthly summary records) on health and health-related activities at the community, health facility, ward and LGA levels. The Ward Focal Person/Supervisor must take responsibility for data emanating from his or her Ward to ensure accurate data reporting.

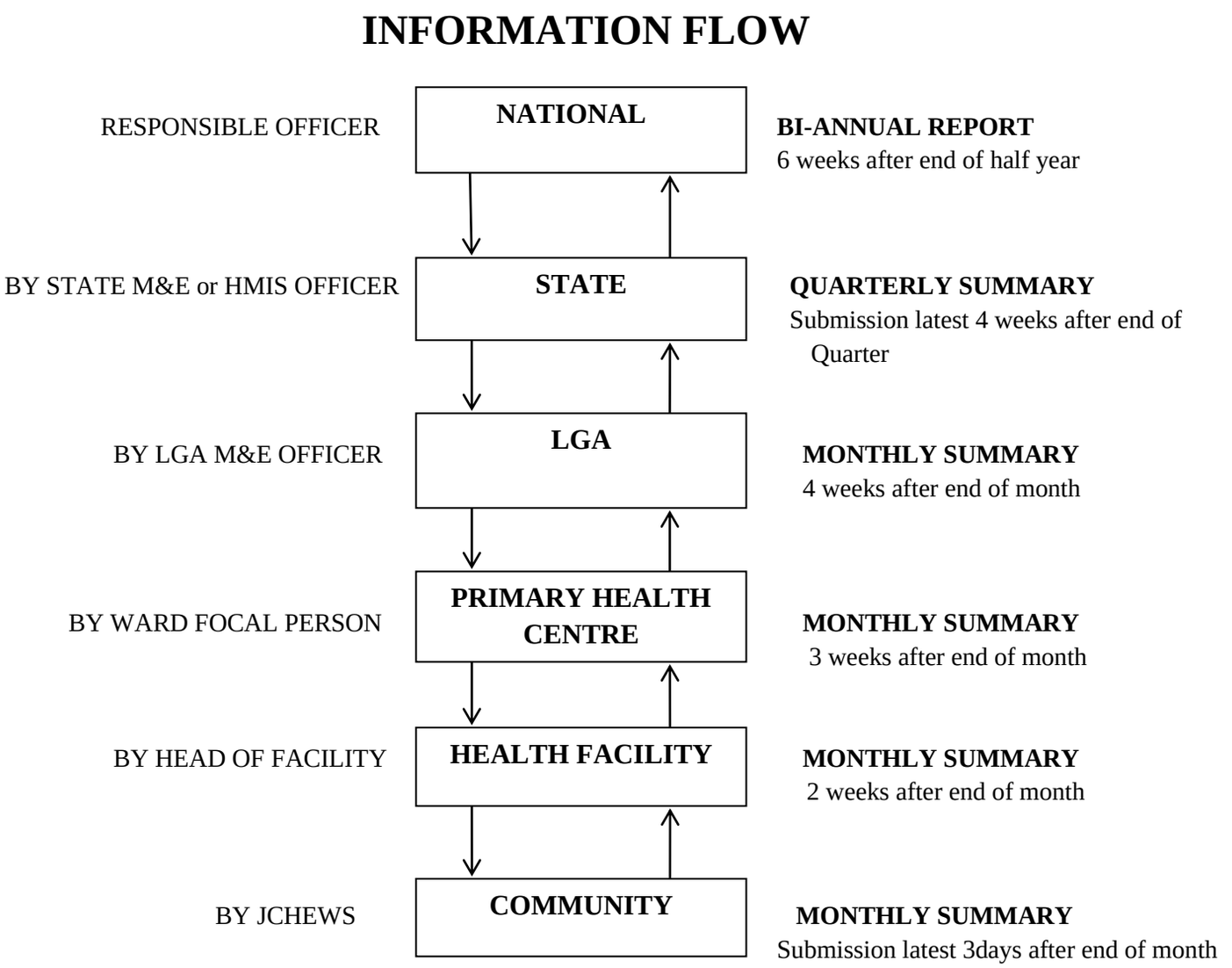


Figure 4: Information Flow Chart

5.5 Integrated Supportive Supervision (ISS)

The National Primary Health Care Development Agency introduced the Integrated Supportive Supervision (ISS) “to strengthen the Primary Health Care System towards achieving the goals and objectives of PHC programmes and activities. Integrated Supportive Supervision (ISS) is a strategy to ensure that PHC programmes/activities and implementers are regularly monitored and mentored.

ISS is designed to improve the quality of routine PHC service provision at all levels. The exercise includes routine PHC facility visit by superior officers from the LGHA and or the SPHCB to observe and provide guidance and support to staff at the lower level. An appropriate checklist is used to record down key information regarding gaps and challenges in the quality of PHC services at all levels of PHC services delivery. It also provides an opportunity to teach and support the lower level staff and is a learning opportunity for all. Information collected using a checklist is then collated and analysed to identify common trends and to compare changes made. The review process provides useful information for management action at all levels.

The goal is to integrate relevant systems into routine supportive supervision so that constant attention is given to improving quality, coverage and data management of PHC services.

The objectives of ISS include:

- Motivate people at the lower level through interaction and sharing of information
- Assessment of functioning of different systems at facility and other levels
- Capacity-building and mentoring of field staff
- Jointly identify and solve problems
- Measuring level of implementation of activities in work plans
- Measure the quality of services from client’s perspective to jointly improve services
- Maintain good linkage and communication between levels of the health sector

Observations/findings from the ISS serve to guide the smooth implementation of PHC programmes/activities and this is also periodically shared with relevant stakeholders to jointly look at the progress, challenges and way forward for a seamless PHC implementation in Nigeria.

CHAPTER 6: HEALTH CARE FINANCING

6.1 Introduction

Millions of people (mainly the poor) across the globe are suffering from avoidable health problems in the form of infectious diseases, malnutrition and complications of childbirth simply because they were not able to afford necessary basic health services. Governments and international organizations have long recognized the need to improve the health of the poor through the promotion of equity and fairness by devising efficient direct or indirect payment mechanisms to ensure an unhindered access to health service delivery.

In order for a health system to perform efficiently and effectively, appropriate amount of revenues must be generated, risk pooled effectively, appropriate incentives provided, resources allocated for effective, efficient and equitable interventions and services (WHO, 2003). This makes health financing a particularly important component of any health system.

Through understanding health care financing, the following questions can be answered:

- Are resource mobilization mechanisms equitable, do the rich subsidize the poor and vulnerable groups?
- Is the distribution of resources equitable, efficient, or are richer populations benefiting more from public financing than poorer populations?
- Do provider payments reward efficiency and quality?

6.2 Functions of Health Care Financing

There are three key functions of health financing:

1. **Revenue Generation/Collection.** This is concerned with the sources of revenue for health care, the type of payment (contribution mechanism), and the agents that collect these revenues.
2. **Pooling of resources**. This aspect of health care financing is the accumulation and management of funds from individuals or households (pool members) in a way that insures individual contributors against the risk of having to pay the full cost of care out-of-pocket in the event of illness. Tax-based health financing and health insurance both involve pooling.
3. **Allocation/Purchasing of health /resources/services.** This is done by public or private agencies that spend money either to provide services directly or to purchase services for their beneficiaries. Purchasers of health services are typically the Ministry of Health (MOH), Social Security agencies, insurance organizations, and individuals or household (who pay out of pocket at time of using care).

6.3 Mechanisms of Health Care Financing

Health care financing aims to provide good health through greater access to health services. The mechanisms that guide the operation of health care financing include; access, equity, efficiency, impact on quality, and sustainability (WHO, 2010).

***Access*:** Access to health care services means that an individual can utilize health care services in a timely fashion to achieve satisfactory health outcomes. Access is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Financing mechanisms such as subsidization or risk pooling enhances people's ability to utilize health services at a reduced financial risk, through the reduction of socio-economic, physical or other barriers.

***Equity*:** Equity is the absence of avoidable disparities among groups of people, whether those groups are defined socially, economically, demographically or geographically. In an equitable system basic required health care services are accessible by all regardless of their financial status. Given that the vast majority of the poor pay for health services at the point of care they are consistently driven deeper into poverty. Health care financing, therefore, makes arrangement for payment of health care services such that out-of-pocket payment and other limiting factors depriving people of the needed health services are addressed.

Efficiency: Efficiency refers to obtaining the best possible value or outcome for the resources used. Health care financing therefore aims to allocate resources in a way that ensures obtaining the maximum possible sustained health outcomes. The focus of health care financing is striving to make someone better-off without making someone else worse-off.

Impact on Quality: Quality of care is the degree to which health care services increase the likelihood of desired health outcomes for either an individual or a population. Health care financing is therefore key to improving the quality of care through providing the necessary quality of care.

***Sustainability*:** Sustainability refers to the endurance of a system or process. In the health sector, service provision should be sustainable; both financially and institutionally such that health care services can be provided for a long period of time. Sufficient health financing is fundamental to sustaining health outcomes that can be achieved by a health system. All processes to address sustainability issues in health care service provision (institutional, programmatic, political and health outcomes) require financing for its operations.

6.4 Sources of Health Care Financing

Health care financing obtain funds, through a mix of public, private, and donor sources which varies widely across countries. The main sources of health care financing in Nigeria include:

6.4.1 Government

The three tiers of government (Federal, State, and LGA) have different responsibilities concerning health care financing in Nigeria. The Federal is concerned with the tertiary health sector whilst the State is concerned with both secondary and primary health care (the latter through Primary Health Care Under One Roof- PHCUOR). This is done in the form of budgetary allocation to health sector by both national and state government.

- **Basic Health Care Provision Fund (BHCPF)**

The BHCPF or "The Health Care Fund" was established under Section 11 of the National Health Act, as the principal funding vehicle for ensuring access to the Basic Minimum Package of Health Services (BMPHS), whilst at the same time serving to increase the fiscal space and overall financing to the health sector. It is expected that the associated increase in service delivery arising from this funding, would assist Nigeria to achieve Universal Health Coverage (UHC). Funding of this BHCPF would be derived, as stipulated in the Act, from contributions including

(a) An annual grant from the Federal Government of Nigeria of not less than one per cent (1%) of its Consolidated Revenue Fund (CRF);

(b) Grants by international donor partners;

(c) Funds from any other source.

Under the fund, 50% would be used to finance the BMPHS by NHIS, 45% through the NPHCDA would be utilized to support primary health care systems and PHC facility operations (medicines, medical equipment, infrastructure and staffing) while 5% is for emergency medical treatments. The NPHCDA component of the fund when operational would operate based on the principles of PHCUOR, with the SPHCB receiving counterpart funding from the Federal Government (NPHCDA) to support Primary Health Care development within the states. This would include elements of direct facility financing to point of service delivery.

The NPHCDA component would be designated as the NPHCDA Gateway (45%) while funds through the NHIS are the NHIS Gateway (50%).

Based on the National Health Act, under the NPHCDA Gateway, it is expected that the 45% of the BHCPF would be utilized in the following manner:

- 20% for PHC drugs, consumables, and vaccines
- 15% for PHC Infrastructural development and transportation
- 10% for PHC human resource development

States and local governments are also required by the law to provide 25% of the cost of any project to be implemented with the BHCPF within their locality as counterpart funding.

