FEDERAL GOVERNMENT OF NIGERIA

NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY

INTEGRATING PRIMARY HEALTH CARE GOVERNANCE IN NIGERIA

(PHC Under One Roof)

IMPLEMENTATION MANUAL

DRAFT 1

August, 2013

FEDERAL GOVERNMENT OF NIGERIA

NATIONAL PRIMARY HEALTHCARE DEVELOPMENT AGENCY

INTEGRATING PRIMARY HEALTH CARE GOVERNANCE IN NIGERIA

(PHC Under One Roof)

DRAFT 1

August, 2013

Contents

1. Introduction

Resolution 29 of the 54th National Council on Health (NCH) Meeting in May 2011 statesCouncil noted the thrust of the National Health Bill in strengthening Primary Health Care (PHC) through the creation of PHC Boards/Agencies and the PHC Development Fund. Council noted efforts in "Bringing PHC under One Roof" in line with the provisions of the National Health Bill. Council also noted the importance of enacting relevant state legislation and regulations that will facilitate the implementation of National Health Bill. Council therefore approved the Implementation Guide on Bringing PHC under One Roof (PHCUOR) as a working document to be used by the three tiers of government and approved that all states establish Primary Health Care Boards."

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

In anticipation of the passage of the new National Health Bill, many states have proceeded to establish State PHC Management Boards (SPHCMB) or State PHC Development Agencies (SPHCDA). Many states have encountered several challenges in establishing SPHCMBs or SPHCDAs, resulting in the establishment of institutions and structures that are not aligned with national health policy and the National Health Bill.

This Implementation Manual has been developed by the NPHCDA to assist with the process of establishing either SPHCMBs or SPHCDAs. It is not intended to encompass all the tasks required to sustain and develop primary health care (PHC) in the long term, but to help stakeholders, health policy advisors, legislators, governing bodies and managers establish the key elements of state PHC institutions that can take root and thrive.

During 2012, the NPHCDA developed a checklist for monitoring progress, which was shared at the national workshop in September 2012 and is included below as Annex 2. The checklist was then used to assess progress in all states. This Implementation Manual has been developed from the Themes used for the 2012 checklist. In the process, the Themes have been modified and enhanced as a result of the September 2012 national workshop, the June 2013 capacity building workshop on PHCUOR, and discussions with development partners and other stakeholders.

Each Theme is explained in detail below. *Key questions* are followed by an *Overview* of the Theme, which discusses requisite actions at Federal, State and Local Government Area (LGA) levels, as applicable. *Options* adopted by the different states are presented because ''no-one-size-fits-all''. Some of the *Challenges* that have been encountered or are anticipated are discussed, followed by recommended *Steps* for implementation, along with suggested *Indicators*.

It must be remembered that extensive health sector reform requires a sustained effort over considerable periods of time. For example, the health sector reform process in Jigawa started in

2003 and started to bear fruit approximately five years later, with tasks still remaining for completion. States need to be wary of "quick and easy" solutions, which skip necessary steps, and instead be prepared for the lengthy period of time required for transformation to take shape and develop roots. The focus must be on improving the quality and coverage of health service delivery and promoting a culture of transparency, accountability and participation by all stakeholders.

a) Principles for "Bringing PHC under One Roof"

"Bringing PHC under One Roof" is modelled on guidelines developed by the World Health Organization for integrated district-based service delivery and is based on the following key principles:

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

Although the principles are relevant to all states, each state needs to bring PHC under One Roof in ways that suit its particular circumstances. The differences between and among states mean that no single model should be imposed. This is the principle that "No one size fits all". Each state has to design or adapt its models and structures based on the listed principles but this will inevitably mean different ways to address implementation of "Bringing PHC under One Roof".

b) Checklist for monitoring progress

The checklist in Annex 2 is strongly recommended as a guideline for managers in the state health sector to assess progress, in addition to developing and implementing solutions to obstacles as they appear during the proposed quarterly review process. The checklist covers the following Themes:

Governance and Ownership

Legislation

Minimum Service Package (MSP)

Repositioning

PHC Systems Development

Operational Guidelines

Human Resources

Funding Structure and Sources of Funds

Infrastructure Establishment

The checklist should be seen as a guide and should be adapted for local use. Annex 2 illustrates how the checklist was utilised to do state level assessments in late 2012.