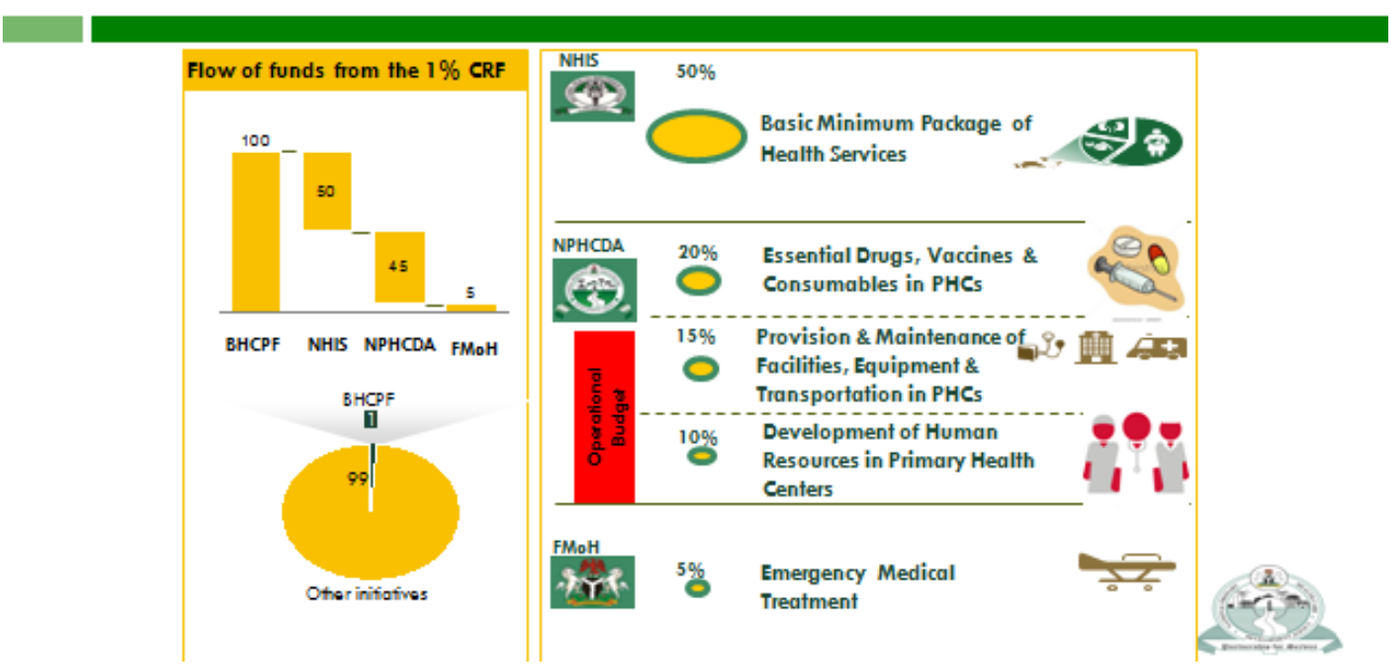
Within the NPHCDA Gateway, a proportion of the funds would be utilized as additional funding for the procurement of bundled vaccines for immunization while the balance funds would on a quarterly basis be released to the SPHCBs. The SPHCBs would in turn periodically release operational cost to PHC facilities as Direct Facility Funding (DFF), to meet basic operational cost for drugs, commodities, minor repairs, outreaches, local retrieval of vaccines for routine services and running of utilities in the PHC centre. Other aspects of the funding at State level would be utilized for PHC human resource development that would support the PHC Revitalization goal of one functional PHC facility per political ward.

The specific proportion of the BHCPF utilized for vaccines, DFF and human resource development may differ annually depending on related issues such as level of fulfillment of the funding requirement of vaccines and priorities of benefitting states.

Similarly, funds through the NHIS Gateway would be utilized to purchase a Basic Minimum Package of Health Services (BMPHS) from the PHC facilities and to a lesser extent from Secondary Health Care facilities for referred cases. The nature of provider payments shall be as determined by the NHIS i.e. fee-for-service, capitation or modified fee-for-service depending on the level at which care is provided and nature of care provided. The specific content of the BMPHS and the method of purchaser payments would be as contained in the relevant guidelines for BHCPF programme implementation.

All BHCPF facilities would operate a bank account with signatories derived from the facility and community. Funds received by PHC facilities from all sources would be expended based on a set of 'financial management system protocols' involving the use of quarterly business plans and monthly activity plans which would be the basis for 'cashless payments and transfers' to vendors and end-users for the provision of services and commodities. LGHA would initially endorse quarterly business plans which would then be approved at the SPHCBs prior to funding release to the Primary Health Centres.

Figure 5: NHAct Stipulations for the BHCPF



6.4.2 Donor Agencies

Agencies such as WHO, UNICEF, World Bank, Bill and Melinda Gates Foundation, other NGOs and Private Individuals have formed an important segment of the sources for health care financing in Nigeria. They finance health programs directly as well as provide funds and technical assistance to the government on implementing the national health agenda.

6.4.3 Out-of-pocket-expenditure (OOPE)

In Nigeria, 70% of the total expenditure on health is private expenditure. 90% of this private expenditure is out-of-pocket. Out-of-pocket expenditure therefore remains the main mode of financing health care in the country.

6.4.4 Insurance

Within Nigeria, there are four main types of insurance for health; the National Health Insurance Scheme (NHIS), State Health Insurance Scheme, Community Based Health Insurance and Private Health Insurance.

National Health Insurance Scheme (NHIS)

The National Health Insurance Scheme (NHIS) was established to ensure universal health coverage for Nigerians. It became operational in 2005. It is a social security establishment that is meant to provide a sustainable funding source for the improvement of health care delivery. It is a form of financial security to the health needs of Nigerian citizens. The main objective of the NHIS is to remove any socioeconomic hindrance to the access to health care services. Presently, the Law that established the NHIS requires the following categories of people to register:

1. The Federal Government's employees.
2. Private sector businesses with 10 or more workers.

The operation of the NHIS is through a prepayment contributory system called capitation. This is paid by all registered members every month regardless of whether or not they use the services. What each member pays is determined by what the person earns. Typically, an employee pays 5% of his/her basic salary while the employer pays 10% of the employee's basic salary. It is however not uncommon for the employer to pay the entire contribution. The healthcare benefit of these contributions has a coverage that includes the employee, a spouse and four biological children below the age of 18 years. Additional dependents or a child above the age of 18 could be covered on the payment of additional contributions by the principal beneficiary. It is also noteworthy that someone who is paying considerably less (because of a lower income) can have access to the same level of care as someone who is paying much more. This helps to provide equitable access to health care in Nigeria.

Despite the benefits of the scheme, there are many challenges associated with NHIS that has hindered the achievement of universal health coverage. A major limitation of the NHIS is its inability to cover majority of Nigerians. Since the NHIS Act was signed into law in 1999 and became operational in 2005, only about 2% of the Nigerian population has been enrolled as at 2014 (National Health Insurance Scheme, 2005; Odeyemi, 2014). This limitation is also related to

the challenges of poor funding and insufficient risk pooling. Other challenges like weak governance and poor infrastructure also need to be addressed to improve the scheme and accelerate the country towards the attainment of universal health coverage.

State Health Insurance Scheme (SHIS)

In an attempt to get larger number of Nigerians covered under a health insurance scheme, the State supported Health Insurance Scheme (SSHIS) was conceived under the NHIS Act. As a result, states can set up their own health insurance scheme. This development has led into some states enacting their own laws for the scheme. In many of the states that have made progress in establishing the SSHIS, it is made compulsory for the public workers as opposed to the voluntary arrangement of the NHIS.

States have adopted different strategies to get as much funds as possible into the pool of fund. Essentially, the funding of SSHIS is from multiple sources which include the premium paid by the public workers (which is certain percentage of individual consolidated salaries), the counterpart contributory fund by the government, compulsory solidarity contributions from residents who are registered in the private insurance scheme, consolidated funds (from the BHCPF) and grants from donors and other agencies. One major advantage of the SSHIS is the fact that the states are able to be in charge and health care delivery is closer to the people. In addition, more people are covered.

The SSHIS is not without its shortcomings. Many states have not also been able to key into the scheme. Due to the fragmentation of the pool of funds, states have more work to do in terms of sourcing for fund, risk pooling, accountability, governance and regulations. There is also need for the states to increase the states' investment in health to improve the quality of care at both the primary health care and secondary care levels.

Community Based Health Insurance Scheme (CBHIS)

CBHIS can be described as a mechanism where households in a defined geographic area with varying demographic characteristics finance the costs associated with health services for their community and as such are involved in the management of the scheme and the organization of the healthcare services (Carrin, 2003). The target of the community-based health insurance scheme (CBHIS) is the informal workers and rural members of the Nigerian population in line with the NHIS operational guideline (National Health Insurance Scheme, 2005). This is an effort to get more people, especially the rural dwellers and the vulnerable, to benefit from social security. It is also important to note that the NHIS play a key regulatory role in the establishment of a CBHIS and participants in the non-profit social insurance. In order for a community to establish a CBHIS, the following laid down NHIS operational policy must follow:

1. A mutual health association (MHA) must be formed and registered with an associated bank account.
2. An individual or household can become member voluntarily and they contribute an agreed amount.

3. A seven-man representative board of trustees (BOT). Representative is elected by the contributing enrollees. The BOT include the chairman, Secretary, a treasurer and other four members.
4. It is the responsibility of the BOT to collect the contributions, pay the healthcare providers and open and operate an NHIS accredited bank account. The BOT also has executive powers.

It is essential for the CBHIS to define the service or set of services it covers. Typically, such schemes focus mainly on the primary health care services. The funding sources for this mechanism of health insurance include the contribution from members, subsidies from the government or/and subsidies from donors.

Private Health Insurance (PHI)

Private health insurance is based on the concept of the distribution of risk between the sick and the well. The PHI is often "risk-rated," meaning that those who are judged more likely to need health care pay a higher insurance premium. Payments in to private health insurance schemes are often paid out-of-pocket of the individual or on behalf of the individual by their employers. This arrangement often limits those covered by private health insurance to employees and benefits do not reach lower income populations and those in the informal sector.

6.5 Models of Health Care Financing

1. Input financing

Traditionally within Nigeria health care financing has taken the form of input-based financing i.e. a line-item approach whereby government, donors or individuals finance a health facility or health authority through the provision of inputs such as human resource, equipment, medicines and infrastructure.

2. Results based financing

Results based financing shifts attention from inputs to outputs and over the course of time to outcomes. Within a results based system, health providers are at least partially funded on the basis of achieving a certain set of results. Usually both the quantity and quality of health care services that are provided determine the amount of funds that a health facility would receive. This approach also gives the health facilities a greater level of autonomy and accountability, promotes decentralization and applies private sector management practices in public structures. The results based financing approach has been piloted in Nigeria in Adamawa, Nasarawa and Ondo since 2011 through the Nigeria State Health Investment Project with significant positive results.

3. Direct facility financing

This involves directly providing financial resources to the health facility. It differs slightly from the result based financing because it does not necessarily reward outputs and outcomes but enables facilities to identify and fund their priority needs for effective operation and provision of quality care. Under this mechanism, facilities who demonstrate increased utilization by clients and fulfils identified quality criteria are rewarded with further fund transfers; while poor performers are

sanctioned by reduction of the funds transferred or exclusion. The BHCPF when fully implemented is likely to adopt this method of financing.

Both result based and direct facility financing require the facility to have high levels of financial autonomy and operate bank accounts with at least two signatories from the health workforce and the community.

CHAPTER 7: INITIATIVES IN WARD HEALTH SYSTEM

7.1 Primary Health Care Under One Roof (PHCUOR)

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

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

It is in response to the foregoing development that the National Primary Health Care Development Agency in collaboration with key stakeholders introduced the "Primary Health Care Under One Roof" (PHCUOR) initiative as part of a new governance reform designed to improve primary health care implementation at state and sub-state levels. Primary Health Care Under One Roof is a policy for the integration of all PHC services under one authority (State PHC Board) to reduce fragmentation in PHC management and service delivery. This is in line with the National Health Act and Sustainable Development Goal 3 (SDG3) to achieve Universal Health Coverage (UHC). All thirty-six States and the FCT have established their State Primary Health Care Boards and are being assisted by the NPHCDA to establish the sub-state structures (Local Government Health Authorities and Ward Development Committees) for effective implementation.