The nine Themes highlight different aspects that need to be considered in “Bringing PHC under One Roof”. Although there is overlap between the Themes, they are dealt with separately to emphasize the importance of different component Themes

Theme 1: GOVERNANCE AND OWNERSHIP

Key questions

Does your State health policy or other relevant documentation clearly state shared PHC responsibilities with the community?
Is there a balanced representation of community, official and political stakeholders on the PHC Board governing bodies at state and sub-state levels?
Does the Board have a clear understanding of the benefits of PHC?
Is the SPHCMB or SPHCDA served by a strong management team to implement its vision?

a) Overview

The governing body is crucial for setting the PHC vision, winning resources, and holding implementers to account. This role is sometimes called "stewardship

Primary Health Care Boards – No-one-size-fit-all

Under the proposed National Health Act, every state will need a single PHC Board whose job is to oversee and ensure the implementation of the state's approach to primary health care.

It is up to each state to decide how its PHC Board will operate, and what it will be called, provided it conforms to any mandatory requirements in the final National Health Act. Some states have called these governing bodies the "State PHC Management Board" or "State PHC Development Agency". In Jigawa the governing body is the "Gunduma Health Services Board".

Each PHC Board consists of a state-level *governing body* (which meets at least quarterly) and a *Board management team* (full-time employees). This structure is repeated at lower levels.

This Implementation Manual uses the term PHC Board for all State PHC Management Boards, State PHC Development Agencies and any other body charged with overseeing the development and delivery of PHC in the state.

The PHC Board's governing body needs a balanced inclusion of voices to:

establish a focus on the health needs of the entire population in the state

have a vision for how an integrated PHC approach can address these needs more effectively than current fragmented approaches

have the influence, power and authority to address these needs

drive improvement and hold implementers to account.

To achieve this, the governing body membership is likely to include community, professional, official and political interests. The governing body must include women and men, together with community leaders able to represent the needs of the whole population, particularly those groups who have been historically excluded or are otherwise often excluded.

One of the cornerstones of PHC is the involvement of communities in all aspects of health care. Often this is only partially addressed or not addressed at all. It is important for communities to be involved in the governing bodies of the SPHCMB or SPHCDA at both state and sub-state levels. In addition, communities need to be engaged in health care activities at ward, community and facility levels.

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

The governing body is not a body of experts or a manager, and must remain outside the day-to-day running of services. This requires one or more technical committees to provide specialist input to the Board, as well as a strong management team to transform Board vision and ideas into action.

a) Options

Careful consideration needs to be given to the scope, mandate and membership of a PHC Board's governing body. Although some or all of these issues may be subject to federal legislation, a state requires clarity about its needs and intentions, which in turn should inform the law enacted by the state House of Assembly and regulations adopted by the state.

The *scope* for the governing body includes broad issues of policy, accountability, and quality health care. Stakeholders need to consider not only services delivered by the state in health facilities, but other aspects of health care – for example, the regulation of private providers of health care (including faith-based facilities, traditional healers, sale of medicines and private doctors), public health emergencies such as epidemics, and wider determinants of health, such as sanitation.

The *mandate* of the PHC governing body needs to be considered. The PHC governing body needs a clear role, distinct from both the Board Management Team and the role of parliamentary or other official bodies. Thus, the Board will require statutory authority to hold the Board Management Team to account, but cannot intervene in day-to-day management of services, which would be very disruptive.

The *membership* of both state and sub-state governing bodies needs to reflect the desired balance of community and other members at state and sub-state levels. In addition, community involvement needs to be sought for and by ward development, village health and facility health committees, with structures differing from state to state. Representation of the health professions may be important on the governing body. There also needs to be adequate technical skills within the governing body, with the experience and expertise to advise the Board on clinical and financial matters.

The *design* of the governing body needs to reflect practical considerations, such as a reasonable duration of appointment, and realistic requirements, including time and costs for travel and meetings. If the number of Board members is too large, that is more than 12-15 members, it becomes harder to run a coherent body, reaching clear decisions.

Having agreed on these issues with stakeholders, legislation, and as appropriate regulations, should provide for clear criteria for PHC Board membership, including but not limited to processes for both appointment and election of Board members and conduct of meetings, issues discussed in Theme 2 Legislation. It is imperative that clear descriptions of criteria and the engagement expected from Board members and communities are carefully formulated, memorialised and documented. All documents need to be developed in conjunction with community members and leaders and then widely disseminated to Board members, each structure reporting to the Board, community leaders, community groups, and any interested person.

b) Challenges

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

Lip service is paid to community engagement

Traditionally, health service providers and managers have not paid enough attention to community involvement in and ownership of health services. An extensive change in mind-set enables communities to participate fully. It is not enough to appoint local people to the PHC Board and structures reporting to the Board. The Board and structures reporting to the Board must learn to use community members effectively. This may mean stronger local engagement to bring out local concerns, which can then be taken forward at sub-state and state levels.