Principles for Bringing "Primary Health Care Under One Roof"

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

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

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

PHCUOR Pillars.

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

1. Governance and ownership: Existence of SPHCB, adequate representation of stakeholders and separation of governing board from management team.
2. Legislation: SPHCB Law signed by the Governor and published in the Gazette, regulations for operationalizing the Law and establishment of Local Government Health Authorities.
3. Minimum Service Package (MSP): Classification of facilities based on minimum services to be provided and resources required, costing and development of investment plans.
4. Repositioning: Movement of PHC staff and programmes from the SMoH to the SPHCB, new roles identified for SMoH and orientation conducted for key staff.
5. Systems Development: Identify existing systems and adapt them; develop costed operational plans.
6. Operational Guidelines: Develop, print and disseminate SPHCB Operational Guidelines to streamline procedures (Human Resources, Administration, Logistics, Finance & Accounts, Procurement etc).
7. Human Resources: Plan and manage human resources at state and sub-state levels.
8. Sustainable Funding: Dedicated budget and effective financial control with external audit system.
9. Office Set-up: Suitable independent offices with necessary working tools for SPHCB and LGHAs.

Benefits of Implementing PHCUOR

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

7.2 Emergency Routine Immunization Coordination Centres

Vaccine Preventable Diseases (VPDs) account for over 40% of deaths of children under-five years of age in Nigeria. Despite recent program successes such as new vaccine introductions (Pentavalent, Pneumococcal Conjugate and Inactivated Polio Vaccines), Routine Immunization (RI) Coverage remains low as evidenced by the 33% Penta 3 coverage from the 2016 MICS/NICS survey.

To address the issues of poor access and weak utilization of RI services, the National Primary Health Care Development Agency (NPHCDA), in collaboration with Partners declared a State of Public Health Concern on Routine Immunization Programs on the 17th of June 2017. This was closely followed by a corresponding decision to establish the National Emergency Routine Immunization Coordination Centre (NERICC) to work in an emergency mode to rapidly improve RI performance in the 18 lowest performing states over 18-24 months, while maintaining targeted support to the other medium to high performing states to improve their current performance.

As a matter of urgency, all the States are also expected to ensure establish of the State Emergency Routine Immunization Coordination Centre (SERICC) and Local Emergency Routine Immunization Coordination Centre (LERICC).

All the states are also expected to facilitate the establishment and inauguration of the State Emergency Routine Immunization Coordination Centre (SERICC) and Local Government Emergency Routine Immunization Coordination Centres (LERICC) ***before the end of December, 2017*** to ensure the achievement of the national target of at least 85% for all Antigens by the end of 2019.

Vision

To achieve at least 85% immunization coverage for all antigens in Nigeria by end of 2019

Goal

To provide a national and sub-national coordination mechanism to manage the full implementation of the routine immunization programs, strategies and other recommendations of various expert committees towards achieving routine immunization coverage of at least 85% for **ALL** antigens at national, states and LGAs levels.

Objectives

I. Improve detection and responsiveness in the resolution of RI gaps.

II. Strengthen leadership and accountability for Routine Immunization.

III. Strengthen coordination for Routine immunization.

IV. Increase Immunization data visibility, quality and use for action at all levels.

V. Increase outreach services for immunization for traditional vaccines especially in the very low performing states.

Expected Outcome

I. Harmony and synergy in the provision of RI services and partner support.

II. Speedy resolution of issues and improved efficiency and quality in RI service delivery.

III. Increased immunization coverage rates in the state and LGAs and HFs.

IV. Adequate implementation of accountability framework (rewards and sanctions) for immunization service delivery.

Structure and Mode of Operations

The National Emergency Routine Immunization Centre (NERICC) shall function as the governing arm for routine immunization programmes and projects within the country with direct reporting line to the ED/CEO of NPHCDA during its operation. The Centre has taken over the functions of the Routine Immunization working group of the ICC technical working groups; and is semi-autonomous to allow for quick decision-making and to avoid bottlenecks. Its jurisdiction covers the entire country routine immunization landscape. Membership of the Centres shall be from Government and immunization Partners.

NERICC Terms of Reference and Mode of operations

The following constitutes the NERICC terms of reference:

1. Coordinate all governments and partners within the routine immunization landscape and ensure accountability at all levels of implementation
2. Provide guidance and oversights to the sub national levels on routine immunization.
3. Design a roadmap to address key drivers of poor RI coverage so as to rapidly improve routine immunization coverage.
4. Implement strategies/ innovations for the revitalization of routine immunization.
5. Implement long term plans for strengthening the immunization health system as outlined in the NRISP, cMYP and other strategic plans.
6. Monitor and track implementation of such strategies and innovations.
7. Evaluate progress on a monthly basis of these strategies and make recommendations for intervention, which are also tracked.
8. Review all documents for EPI capacity building and implement trainings, which will allow for increase in HCW knowledge retention and improvements in HCW practice.
9. Identify states that require advocacy and advise and support NPHCDA management to conduct advocacy to such states.

Government of Nigeria with contributions from donors and partners shall be responsible for the funding of the National Emergency Routine Immunization Centre.

State Emergency Routine Immunization Coordination Centre (SERICC) and Mode of Operations

At the sub-national level, State Emergency Routine Immunization Coordinating Centres (SERICC) and Local Emergency Routine Immunization Coordination Center (LERICC) will provide dedicated state and LGA coordination for Routine Immunization. The SERICC and LERICC in each state will work closely with the NERICC to manage the full implementation of the routine immunization programs, strategies and other recommendations to improve RI coverage.

The SERICC/LERICC Centres shall also take over the functions of the Routine Immunization Working Groups with direct reporting line to the Executive Secretary of the State Primary Health Care Board and the LGHA PHC Director respectively. Membership of the Centres shall be from Government (State Immunization Officer, State Cold Chain Officer, other immunization staff at the SPHCDA) and all routine immunization Partners at the State/LGAs. .

A Programme Manager (PM) shall be selected through a competitive process for the day-to-day running of the SERICC Centre. The PM shall be supported by two (2) Deputy Programme Managers to be selected through a mixture of competent officers from within Government and Partner agencies within the states or where applicable.

SERICC Terms of Reference and Mode of Operations

The SERICC will:

1. Coordinate all Routine Immunization activities and ensure accountability at all levels of implementation
2. Identify program bottlenecks and barriers to high Routine Immunization uptake and design and implement strategies to address these barriers so as to increase RI coverage
3. Monitor and evaluate Routine Immunization performance across the LGAs with the aim of making intervention where necessary.
4. Ensure the Reaching Every Ward (REW) strategy is fully operational within the states through activities such as:
    i. Support to LGAs and HFs to update health facilities micro-plan
    ii. Ensure full implementation of micro plans including all fixed sessions and planned outreaches
    iii. Map out low performing communities and LGAs with higher number of unimmunized children
    iv. Support LGAs and HFs identify and vaccinate all eligible unimmunized children through tailored, state specific approaches
    v. Ensure there is sufficient vaccines available at LGA stores and health facilities to support fixed and outreach RI services
5. Conduct quarterly RI data cleaning/harmonization (including data quality checks).

6. Ensure only accurate RI data is reported from health facilities and LGA and implement sanctions for HCWs and EPI Managers that falsify data
7. Conduct data-driven bi-monthly supportive supervision to LGAs and health facilities and provide regular feedback
8. Provide guidance and weekly feedback on Routine Immunization
9. Provide advice and guidance to the SPHCB, SMoH and the State task force on Immunization on all matters relating to Routine Immunization.
10. Ensure long term plans for strengthening the immunization health system as outlined in the NRISP, cMYP and other strategic plans are implemented within the state.
11. Identify training gaps and in conjunction with relevant working groups, plan and implement training on routine immunization service delivery which will ensure knowledge retention and an improvement in practice.
12. Monitor and track implementation of all strategies and innovations.

Local Emergency Routine Immunization Coordination Centre (LERICC) and Mode of Operations

At the sub-national level, State Emergency Routine Immunization Coordinating Centres (SERICC) and Local Emergency Routine Immunization Coordination Center (LERICC) will provide dedicated state and LGA coordination for Routine Immunization. The SERICC and LERICC in each state will work closely with the NERICC to manage the full implementation of the routine immunization programs, strategies and other recommendations to improve RI coverage.

The LERICC Centre shall take over the functions of the Routine Immunization Working Groups. Membership of the LERICC Centre shall be from Government (LGA Immunization Officer, LGA Cold Chain Officer, and immunization staff at the LGA) and all routine immunization Partners at the LGA.

Each of the 774 LGAs shall appoint two (2) Routine Immunization Focal (RIF) persons different from the Local Immunization Officer for the LGA to support the implementation of routine immunization strategies and program of activities across all the wards and settlements. LERICC is to be led by one of the RIF persons with direct reporting line to the LGA PHC Coordinator. Job description for the RIF person is attached.

LERICC Terms of Reference and Mode of Operations

The LERICC shall:

1. Coordinate all routine immunization activities within the LGA and ensure accountability at all levels of implementation.
2. Identify program bottlenecks and barriers to high Routine Immunization uptake and design and implement strategies to address these barriers so as to increase RI coverage.
3. Monitor and evaluate routine immunization performance across the LGAs with the aim of making intervention where necessary.
4. Ensure the Reaching Every Ward (REW) strategy is fully operational within the states through activities such as:

i. Support to HFs to update health facilities micro-plan.
ii. Ensure full implementation of micro plans including all fixed sessions and planned outreaches.
iii. Map out low performing communities with higher number of unimmunized children and support HFs to map out and implement plan to vaccinate all eligible unimmunized children.
iv. Ensure there are sufficient vaccines available at LGA stores and health facilities to support fixed and outreach RI services.

5. Conduct monthly RI data cleaning/harmonization (including Data quality checks).
6. Ensure only accurate RI data is reported from Health Facilities and LGA and implement sanctions for HCWs and EPI Managers that falsify data.
7. Conduct data-driven bi-monthly supportive supervision to LGAs and Health Facilities and provide regular feedback.
8. Provide guidance and weekly feedback on Routine immunization.
9. Identify training gaps and in conjunction with the SERICC, plan and implement training on RI service delivery which will ensure knowledge retention and an improvement in practice.
10. Monitor and track implementation of all strategies and innovations.

Implementation Strategies

In the first six (6) months, NERICC will provide focused support to 18 identified high priority states; while providing light touch support for all other states to ensure increased immunization coverage. The categorization of states for interventions is shown in figure 6 below.