Proceedings/processes do not allow for full participation

Timing of meetings, words used and other methods work against full community involvement, especially from grassroots community people. Care needs to be taken to ensure that all possible and innovative methods are developed for communities to become engaged in PHC delivery. Bottlenecks and other obstacles need to be identified, addressed and removed.

Women are marginalised

Historically men have been the participants. Specific notes in documents and selection/appointment criteria should emphasise the need for the involvement of women in structures at all levels.

Technical and secretarial support to governing bodies

An effective PHC Board, sub-state and facility level bodies need strong technical and practical support to ensure members are well informed and able to make good decisions. Members can only make limited commitments to work between meetings. The Board Management Team therefore needs to be ready to provide briefings and reports and provide an efficient secretariat to convene meetings, manage papers, agenda and provide prompt minutes. Support may be required to develop good working practices. A productive working relationship between the Board chair and Board Management Team is essential.

c) Necessary steps

STEP 1: *Engage stakeholders in agreeing on the scope, mandate, membership and design of the PHC Board governing body*. To ensure that women and community members are adequately represented on the governing structures at state and sub-state levels and at facility level, clear criteria need to be drawn up on the membership and the selection process. This needs to be done in conjunction with community members, leaders and groups. The working of the PHC Board and structures at state, sub-state and the facilities levels needs to be set out in easily understood laymen's language

STEP 2: *Ensure that the Law and Regulations reflect the agreed plan for the working of the PHC Board and structures at sub-state and facilities levels.* Following the passage of the new Bill and Regulations, the PHC Board and Board Management Team need to ensure that documents are drawn up highlighting the need for and explaining the process and mechanisms of community involvement. These documents need to be drawn up in conjunction with communities and not for or on behalf of communities.

STEP 3: *Widely explain and publicise the changes.* As proposed changes begin to produce a unified and decentralised PHC system, service delivery should improve because of clearer roles and responsibilities and the unification of the management of resources in the health system. It is important that State and LGA politicians and PHC service providers as well as other 'champions' of the system communicate these potential benefits to professional unions, health professions organisations, traditional and religious leaders and to the community at large. Their support will greatly enhance the proposed changes and ensure a smoother transition.

d) Indicators

Design of PHC Board and structures at sub-state and facilities levels agreed with key stakeholders, including but not limited to community representatives

Law and Regulations reflect agreed design of PHC Board and structures at sub-state and facilities levels

Governance processes widely explained and understood

Theme 2: LEGISLATION

Key questions

Has the State drafted a PHC Bill and Regulations?
Has the PHC Bill been passed by the State House of Assembly?
Has the PHC Bill been assented to by the Governor?
Have the Regulations been assented by the Governor or Commissioner of Health, as
Have the PHC Law and Regulations been gazetted?

a) Overview

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

There is a need for both legislation and regulations. Legislation, initially in the form of a Bill, is, in general terms, an enabling document and provides the long term view. It is anticipated that legislation may remain in place for 20 to 30 years or perhaps longer. A Bill needs to pass through the whole legislative process, including but not limited to being approved by both houses of the House of Assembly, including passing through the Health Committees of both houses and possibly including public hearings. Legislation is termed a “Bill” until passage by both houses, at which time it becomes a “Law”. A Law passed by both houses of the legislature then goes to the Governor for final assent. A Law comes into effect only after being signed by the Governor. Each step allows for alterations to the draft Bill and also can be bottlenecks (as with the National Health Bill).

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

It is critical that there is wide consultation on the development and passage of any Bill, with this true to a lesser extent for Regulations, which are more technical and should be developed to fulfil the vision contained in the resulting Law. Political, religious and traditional leaders, professional associations in the health sector and communities need to be consulted in the

development of a Bill addressing health. A Bill should reflect the aspirations of the people of the state. It is also critical that the processing of the Bill through the State Houses and by the Governor is monitored at all times to ensure that key aspects are not watered down or removed because they are not understood or for any other motive.