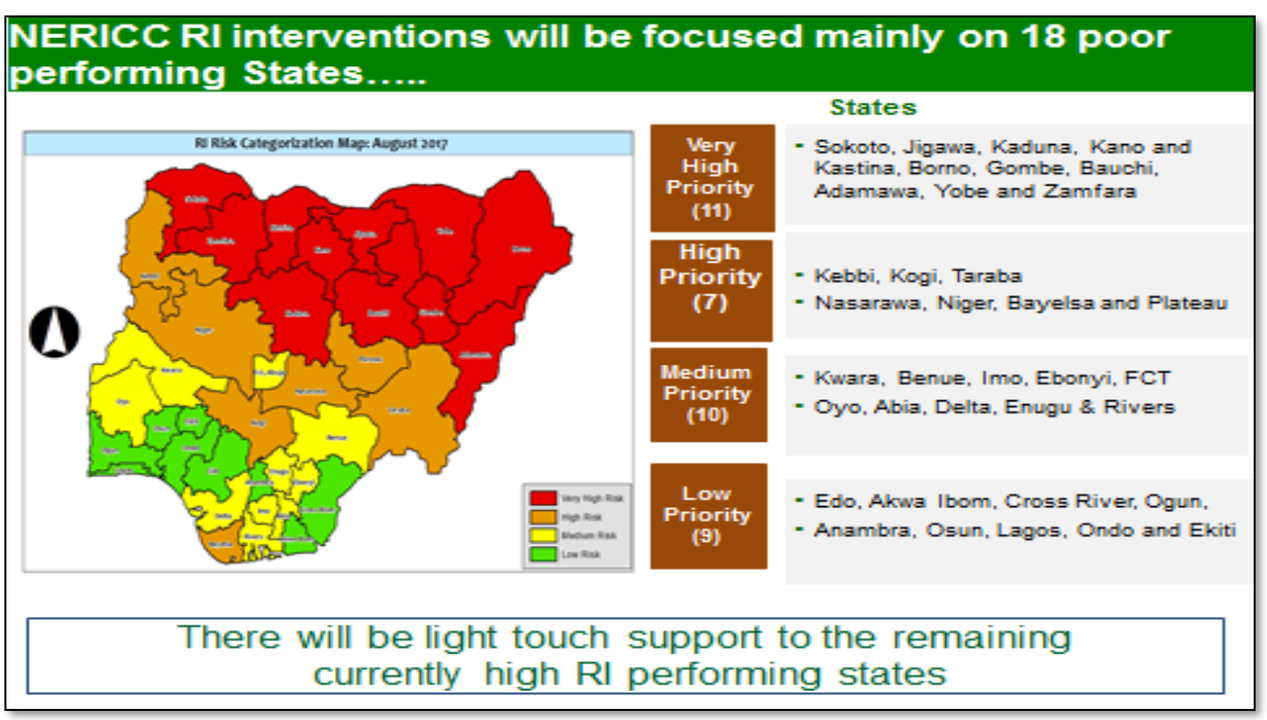


Figure 6: Categorization of States for NERICC Interventions

The National/States/LGAs Centres shall work with a 5-pronged approach, largely leveraging on lessons learned from the Polio EOCs, namely; War Room Approach; Dedicated Cross-functional Talent; Fast-paced Analytics and Frequent Synthesis; and Rapid Decision Making and Syndication and Intensive Program Management. Refer to Figure 7 below.

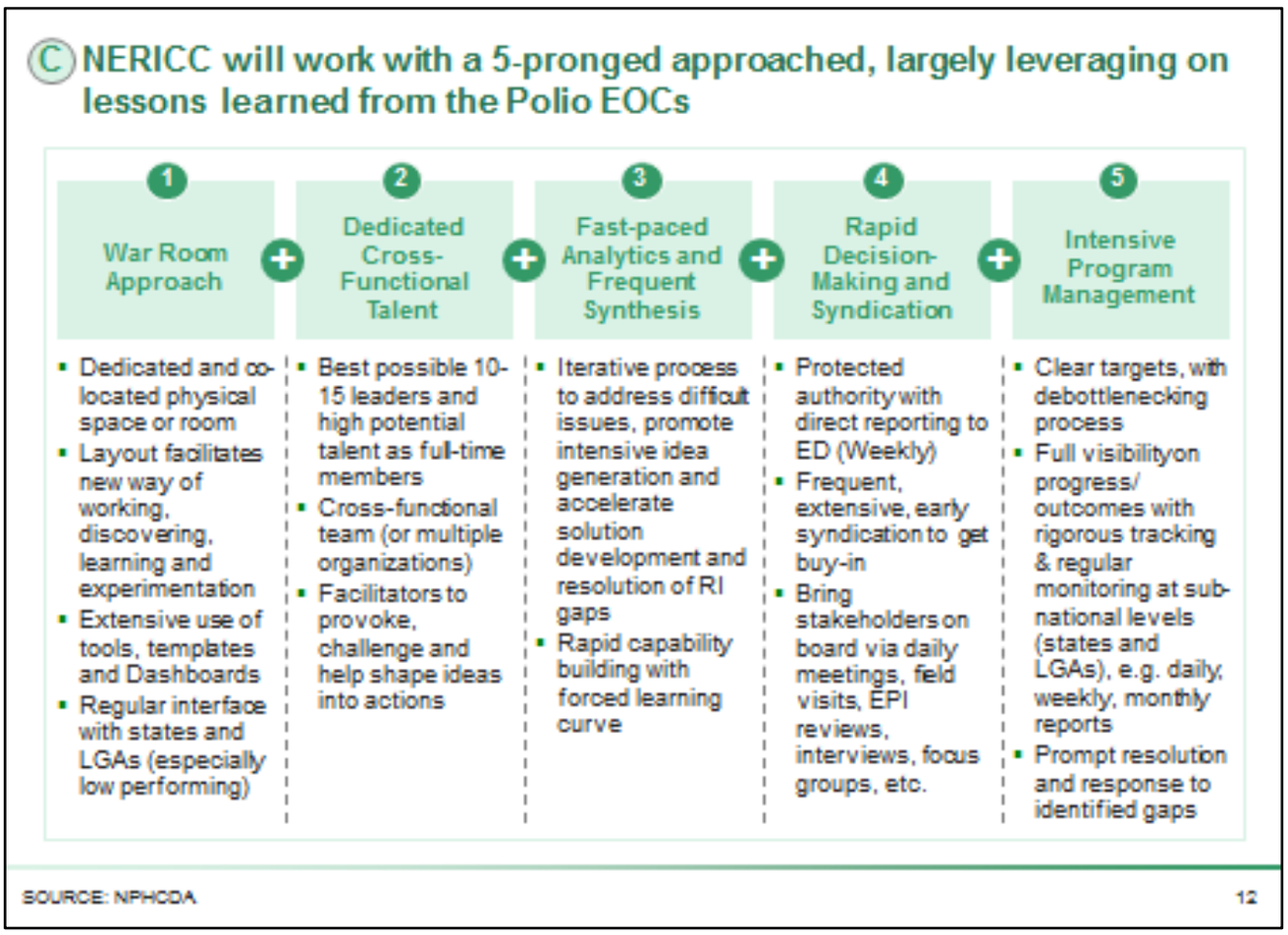


Figure 7: NERICC 5-pronged approach

Sustainability Plans

At the end of 18-24 months, the achievement of the NERICC/SERICC will be evaluated and the functions of the centres will return to the mainstream RI division of NPHCDA/SPHCB/LGHAs respectively, which will continue with the activities as appropriate to ensure the gains are sustained.

The NERICC activities are also planned to feed into the broader Nigeria's strategy to transform immunization program, achieve greater sustainable results and strengthen PHC 2018 – 2030, which is being developed and is expected to come into effect in third quarter of 2018.

7.3 Primary Health Care Revitalization

Across the country, dilapidated physical health infrastructure, inadequate and poorly maintained medical equipment, and shortage of health workers and essential health commodities and medicines abound. Basic life-saving commodities and drugs are commonly out of stock in primary health centres, and not affordable for the poorest when they are available from other sources. Qualified health worker distribution is uneven, with most located in urban centres and towns and in private facilities. These challenges along with poor remuneration of health workers, and poor funding of operational costs for facilities and community-level outreach services, also contribute significantly to poor functionality of health facilities, and ineffective mobilization and delivery of community-based interventions.

Out of 9556 wards across the country, about 800 are without a single primary Health Care facility. Of the 30,000 primary health care facilities in Nigeria, only about 6,000 health facilities (20%) are functional. The poor functionality of primary health care facilities results to a dependence of citizens that can afford it on private facilities for basic health care. Hence, the private sector plays a significant role in delivering and financing healthcare in Nigeria – and accounts for 40% of healthcare facilities.

Health service delivery has been affected negatively by the fragmentation of primary health care programs leading to duplication of resources, poor coordination, weak management, poor integration and lack of accountability. Roles and responsibilities are not clearly defined resulting in ineffective service delivery.

Significant variations in service delivery amongst geopolitical zones, and States, are accounted for by wide differences in the demand for and supply of healthcare services. There are nationwide and intra-State variations in the availability and equitable distribution of qualitative services (supply-side). In addition, effective demand for health is shaped by critical factors including awareness or health literacy, ability-to-pay, and access to service delivery points. In Northern Nigeria, cultural, financial and physical barriers have converged in lower demand for key health interventions. **On the supply side, physical health infrastructure is dilapidated in most rural and remote areas, while medical equipment, where present, is rarely well maintained and quickly becomes obsolete.** Basic life-saving commodities and drugs are commonly out of stock in primary health centers, and not affordable for the poorest when they are present in secondary and tertiary hospitals. Logistics systems are mostly dysfunctional and inefficient.According to a World Bank facility survey, private facilities are 5 times as likely to have running water, 2 times as likely to have sterilizing equipment and 2.5 times as likely to have electricity.

Qualified health worker distribution is uneven, with most located in urban centers and towns and in private facilities. Health workforce faces many challenges including inadequate training / production, attrition, losses to urban and career switches, as well as frequent industrial disputes that negatively impact productivity. In addition, as a result of health worker attrition and the limited production and capacity of midwives and community health workers, most community health workers remain in facilities to deliver care, leaving a vacuum in the delivery of community based interventions in most high burden jurisdictions**.**

The national agenda for PHC re-vitalization holds great potential in reversing negative trends in maternal and child health survival, as well as making significant reductions in economic losses associated with morbidity and mortality of women and under-five children. According to a study commissioned by the Partnership for Maternal, Newborn and Child Health, **there is a strong bi-directional causal relationship between health outcomes (maternal and under-five mortality) and economic growth (GDP)**; this means that **investments in maternal and child health yield positive returns in GDP.** In addition, a systematic review on this subject matter confirmed that the health of women and children remain critically linked to the long-term economic productivity and development of countries, and highlighted the untapped potential of initiatives for improving MNCH (Onarheim et al, 2016).

Interventions to improve the primary health care system are a necessary foundation for effective delivery of health services. Such interventions aim to address gaps in governance and Leadership, Human Resources for Health, PHC infrastructure, tools and equipment, financing, service delivery, Data and Community services and structures. The strategies to revamp Primary Health Care in Nigeria are outlined below.

Goal

The goal is to reduce the high MNC morbidity and mortality through increased utilization and citizen trust in a health system that delivers.

Objectives

- To commence the revitalization of 10,000 PHCs in Nigeria by ensuring one well-functioning PHC centre in each senatorial ward to improve access
- To improve the availability of essential health commodities by strengthening the supply chain system for PHC commodities
- Strengthen Logistics and supply chain management
- To fully implement the PHC financing programme to mobilise resources
- Establish a PHC data service centre to increase data visibility and coordination on revitalization
- To increase demand and utilization of PHC service

Scope of PHC Revitalization

The target is to make Primary Health Centres functional based on NPHCDA-defined minimum standards for PHC in Nigeria and to show increase in service coverage and health outcomes for key MNCH indicators (immunization, health facility delivery with SBA)

1. Strengthen Governance and Leadership

Governance and leadership impediments to the achievement of immunization and primary health care objectives will be addressed by identifying and intervening on gaps in PHCUOR implementation in States and Local Governments. Currently, states in Nigeria are at various stages of implementation. Starting with states that perform poorly with regards to PHC indicators, a number of critical steps will be implemented to address governance issues.

2. **Human Resources for Health**

This involves ensuring minimum standards of personnel at the PHC facilities, distribution of personnel and tracking of personnel

3. **Implement a comprehensive PHC revitalization plan including infrastructure, tools, and equipment upgrade**

The PHC revitalization strategy is aimed at achieving at least one functional PHC facility per ward in the country, to support service delivery. Improving PHC functionality involves the upgrading physical infrastructure to meet minimum standards as described in the Minimum Standards for Primary Health Care. Other important considerations for prioritization of PHC infrastructural improvement include disease burden/coverage of essential MCH services, and inequities in service delivery distribution.