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

There is no time limit for consultation and depending on the level of acceptance or strong differences of opinion, the process can take from a few months to one year or more. This time is never wasted time because when most stakeholders buy in, the next steps could move very fast. It is also essential to note that consultation is an ongoing process that continues even after a Bill has been passed and becomes a Law, with the PHC Board established.

b) Options

The options available to states are to decide:

whether or not to bring PHC under One Roof

whether to focus solely on primary health care services or to include other components such as secondary hospital services

what sort of management structure should be provided in legislation

Opting in to PHCUOR

Most states have opted for "Bringing PHC under One Roof". Previously, PHC services have been delivered and managed by multiple roleplayers – for example the State Ministry of Health (SMOH), State Ministry of Local Government and Chieftaincy Affairs, (SMOLGCA,) LGAs, NPHCDA, Local Government Service Commission (LGSC), and more. States have thus drafted legislation to create one structure, generally either an SPHCMB or SPHCDA to manage all PHC services in the state.

Options for the Legislated Structure

In creating a single system for the management of PHC services, and in Jigawa State both PHC and secondary health care (SHC) services, states have created different management structures below the state level. These include:

in Jigawa, the Law created an overarching Gunduma Health Services Board and nine Gunduma Councils, each responsible for health services in two to four LGAs;

in some states, a SPHCMB or SPHCDA has been created, with zonal structures either created or strengthened (if pre-existing) to manage the PHC services in two to three LGAs; and

in some states the SPHCMB or SPHCDA deals directly with LGAs which provide PHC services.

In some states, the process started with PHC but there are plans to further the integration by including SHC services at a later stage.

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

Creating different management structures highlighted above is in alignment with three of the key principles of "Bringing PHC under One Roof" as agreed to by the National Council on Health (NCH).

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

The different structures that have been adopted reflect the principle of no-one-size-fits-all and the need for states to tailor their approach and legislation to fit their state context and needs.

a) Challenges

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

Time

Many people want legislation to be developed as soon as possible. This contradicts the critical need for adequate consultation, developing a full understanding and creating ownership of the process and the product. All this takes time. It is important for key stakeholders to discuss and understand the implications of the transformational shift in how health services are delivered and managed. This may require exposure to states in Nigeria which have already embarked on the process and possibly to countries, for example Ghana, which followed this route two decades ago. The requirement of change and not taking too long, together with providing for adequate time, should be fully considered to ensure the planned and implemented structure may be implemented without challenges down the road.

Process (Consultations)

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

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

Budget implications

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

Bill and Regulations

As discussed, there needs to be both a Bill and Regulations. The Bill won't provide enough details for the health managers to implement what is required. Far too often, the focus is on the Bill, with Regulations only developed belatedly after the Bill has become Law. It is strongly suggested that a Bill and Regulations thereunder are developed at the same time. When the Law is assented to by the Governor, Regulations can then be signed, by the Governor or Commissioner for Health, as required by applicable state law.

Altering the Bill (Legislative Process)

One of the common problems is that a draft Bill can be and often is substantially revised in the course of its passage through the legislative process. Some alterations should be expected. But if substantive changes are made, this could impact on the suitability of the final version and the viability of PHC service delivery. For example, the Enugu Bill, assented to and becoming a Law in 2005, was altered at the last minute to allow for the creation of 56 local management areas – in addition to districts and LGAs. This created an unwieldy and expensive management structure. The Law is only now being reviewed to resolve the issue.

It is strongly recommended that a committee be formed to shepherd and monitor the Bill through the legislative process to its assent by the Governor. The committee should be senior enough to advise politicians of the implications, as well as the costs, of any substantive changes.

b) Necessary steps

STEP 1: *Build strong consensus among all stakeholders* including government structures, for example the SMOH, SMOLGCA, LGSC, State Ministry of Finance, SMOJ, State Civil Service Commission and State Ministry of Women Affairs; legislators; LGA council chairmen, council and management; partners, community-based organisations, professional groups; traditional and religious leaders; private health professionals.

STEP 2: *Involvement of LGA chairmen and PHC co-ordinators and teams.* It is critical that local government politicians and health service providers are included in the discussions to build the necessary consensus for the envisaged changes. Representatives from local government need to be included in the technical committee. Because some of the expected changes will affect

how local government personnel and finances are managed, it is key that they are part and parcel of the planned changes.

STEP 3: *Establish a technical committee* to facilitate the process and drafting of a law utilising clear guidelines from the Federal Ministry of Health (FMOH) and NPHCDA and aligned with the National Health Bill. The committee should be comprised of representatives from line ministries, as noted in Step 1, and relevant stakeholders. Different states have adopted different approaches to the committee step. In Jigawa, one committee drove the process from beginning to end. In other states, there have been several committees – for example, one committee to draft the proposal, another to oversee the implementation and yet another for the repositioning.