Additionally, the revitalization effort will include ensuring the availability of consumables including essential drugs and commodities required for maternal, newborn and child health, as well as treatment of common ailments and injuries and strengthening logistics and supply chain management. It will also include ensuring adequate power supply, providing equipment which is required for basic consultations, investigations and minor surgical procedures, adopting strategies for PHC financing at the facility level, strengthening the PHC data management systems as well strengthening facility and outreach services.

4. **PHC Systems Financing Mechanisms**

The PHC improvement strategy provides a unique opportunity for improving coordination and harmonization of multiple and poorly coordinated investments in PHC programme in the country, and consequently, improving cost efficiency. It serves as a framework to actively transition resources for duplicated programmes, temporary emergency campaigns, outreaches and interventions that seek to reach households. Programme implementation requires allocation of start-up funds for the first year, increase in government funding for PHC in Nigeria, and sustenance of development funding.

The private sector which includes private foundations can provide funding directly or indirectly through provision of commodities and kits, equipment, printed materials, and facilitation of trainings. In view of the challenging economic realities in Nigeria, it is also expected that development partners, in providing technical and financial support to the country, will align with government's efforts to improve resource use through integrated and cost-effective approaches that have potential for achieving value for money.

Various opportunities for mobilizing existing and additional resources for aspects of the PHC improvement strategy as follows:

- Direct allocation of public funds to the revitalization at all levels of government with creation of clear budget lines
- Direct funding support from the various stakeholders to implementing agencies
- Use of the BHCPF contributions from federal and state governments to fund implementation of specific components through decentralized financing for accountability and results
- Grants from both international and local Non-Governmental Organizations and MDAs

- Engaging with states and federal governments to cover personnel costs for CHIPS Programme and mobilizing partner support for commodities
- Adoption of the revitalization and CHIPS Programmes as a high value community service by members of the National Assembly and their state counterparts, and to channel constituency projects to specific resource requirements
- Community mobilization of funds and other requirements from community members and through the traditional institutions
- Encouraging the private sector including private foundations to invest in the facility revitalization and CHIPS Programme as a community level approach that holds promise for yielding immense value

5. Implement strategies for production, management and use of PHC data for action

The availability of comprehensive well-reported data for Primary Health Care requires that data is collected from the facilities, from outreaches and also from the households in communities on a regular basis.

Specific steps that will be taken are:

- Revise and establish domains for compositely measuring the performance of states (see figure below)
- Digitalize and create interface between other HMIS platforms with DHIS 2 within health facilities
- Digitalize (rapid SMS) and integrate community level data with DHIS 2
- Harmonize and integrate supportive supervision
- Harmonize M&E structures especially at the facility and community levels
- Document best practices for PHC services improvement

The community level data provides information that is not in the DHIS system, which is necessary for analysis of information at the ward level. Such information will be useful for community-level decision-making, identifying local challenges and jointly developing practical solutions to address such issues

6. Harmonize, strengthen and scale up Community Health Services through the Community Health Influencers, Promoters and Services (CHIPS) Programme

The CHIPS Programme is a community-focused strategy that is structured to stimulate and support households in communities to seek and obtain primary health care services through various delivery platforms, namely, the facility, outreaches, and home services in wards in Nigeria. The overall aim of the programme is to improve access and provide coverage for essential health services, especially those related to maternal and child survival at the household level. The programme involves engaging, equipping and deploying community-level personnel to carry out the following functions:

- Health education, behaviour change communication and basic service delivery to households
- Community mobilization for outreaches and support during outreaches
- Community surveillance, routine health-related information collection, record keeping and

transmission

- Promote referral of sick community members to health facilities and to provide after-care follow-up and support where these may be needed

7.4 Community Health Influencers, Promoters and Services (CHIPS) Programme

The Community Health Influencers, Promoters and Services (CHIPS) Programme is designed to improve on the Village Health Worker (VHW) concept to increase demand for Primary Health Care services. It was established by the NPHCDA and endorsed by the Federal Government of Nigeria.

The programme is structured to stimulate and support households in communities to seek and obtain Primary Health Care (PHC) services through various delivery platforms, such as the facility, outreaches and home services.

The overall aim of the CHIPS Programme is to improve access to and provide equitable coverage for essential health services, especially those related to maternal and child survival. This will be achieved by harmonizing and coordinating the existing VHW-type programmes and promoting efficiency by optimizing use of these last-mile human resources for delivery of high-impact interventions.

Additionally, up-scaling the programme across the country will help promote gender empowerment, job creation and overall economic and social management, especially among the rural and poorer households.

CHIPS agents are members of the community who are engaged by the government to provide health education and basic health services in households within communities, link the community to primary health care services in the facilities, and improve integration of services across the facility, outreach and household service delivery mechanisms.

CHIPS agents are community-selected and community-based human resource components of the PHC system. A minimum of 10 will serve in each ward in the country to bring services even closer to beneficiaries (especially women of childbearing age, pregnant women and children under - five) at the last mile. Additionally, male Community Engagement Persons (CEPs) will be recruited to aid the work of CHIPS agents especially to organize and hold health talks with married men, encourage them to have birth preparedness plans for their pregnant wives, support outreach sessions to “hard to reach” and security compromised settlements.

CHIPS agents are carefully selected through community-level structures such as the Ward Development Committee and Traditional Leaders based on a set of criteria aimed at ensuring that they live in and are active members of the socio-economic lives of their communities. They are trained and engaged by the government through NPHCDA to provide basic health care services in their communities.

It is recommended that all existing community level workers (VHWs, trained TBAs, VCMs, CORSPs, CBDs, etc.) that are suitably qualified should be selected, retrained and kitted to function as CHIPS agents. All partners, states, organizations using strategies that involve community-level workers should appropriately train and designate them as CHIPS agents.

CHIPS agents are available to increase demand for Primary Health Care services. The programme raises awareness within the community on PHC services and health issues, creates demand for PHC services, helps strengthen referral services, improves maternal and child health interventions especially in the rural areas and addresses the barriers between the community and the Primary Health Care system.

Specifically, the roles of the CHIPS agents in the community are to provide primary health education, influence positive behavior change towards healthy living, offer basic service delivery to households during home visits and essential first aid services in cases of emergency and refer.

Other roles include community mobilization for outreaches and support during outreach services, household record keeping and transmission to officers in charge of PHC facilities, promote referral of sick members of the community to health facilities and to provide after-care follow-up and support where these may be needed and tracking of immunization and other health service defaulters.

Effective management of the programme will be achieved by leveraging and applying existing and proven strategies for governance, financial management, data reporting and use, integrated supportive supervision, monitoring and evaluation and commodities supply chain in a way that minimizes duplications and promotes efficiency.

The CHIPS programme implementation is carried out at the National, State, Local Government, Ward and Community levels. The implementation process includes three phases, pre-implementation, implementation and monitoring and evaluation.

Pre-implementation includes engagement of stakeholders, baseline assessment, development of work-plan, procurement of CHIPS commodities and program launch. During the implementation, the CHIPS agents are selected, trained and deployed to their respective communities to carry out their functions.

The phase of monitoring and evaluation involves the conduct of systematic collection and analysis of information/data on the CHIPS programme to improve program implementation and assess its effectiveness. This phase includes supportive supervision, based on existing guidelines for supervision. This should occur periodically, and information collected during control will complement that from other surveys.

The programme was initiated to address the barriers between the community and the Primary Health Care system and improve maternal and child health indices especially in the rural areas. It is crucial to ensure sustainability of the CHIPS strategy at scale, and integration of improvements into the nation-wide PHC system as well as the national and state strategic health plans for Primary Health Care. Communities, Wards, LGAs, State government, NPHCDA and the Federal Government are the responsible and main key actors of the CHIPS Programme. Across the country, the inadequate and poor physical health infrastructure, medical equipment and a shortage of health workers have contributed to the weak demand for health facilities. Alternative health services from private health facilities are more expensive, making them inaccessible to rural and poorer households. Through the CHIPS programme, we will improve access and provide equitable coverage for essential health services, especially those related to maternal and child survival.

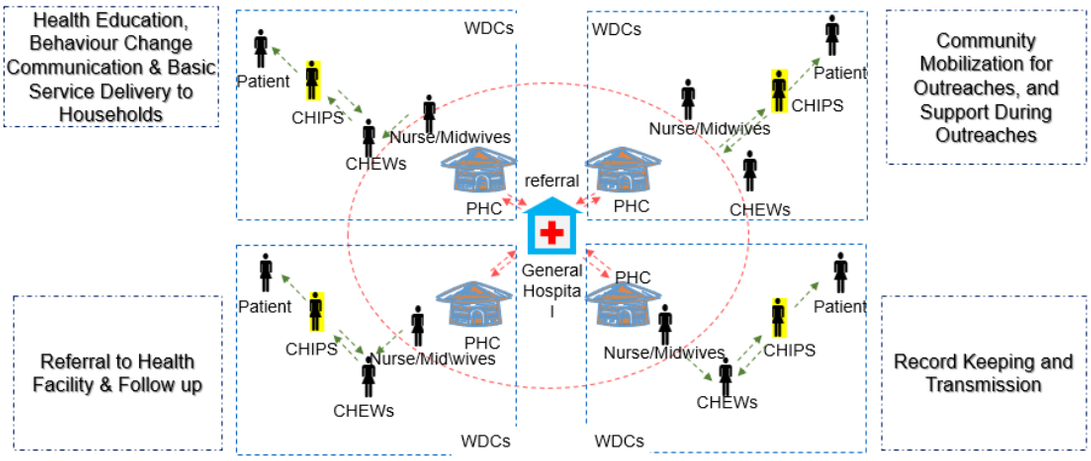


Figure 8: CHIPS agents will provide community level services, supported by community structures such as traditional/community institutions and WDCs

7.5 OPTIMIZED INTEGRATED ROUTINE IMMUNIZATION SESSIONS (OIRIS)

Background

Nigeria accounts for 18% of the 19.5 million un-immunized/under-immunized children globally. Vaccine Preventable Diseases (VPD) are responsible for 53% of under–five mortality in Nigeria. The most recent immunization survey reported a national Penta3 coverage of 33%. The National Primary Health Care Development Agency adopted the survey result and in collaboration with developmental partners working in the immunization landscape agreed to an approach to strengthen the operationalization of Reaching Every Ward (REW) strategy. The approach is tagged Optimized Integrated Routine Immunization Sessions (OIRIS) as a response to the poor routine immunization coverage in Nigeria.

Aim of OIRIS

To rapidly improve equitable immunization coverage through the conduct of optimized and integrated routine immunization sessions in 18 NERICC low-performing states and the other states in the country.

Specific Objectives

- To improve routine immunization coverage from 36% to 43% (appropriately immunized – LQAS) in the 18 NERICC low-performing states by December, 2018 through the conduct of optimal integrated outreach and daily fixed sessions with the involvement of national, state teams and partners
- To achieve at least 90% of targeted urban primary, secondary and tertiary health facilities conduct optimal daily fixed sessions by end of 2018
- To achieve at least 90% of targeted health facilities intensify routine immunization sessions by conducting at least once weekly integrated outreach sessions by end of 2018

- To scale up community engagement activities to facilitate increased demand for immunizations

OIRIS is hinged on four key pillars with ownership at all levels

Ownership – State Primary Health Care Boards (SPHCBs) responsible for driving improvements in RI performance and a strengthened PHC.

Optimized Routine Immunization Sessions - Increase the frequency of fixed, outreach and mobile sessions to be able to reach all partially immunized and unimmunized children in the communities.

Integration - Integrate RI with other health services and commodities to attract caregivers to immunization and strengthen PHC service delivery in focal communities.

Community Engagement - Engage the community and traditional leadership institutions to create demand for RI, track and refer defaulters and unimmunized children to health facilities.

Supportive Supervision -Rollout of standardized monthly RI supportive supervision visits to health facilities with support from NERICC.

Accountability - Rewards and sanctions + vaccines accountability, data accountability – zero tolerance for data falsification.

The success of OIRIS is hinged on pro-active governance, improved resource management and coordination, improved visibility to lower levels and monitoring and use of data for action.

Improved strategic thinking and optimal operationalization of the REW strategy is the basis of OIRIS. The context of the REW implementation is to reach every child but this has not been the case in the past. OIRIS is a reinvigoration of the REW.

REW in the past showed:

- Irregular conduct of fixed and outreach sessions by primary, secondary and tertiary health facilities
- Poor linkage of health facilities with the community to mobilize children and plan for sessions
- Inadequate number of children immunized
- Missed opportunities for vaccinations
- Hard-to-reach settlements often excluded
- Urban slums often neglected
- Children are immunized based on target populations which may not fully reflect the number of eligible children in focal communities

The OIRIS approach advocates:

- Conduct of daily sessions by secondary and tertiary health facilities and all urban PHC facilities
- Conduct of at least once weekly fixed and outreach sessions by rural PHC facilities

- Rural health facilities in agreement with the community to set aside specific day(s) at the end of the month for outreach where applicable (e.g.as in monthly sanitation)
- Development of GIS-based detailed REW microplan to ensure all eligible children are reached
- Prioritization of low performing areas/settlements with increased immunization sessions in urban slums and hard-to-reach areas
- More focus on reaching every eligible child through proper planning and quality REW implementation
- Optimizing service delivery points for immunization through PHC strengthening in secondary and tertiary health facilities

OIRIS architecture for health facility services - RI will no longer be conducted as an isolated activity but integrated with other services and commodities at fixed posts and outreach sites.

- The labour and delivery (L&D) room ensures each newborn is immunized following delivery
- L&D room provides counselling to caregiver on importance of immunizations, scheduling and referral to immunization unit
- Service Delivery Points (SDPs) in health facilities review the child's immunization status and ensures the child is immunized where it is required
- SDPs request for Child Health Card whenever a child is attended to
- The RI unit refers the child and caregiver to other PHC services within the facility
- Counsels care-giver to retain Child Health Card and present same to health facility when accessing health services
- RI sessions (daily, fixed and mobile) to include health commodities and PHC services where applicable (see minimum list of PHC services & commodities)

Integration of services and commodities with routine immunization during fixed and outreach sessions at the Health facilities and communities.

Proposed services for Integration

- Growth monitoring
- Health education (includes nutrition & hygiene advice)
- Food demonstration
- Antenatal and postnatal care
- Management of common illnesses e.g. diarrhoea, malaria and fever
- Family Planning
- Vocational training for women during RI sessions
- Community Management of Acute Malnutrition (mobilization, screening, referral)
- Integrated Management of Childhood Illnesses (health facility-based)
- Integrated Community Case Management of Childhood Illnesses (community-based)

Proposed commodities for integration:

- Paracetamol and Albendazole
- Zinc DT - Oral Rehydration Salts (Zn DT-ORS)
- Anti-malarials
- Vitamin A
- Ready to Use Therapeutic Foods (RUTF)
- Full immunization certification/awards

Standardized RI supportive supervision (RISS) visits will be conducted to health facilities at least once a month to monitor implementation.

OIRIS recommends:

- Capacity-building for staff in identified skill and knowledge deficiencies
- Feedback is mandatory
- State and LGA teams visit health facility together
- NERICC teams to join State and LGA teams to visit health facilities in the last week of each month
- At least once a month joint supervisory visits by LGA teams conducted using the RISS flow chart for capacity building (refer to RISS SOP)

OIRIS Community Engagement Framework

To ensure demand creation and increase uptake of RI and PHC services, all community engagement and mobilization efforts will be harmonized. The core principles of OIRIS community engagement strategy are:

- Line-listing of children under one year - Settlement heads, supported by various community resource groups, compile and regularly update a line-list of U-1 children in their settlements and their vaccination status.
- Reconciliation - Settlement heads reconcile this list with the health workers where they update child registers with all U-1 children, update vaccination status on line-list and identify defaulters and unimmunized children.
- Defaulter tracking - Community resource groups work with other mobilization personnel (CMAM, Polio etc.) to inform care-givers of relevant RI and PHC services close to their locations and track RI defaulters and unimmunized children.

Community resource groups involved in driving uptake of PHC services:

- Community leaders (Settlement heads, village heads and district heads), local barbers, traditional birth attendants and religious leaders (Imams, Pastors etc.)
- Community Health Influencers, Promoters and Services (CHIPS) Agents
- Civil Society Organizations (CSOs) and RI Ambassadors identified in each community

Accountability

OIRIS enforces accountability to drive positive changes in attitudes towards Routine Immunization Service Delivery. Accountability obligations for the different levels are stratified as thus;

SERICC - Provide an SPHCB toll free helpline for complaints and community feedback. Publicize and ensure toll free helplines are functional and regularly utilized to strengthen RI program performance.

SERICC/LERICC - Implement rewards and sanctions; ensure MoU on RI accountability is implemented by all stakeholders. Lead the drive change in attitude and service delivery at state and sub-state levels, communicate the "elimination of set RI target" directive to all health workers and partners. Ensure vaccine and data accountability enforcing zero tolerance for data falsification and drive effective planning, monitoring and use of data for action in all RI sessions.

Health facilities - Ensure all planned immunization sessions are conducted with the aim to immunize all eligible children in focal communities. Conduct RI sessions maintaining good interpersonal communication with care-givers. Take responsibility for date emanating from the facility to ensure accurate data reporting while ensuring vaccine vial retrieval and vaccine accountability.

The OIRIS approach is not a campaign but change in the culture of work for Routine Immunization (RI) service delivery to optimize the REW strategy with the full participation of community structures in the planning, implementation and evaluation of RI and PHC interventions for improved health outcomes.

7.6 NIGERIA STATE HEALTH INVESTMENT PROJECT

BACKGROUND

Nigeria has made some progress in the development of the Primary Health Care system and, by extension, the health sector. From 2003 to 2013, for instance, the country has witnessed the progressive decline in infant mortality rate from 100 to 69 per 1000 live births, under-5 mortality rate from 201 to 128 per 1000 live births and maternal mortality ratio from 800 to 576 per 100,000 live births. There has also been marginal improvement of birth attended by the skilled personnel from 36% to 38% within the same period.

However, despite the progress made in the maternal and child health indices as stated above, Nigeria still missed the MDG targets in 2016. This situation is unacceptable. If changes are not made, the country may also find it difficult to meet up with the Sustainable Development Goals (SDGs) targets.

Furthermore, the public health expenditures have more than doubled - from about 3% to 7% of the total budget between 2002 and 2012. This spending, as well as donor funds to improve health service delivery, have concentrated on increasing critical inputs, such as infrastructure, equipment, supplies, drugs and vaccines. And despite these heavy investments, the Nigerian health system is still faced with many challenges including poor quality service delivery, poor accountability,

challenges with the demand side, inefficient essential drugs management, inadequate medical supplies, poor infrastructures, inadequate human resource for health and lack of community ownership amongst others. The available data has clearly shown that the achievements made so far did not correlate with health expenditures in the past decades and the trend shows that increasing health expenditures alone is not the panacea to the dismal health indices of the country. Primary Health Care as the first level of care for the community has remained inefficient and ineffective despite increased investment, different strategies and interventions in Nigeria. A functional Primary Health Care system can prevent and manage up to 70 to 80% of our disease burden.

These challenges compelled experts to try a different, innovative approach using the experiences of some other African countries like Rwanda on implementation of Results-Based Financing (RBF). Hence, the Nigeria State Health Investment Project (NSHIP) was conceived.

NSHIP is a Federal Government project which uses Results-Based Financing (RBF) approach designed to improve primary health care service. The National Primary Health Care Development Agency (NPHCDA), as part of her mandate, provides the technical support for the implementation of NSHIP which aims to strengthen the Primary Health Care system through a focus on results. This intervention was piloted in Adamawa, Nasarawa, and Ondo states from 2011.

The Additional Financing for the Nigeria State Health Investment Project (AF NSHIP) is basically an expansion of NSHIP in the northeast zone of the country (Bauchi, Borno, Gombe, Taraba and Yobe) brought about as a result of the remarkable successes recorded in the three pilot states. This is part of the Federal Government of Nigeria's overall strategy for the development and rapidly strengthening health care delivery in the northeastern part of the country after the devastating effect of the insurgency in the states.

RATIONALE AND OBJECTIVE

Years of the traditional input financing approach in Nigeria has translated into very slow progress in the improvement of health indices, little advances in service delivery and no increase in accountability of providers to users. On the other hand, there is increasing evidence globally of the positive impact of performance-based financing (PBF) on health system performance, provider behavior and quality of care.

Thus, in 2011, the Federal Government of Nigeria adopted a new approach in collaboration with the World Bank to strengthen primary health care through the Nigeria State Health Investment Project (NSHIP). This is a results-based approach to improve both the quantity and quality of health services, by decentralizing health facility financing, addressing structural issues, and motivating health worker performance.

Whereas, there are two variants of RBF (Performance-Based Financing and Decentralized Facility Financing) operating in the NSHIP states, only the Performance-Based Financing (PBF) is present in the AF-NSHIP.

THE PARADIGM SHIFT IN NSHIP

In achieving its objective, NSHIP seeks to provide managerial autonomy to health facilities whilst strengthening accountability mechanisms at the LG Health Authority and State Primary Health Care Boards through a collective package of institutional and operational level results-based financing (RBF) approaches. The following paradigm shifts are associated with the approach:

1. From the traditional input-based financing to result-based financing.
2. Fragmented and unclear accountability to accountability with well-defined indicators that are monitored.
3. Top-bottom health investment (by the national, state and LGA) to bottom-up investment by health facilities leading to health facility autonomy.
4. From centralized supply of drugs and health commodities to decentralized procurement.
5. From lack of verification of performance to thorough performance verification and counter-verification by independent verification agencies.

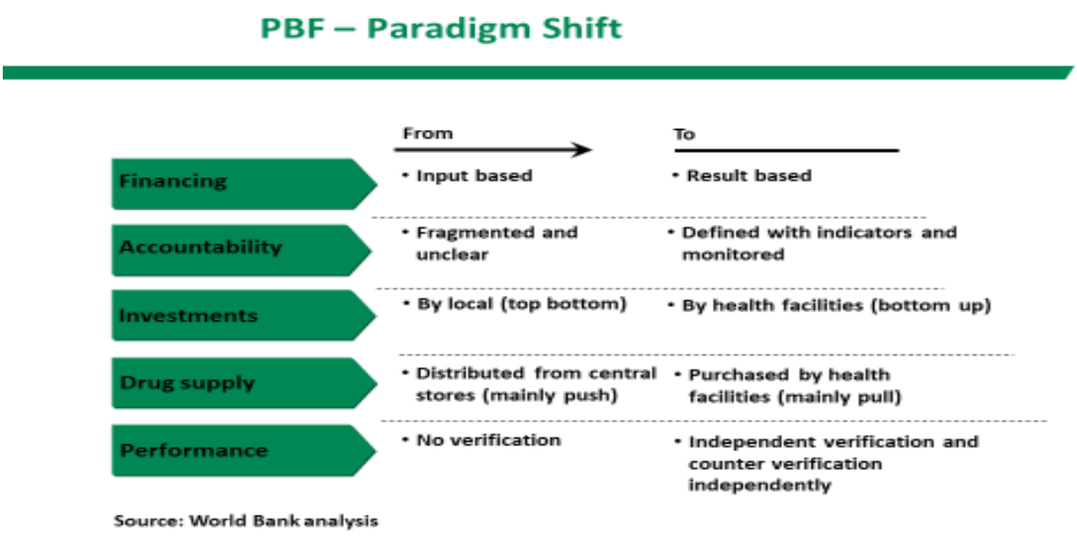


Figure 9: PBF – Paradigm Shift

PBF BEST PRACTICES

1. Separate the functions of regulation, service provision, fund disbursement, contract development & verification and community empowerment.
2. Local community groups defend patient interests.
3. Stimulate competition for contracts among facilities and other stakeholders.
4. Promote public-private partnerships with equal treatment for public, religious and private provider.
5. The regulator does not interfere in facility management but defines output, quality and equity indicators.
6. Providers must assure that revenues and expenditures are balanced while providing high quality and equitable services with motivated qualified staff.
7. Health facilities have autonomy and local decision rights on resources.

8. Independent contract management and verification agencies negotiate contracts and coach facility managers to use business plans and indices instruments.
9. Promote efficiency and cost containment by paying subsidies directly to the health facilities in cash and not in kind.
10. Seek economic multiplier effects to generate employment, economic growth and tax revenues by deliberately injecting cash into the local economy.
11. Extend performance contracting to sectors other than health.

All the above strategies and practices are put in place to ensure availability of quality health services at the PHC facilities as well as the secondary referral centres. It is also important to note that NSHIP/AF-NSHIP is being implemented in line with the federal government's initiative of providing, at least, one functional Primary Health Centre per ward in an effort to improve access to quality health care services.

Additionally, the federal government is currently making efforts to employ the NSHIP approach to implement the Basic Health Care Provision Fund (BHCPF) as a result of the lessons learnt from the NSHIP implementation and the successes recorded.

ANNEXES

ANNEX 1: ESSENTIAL MEDICINES LIST FOR PRIMARY HEALTH CARE FACILITIES

ESSENTIAL MEDICINES LIST						
SN	**NAME OF DRUGS**	**DESCRIPTION**	**FORMULATION**	**PRIMARY HEALTH CENTRES**	**PRIMARY HEALTH CLINICS**	**PRIMARY HEALTH POSTS**
1	**ANAESTHETICS (LOCAL)**					
1.1	Lidocaine	Topical, injection	**Injection:** 1%, 2% + epinephrine (adrenaline) 1:200,000, vial	**X**	**X**	
			Cream or ointment: 2 - 5%			
			Gel or solution: 2 - 4%			
2	**ANALGESICS**					
2.2	Ibuprofen	Tablet **, c**apsule	**Capsule/tablet:** 200 mg and 400 mg	**X**	**X**	**X**
2.3	Paracetamol	Oral liquid, tablet, suppository	**Oral liquid**:125 mg/5 Ml	**X**	**X**	**X**
			Suppository:100 mg			
			Tablet:125mg,500 mg			
			Injection:150 mg/mL			**X**
***Not for children, use with caution in adults**						
3	**ANTI-ALLERGICS**					
3.1	Chlorphenamine	Oral liquid, tablet	2mg	**X**	**X**	
3.2	Hydrocostisone	Injection viale		**X**	**X**	
3.3	Promethazine	Tablet, oral liquid	5mg	**X**	**X**	
4	**ANTICONVULSANTS**					
4.1	Diazepam**	Injection	**Injection:** 5 mg/mL in 2-mL ampoule	**X**	**X**	
4.3	Phenobarbital	Tablet	**Tablet:** 15 mg, 30 mg, 60 mg	**X**	**X**	
	****Use with extra caution**					
5	**ANTIDOTES**					
5.1	Atropine	Injection	**Injection:** (sulfate), 1 mg in 1-mL ampoule	**X**	**X**	
5.2	Charcoal (activated)	Powder	**Tablet:** 1 g	**X**	**X**	
			Powder/granules: 5 g sachet			
6	**ANTIHYPERTENSIVE MEDICINES**					
6.1	Amlodipine	**Tablet**	**Tablet:** 5 mg,10mg	**X**	**X**	
6.2	Amiloride	**Tablet**	**Tablet:**5mg, 10mg	**X**	**X**	
6.3	Hydrochlorothiazide	**Tablet**		**X**	**X**	

	*** Not for children**					
7	**ANTI-INFECTIVE MEDICINES**					
7.1	***Antibacterial medicines***					
7.1.1	Amoxicillin	Capsule, dry powder for suspension, dispersible tablets	**Capsule:** (trihydrate),250mg; 500 mg	**X**	**X**	**X**
			Dispersible tablet: 125mg, 250 mg			
			Injection: (sodium salt),500 mg, vial **Powder for oral liquid:** (trihydrate), 125 mg/5 mL			
7.1.2	Benzathine Penicillin	Injection	**Injection powder**: equivalent to 720 mg (1.2 million units)Vial	**X**		
7.1.3	Benzyl penicillin	Injection	**Injection powder:** (sodium or potassium salt), 600 mg (1 million units)	**X**		
7.1.4	Co-trimoxazole	Tablet, oral liquid	**Oral liquid:** sulfamethoxazole 200 mg + trimethoprim 40 mg/5 mL	**X**	**X**	
			Tablet: sulfamethoxazole 400 mg+ trimethoprim 80 mg	**X**	**X**	
7.1.5	Erythromycin	Tablet , suspension	**Capsule/tablet, enteric/film-coated:** (stearate or ethylsuccinate), 250 mg, 500mg	**X**		
			Injection powder: (lactobionate), 500 mg , vial	**X**		
			Oral liquid: (stearate or ethylsuccinate),125 mg/5 mL	**X**		
7.1.6	Gentamicin	Injection	**Injection:** (Sulphate), 40mg/ml in 2ml ampoule	**X**		
7.1.7	Nitrofurantoin	Tablet	**Tablet:** 50 mg, 100 mg	**X**		
7.1.8	Ampicillin	Capsule	250 mg/500mg	**X**		
7.1.9	Tetracycline *****	Capsule	**Capsule:** tablet, (hydrochloride), 250 mg	**X**		
8	***Antileprosy***					
9	***Amoebicide***					
9.1	Metronidazole	Tablet	**Tablet:** 200 mg, 400 mg	**X**	**X**	
10	***Antihelminthics***					
10.1	Albendazole	Oral liquid, tablet	**Oral liquid:** 100 mg/5 mL	**X**	**X**	
			Tablet: 200 mg			

10.3	Pyrantel	Oral liquid, tablet		**X**		
11	***Antifilarial***					
11.1	Diethylcarbamazine	Tablet	**Tablet:** 50 mg	**X**		
11.2	Ivermectin	Tablet	**Tablet:** 3 mg, 6 mg	**X**		
12	***Antimalarials***					
12.1	Artemether + lumefantrine	Oral liquid, tablet	**Tablet:** 20 mg + 120 mg	**X**	**X**	**X**
12.2	Artesunate	Suppositories				
12.3	Artesunate + amodiaquine	Tablet	**Tablet:** 25 mg + 67.5 mg, 50 mg+ 135 mg, 100 mg + 270 mg	**X**	**X**	**X**
12.5	Quinine**	Injection	**Injection:** (dihydrochloride), 300 mg/mL in 2-mL ampoule	**X**		
12.6	Pyrimethamine + sulfadoxine	Tablet, Oral liquid	**Tablet:** 25 mg + 500 mg	**X**	**X**	
13	***Anti-tuberculosis medicines***					
13.1	Ethambutol	Tablet	**Tablet:** (hydrochloride), 100 – 500 mg	**X**		
13.2	Isoniazid	Tablet	**Tablet:** 100 – 300 mg	**X**		
13.3	Pyrazinamide	Tablet	**Tablet:** 400 mg	**X**		
13.4	Rifabutin	Capsule, tablet	**Capsule:** 150 mg	**X**		
13.5	Rifampicin	Capsule, tablet	**Capsule/tablet:** 150 mg, 300 mg	**X**		
	***Not recommended for children and pregnant women**					
	**** Intramuscular, for pre-referral treatment only**					
	***** Use only with Quinine in first trimester of pregnancy**					
14	**ANTISEPTICS AND DISINFECTANTS**					
14.1	Benzoin	Compound tincture	Compound tincture of benzoin	**X**	**X**	
	Benzyl benzoate	Emulsion	**Emulsion:** 25%			**X**
14.2	Chlorhexidine	Solution/gel	**Gel:** (umbilical cord application) **Solution:** (gluconate), 5% for dilution	**X**	**X**	**X**
14.3	Iodine	Solution	**Weak solution of iodine:** 1%	**X**	**X**	
	Povidone iodine	Tincture				**X**
14.4	Methylated spirit	Solution		**X**	**X**	**X**
14.5	Sodium hypochlorite	Solution	**Solution:** different prep preparations with available chlorine from 1-10%	**X**	**X**	
15	**DERMATOLOGICAL MEDICINES**					

15.1	Benzoic acid + salicylic acid (Whitfield's)	Ointment	Cream/ointment: containing benzoic acid, 6% and Salicylic acid, 3%	**X**	**X**	**X**
15.2	Benzoyl peroxide	Cream/gel	**Cream:** 2.5%, 5%, 10% **Gel:** 2.5%, 5%, 10%	**X**	**X**	
15.3	Benzyl benzoate	Emulsion	**Emulsion:** 25%			
15.4	Calamine	Lotion		**X**	**X**	**X**
15.5	Gentamicin	Ointment				
15.6	Methyl salicylate	Ointment	**Ointment/liniment:** 4 - 20%	**X**	**X**	**X**
15.7	Neomycin + Bacitracin	Ointment, powder		**X**		
15.8	Nystatin	Ointment, cream		**X**		
15.9	Zinc oxide	Ointment		**X**	**X**	
	Zinc oxide plaster	Dressing				**X**
16	**MEDICINES AFFECTING THE BLOOD**					
16.1	Iron Tablets	Oral liquid, tablet	200mg	**X**	**X**	**X**
16.2	Folic acid	Tablet	**Tablet:** 5 mg	**X**	**X**	**X**
17	**DRESSINGS AND MEDICAL DEVICES**					
17.1	Absorbent gauze bandages		Dressing	**X**	**X**	**X**
17.2	Cotton wool (absorbent)			**X**	**X**	**X**
17.3	Disposable gloves			**X**	**X**	**X**
17.4	Disposable syringes	2 mL with needles (19, 21Gauge) 5 mL with needles (19, 21Gauge)		**X**	**X**	
18	**EAR, NOSE AND THROAT MEDICINES**					
18.1	Chloramphenicol	Ear drops	**Ear drops:** 5%	**X**	**X**	
19	**GASTRO-INTESTINAL MEDICINES**					
19.1	Hyoscine N-butylbromide	Tablet	20mg	**X**	**X**	
19.2	Magnesium trisilicate	Compound tablet, oral liquid	**Mixture:** 250 mg/5 mL **Tablet:** 500 mg	**X**	**X**	
19.3	Oral Rehydration Salts	Low Osmolarity Oral Rehydration Salts,co-packed with Zn	**Low Osmolarity Oral Rehydration Salts, co-packed with zinc sulphate tablets:** 20.5 g ORS (sodium chloride) 2.6 g, potassium chloride 1.5 g, sodium citrate 2.9 g, dextrose 13.5 g)+ 20 mg dispersible zinc sulfate	**X**	**X**	**X**

19.4	Zinc	Oral liquid, dispersible tablet		**X**	**X**	**X**
20	**HORMONES AND SYNTHETIC SUBSTITUTES**					
20.1	Barrier methods	Condoms with or without spermicide		**X**	**X**	**X**
20.2	Ethinylestrachol + Levonorgestrel	Tablet	3,000mg	**X**		
21	**OPHTHALMOLOGICAL MEDICINES**					
21.1	Chloramphenicol	Eye drops, ointment	**Eye drops:** 0.5% **Eye ointment:** 1.0%	**X**	**X**	
21.2	Chlortetracycline	Eye ointment		**X**	**X**	
22	**OXYTOCIC**					
22.1	Ergometrine	Tablet, injection	**Injection:** (maleate), 0.5 mg/mL **Tablet:** (maleate), 500 micrograms	**X**	**X**	
22.2	Misoprostol	Tablet , vaginal tablet	**Tablet:** 200 micrograms	**X**	**X**	
22.3	Oxytoxin	Injection	**Injection:** 5 units, 10 units / mL in ampoules	**X**	**X**	
23	**PSYCHOTHERAPEUTIC MEDICINES**					
23.1	Chlorpromazine	Injection		**X**		
24	**RESPIRATORY MEDICINES**					
24.1	Beclomethasone	Inhaler		**X**	**X**	
24.2	Salbutamol	Tablet, inhaler		**X**	**X**	
29	**MISCELLANEOUS**					
29.1	Water for injection	Injection	**Injection:** 2 mL, 5 mL, 10 mL, 20 mL, 50- mL ampoule or , vial	**X**	**X**	
29.2	Dispersing tray with spatula			**X**		
28	**VITAMINS AND MINERALS**					
28.1	Ascorbic acid (Vitamin C)	Tablet	**Oral liquid:** 100 mg/5 mL **Tablet:** 100 mg	**X**	**X**	
28.3	Calcium lactate	Tablet		**X**	**X**	
28.4	Folic acid	Tablet	**Tablet:** , 400 microgram, 5 mg	**X**	**X**	
28.5	Vitamin A	Capsule		**X**	**X**	
29	**MISCELLANEOUS**					
29.1	Water for injection	Injection	**Injection:** 2 mL, 5 mL, 10 mL, 20 mL, 50- mL ampoule or , vial	**X** **X**	**X** **X**	

29.2	Dispersing tray with spatula			**X**	**X**	
	Clinical thermometer					**X**
	Plastic aprons					**X**
	Surgical blades					**X**

LABORATORY CONSUMABLES ONLY FOR PRIMARY HEALTH CENTRES WITH FUNCTIONAL OR EXPECTED FUNCTIONAL LABORATORIES

LABORATORY CONSUMABLES

S/N	Names	Description	Formulation
1	Microscope cover slide pack of 1000		
2	Disodium hydrogen phosphate (NAHPO) (for buffered water)		
3	Distilled water		
4	Dyes (stain powder) :		
5	Ethanol (ethyl alcohol), 70%, 95%,100% (absolute)		
6	Formalin (formaldehyde)		
7	Glacial acelic acid		
8	Glycerol		
9	Hydrochloric acid, concentrated (HCl)		
10	Iodine Crystals (1)		
11	Isopropranol (isopropyl alcohol)		
12	Mercuric chloride crystals (HgCl)		
13	Methanol (methyl alcohol)		
14	Phenol crystals (carbolic acid)		

15	Phospholungslic acid crystals (II,IPO(IV,O)I.511,0)		
16	Polyvinyl alcohol (PVA)		
17	Potassium iodide crystals (KJ)		
18	Potassium dihydrogen phosphate (KH,PO) (for buffered water)		
19	Sodium acelate powder (CH, COONs) or sodium acetate crystals		
20	Sodium chloride (NaCI)		
21	Sodium citrate crystal (C611507Na321120)		
22	Stains (solutions)		
23	Xylene		

ADDITIONAL CONSUMABLES

S/N	Names	Description	Formulation
1	IVF Dextro Saline	1/2 Strength Darrows	
2	Butterfly needle		
3	Cannula	16G, 18G, 2XG	
4	Solu Sets		
5	IV giving sets		
6	Plasters (various sizes)		
7	Malaria RDT kits		

ADDENDUM TO THE CURRENT ESSENTIAL MEDICINES LIST (SIXTH EDITION, 2016)

SN	NAME OF DRUGS	DESCRIPTION	FORMULATION
1	**ANTI -INFECTIVE MEDICINES**		
2	**Antibacterial medicines**		
3	Ampicillin	Injection: Ampicillin for infant 0-59days of Age IV Ampicillin (40mg/kg/dose 6 hourly) Level of Healthcare: All levels	
4	Cefpodoxime	Oral Antibiotics for neonatal sepsis. Tablet:10mg/kg/day in 2 divided doses for 5-7days Suspension:40mg/5ml For Adult: 200mg-400mg twice daily for 10 days Level of Healthcare : All Levels	
5	Vit. K1 (Phytonadione)	Prophylaxis for Haemorrhagic Disease of Newborn (HDN) Injection:2mg/ml Level of Healthcare: All levels	

*FDC: Fixed Dose Combination of all pediatric products is based on the age band of the child.

List of drugs used for HIV

i. Tenofovir+Lamivudine+Efavirenz (TDF/3TC/EFV)300/300/600mg
ii. Tenofovir+lamivudine+Dolutegravir(TDF/3TC/DTG)300/300/50mg
iii. Abacavir + Lamivudine(ABC/3TC)600/300mg
iv. Zidovudine(AZT)Susp50/5ml
v. Raltegravir(RAL)25mg
vi. Darunavir /Ritonavir (DRV/r)600/100mg
vii. Etravirine100mg
viii. Efavirenz600mg
ix. Zidovudine+Lamivudine(AZT/3TC0e600//150mg
x. Atazanavir/Ritonavir(ATV/r)300/100mg
xi. Lopinavir/Ritonavir (LPV/r)200/50mg
xii. Lopinavir/Ritonavir(LPV/r)100/25mg
xiii. Tenofovir+Lamivudine (TDF/3TC)300/300mg
xiv. Lopinavir/Ritonavir (LPV/r)40/10mg

ANNEX 2: ESSENTIAL EQUIPMENT LIST FOR PRIMARY HEALTH CARE FACILITIES

ESSENTIAL EQUIPMENT LIST FOR PRIMARY HEALTH CARE FACILITIES				
		PRIMARY HEALTH CENTRE	**PRIMARY HEALTH CLINIC**	**PRIMARY HEALTH POST**
S/NO.	**ITEM DESCRIPTION**	**QUANTITY**		
1	Hospital bed with mattress	10	6	2
2	Examination couch	3	2	1
3	Artery forceps (medium)	6	3	2
4	Bed pan (stainless steel)	4	3	1
5	Urinal (Female) stainless steel	4	2	1
6	Bowls (stainless steel) with stand	4	2	1
7	Newclime standing fan	6	4	2
8	Plastic chairs	12	10	4
9	Stainless covered bowl for cotton wool	6	4	1
10	Graduated medicine cup (Metal)	10	10	2
11	Dissecting forceps	6	4	2
12	Dressing scissors	4	3	2
13	Sponge holding forceps	2	2	1
14	Dressing trolley	3	2	1
15	Dressing forceps	2	2	2
16	Drinking mug (stainless steel)	4	4	4
17	Dust bin (pedal)	6	6	1
18	Gallipots (medium)	6	6	2
19	Gloves disposal packs of 50	4	4	1
20	Syringes and needles, pack of 100 (2cc & 5cc)	4	4	1
21	Stainless instrument tray	3	2	1
22	Forceps jar	3	2	1
23	Kerosene pressure lamp	4	2	2
24	Rechargeable lamp with flourescent	4	2	2
25	Kidney dish (large) stainless steel	6	4	2
26	Length measures for babies	4	2	2
27	Long benches	12	8	2
28	Mackintosh sheet	2	2	2
29	Medicine cupboard	1	1	1
30	Instrument cabinet	1	1	1
31	Refrigerator medium	2	1	1
32	Urine dip stick for sugar and albumin (pack of 110)	10	10	2
33	Bed screen	5	2	2
34	Wall clock	6	4	1
35	Sphygmomanometer (mercurial, table top)	3	2	1
36	Stethoscope	3	2	1
37	Writing table and chairs	6	2	1
38	Swivel stool	2	1	1
39	Incision and drainage kit	6	2	2
40	Tape measure	4	2	4
41	Thermometer (oral)	10	5	5

42	Thermometer (rectal)	10	5	5
43	Suction pump	2	1	1
44	Weighing scale (Adult)	2	1	1
45	Weighing scale (Child)	3	1	1
46	Filing cabinet	3	1	1
47	Bed sheets & pillow case	24	12	4
48	Pedal bin (metal)	4	4	4
49	Mops	12	6	6
50	Mop buckets	4	2	2
51	Sterilizer (medium) 15 Litre	2	1	1
52	Brooms	10	5	3
53	Buckets (plastic)	6	4	3
54	Drinking mug	10	6	4
55	MUAC Tapes	4	4	2
56	Plastic bucket with tap	3	2	1
57	Stadiometer	2	1	1
58	Diagnostic set	1	1	0
59	Sterilizing drums (set of 3)	1	1	0
60	Stitch removal / suture scissors	3	2	0
61	Suture kit	2	2	0
62	Angle poised lamp	2	1	0
63	Pen torch	2	2	0
64	Drip stand	4	2	0
65	Fire extinguisher (9kg)	2	2	0
66	Delivery couch with stirrups	2	1	0
67	Nursery cots with mattress	2	2	0
68	Baby dressing table for maternity	1	1	0
69	Foetoscope	4	2	0
70	Plastic apron	4	2	0
71	Malaria RDT kits	2	2	0
72	Vagina speculum (Sims, set of 3)	1	1	0
73	Mucus extractor	4	2	0
74	Ambu bag with face mask	1	1	0
75	Filing cabinet	1	1	0
76	Generator set (Firman, STG 5000E))	1	1	0
77	Binocular microscope	1	0	0
78	Microscope cover slide (pack of 100)	1	0	0
79	Test tube rack	1	0	0
80	Blood lancet (Pack of 100)	1	0	0
81	Stool specimen bottles	100	0	0
82	Autoclave	1	0	0
83	Suction pump	2	0	0
84	Motorcycle	1	0	0
85	Centrifuge manual vacuum	2	0	0
86	Manual aspiration set	2	0	0
87	Trolley patient stretcher	1	0	0
88	Microcuvette for Hb 3x1/Box - 2XX	0	0	0
89	Table top cooker	1	0	0
90	Small size cooking gas cylinder	1	0	0
91	Set of aluminium pot & utensil	1	0	0

HUMAN RESOURCES FOR PRIMARY HEALTH CARE FACILITIES				
CLINICAL STAFF				
		PRIMARY HEALTH CENTRE	PRIMARY HEALTH CLINIC	PRIMARY HEALTH POST
S/N	PERSONNEL	NUMBER		
1	Medical officer (If available)	1	0	0
2	Community Health Officers (CHOs)	1	0	0
3	Nurse/Midwife	4	1	0
4	Community Health Extension Workers (CHEWs)	3	2	0
5	Pharmacy Technician	1	0	0
6	Health Records Technician	1	0	0
7	Medical Laboratory Technician	1	0	0
8	Junior Community Health Extension Workers (JCHEWs)	6	1	1

HUMAN RESOURCES FOR PRIMARY HEALTH CARE FACILITIES				
SUPPORT STAFF				
		PRIMARY HEALTH CENTRE	PRIMARY HEALTH CLINIC	PRIMARY HEALTH POST
S/N	PERSONNEL	NUMBER		
1	Accountant Clerk	1	0	0
2	Driver	1	0	0
3	Health Attendant/Assistant	2	2	0
4	Security Personal	2	2	0
5	Cleaners	2	1	1

A minimum of ten CHIPS Agents to be available in the communities of every ward in the LGA.

Two Community Engagement Persons to supervise the CHIPS Agents.