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

It is critical that enough time is spent on the first four steps. Restructuring services is a major task and will take at least five to ten years to complete. It is important that all stakeholders understand the implications, the challenges and the benefits of the proposed changes. There will be those who are reluctant to change for a variety of reasons. However, through structured workshops and retreats, possible study tours to areas where such changes have occurred and an ongoing advocacy and information campaign, most of these concerns can be addressed. But it is important that people are not hurried through these steps.

STEP 5: *Develop the Bill and Regulations thereunder* to support the establishment of a SPHCMB or SPHCDA and relevant lower level health structures and to address transitional measures, for example staffing, financing and structures/services. This is a critical area and states will need to draw on both legal and health policy expertise in these areas. Health and legal experts should be both from within and without the state. Consider using international advisors, if necessary and if funds permit.

c) Indicators

Establishment of one or more technical committees comprised of senior government and other stakeholder representatives

Develop Bill and submission to the state House of Assembly

Law assented to by the Governor

Regulations developed and assented to by the Governor or Commissioner for Health, as relevant under state law

Stakeholders aware of and satisfied with the PHC Board, structures at sub-state and facilities levels, and management arrangements

Theme 3: MINIMUM SERVICE PACKAGE

Key questions

Has your State adopted a Minimum Service Package (MSP) for different facility
Has your State developed a facility assessment and investment plan?
Has your State monitoring team regularly, that is no less than annually, evaluated MSP resource gaps?
Are your State PHC service improvement activities based on a ward health system and statewide facility investment plan?

a) Overview

The key objective for "Bringing PHC under One Roof" is to ensure increased coverage and the quality of health services, as well as access to services at all levels. The adoption of the MSP approach allows states to classify their facilities according to the adopted system and then determine resource needs for each facility. The FMOH and the NPHCDA have been advocating this approach for many years. However, in many states there are still far too many types of facilities and no uniformity in the naming of the different types of facilities and thus there is confusion around the services to be offered by and the resources - human, equipment, drugs and commodities, finances – needed for each facility.

The NPHCDA has developed guidelines on Minimum Standards for PHC in Nigeria, which allow states to classify their facilities into a few basic types. From this classification flows standard resource packages that can then be tailored to the size and business of each facility. The NPHCDA is currently reviewing the costing of these standard packages. Realistic costing of the standard packages of health services will then assist states with determining and allocating resources more wisely. In addition, it will allow states to develop statewide health facility investment plans that can be used to advocate resources and the allocation of these resources to government and development partners.

b) Options

It is important that the new structure, SPHCMB, SPHCDA or equivalent, adopt the MSP approach. This will allow the SPHCMB or SPHCDA to determine its options based on a rational classification of facilities, for the allocation and distribution of resources – human, equipment, drugs and commodities, finances – and for the development of an investment plan that will guide resource allocation in the future.

Various tools exist. The NPHCDA is currently reviewing a set of three tools for clinical services, human resources and facility investment costs. Whatever tool is used, SPHCMB or SPHCDA Board Management Teams and, as appropriate, heads of structures at sub-state and facilities levels will require training in the use of the tools and support in their analysis and interpretation. As with the MSP, this needs to be included in the budget and appropriate funds sourced from government or development partners.

The Repositioning and other Themes highlight the requirements for staffing and finance. Defining the MSP will assist in discussions and negotiations around the transfer of staff and also in the development of appropriate budgets for the functioning of health facilities managed by the new SPHCMB or SPHCDA.

c) Challenges

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

Challenges to classification of facilities

Classification of facilities has a strong political dimension. Communities and leaders often do not take kindly to facility classifications being changed. While many understand the reality that each community cannot have a hospital, communities and their leaders normally work hard to retain, upgrade or win facilities within their communities – even though outside planners may believe that the public health would be better served by using limited resources in other ways. Thus, this aspect of the MSP has to be addressed in a politically sensitive manner. Ideally, a transformation or repositioning committee should drive this process with full communication with and the support of the Governor and the Commissioner for Health. It is critical to understand that facilities classification is an extremely important step on which the rest of the MSP tools depends. Without classification, service provision and resource needs cannot be determined.

Incorrect use of the MSP tool

Although the tool is not that complex, it is suggested that the SPHCMB or SPHCDA Board Management Team undergo training in the use of the tool. If not, the use and interpretation of the results may be problematic.

Free Mother and Child Health (MCH) services

Many Governors have declared free MCH services in their states. Although there may not be resources to implement this fully, politicians are often understandably reluctant to backtrack on their promises. This needs to be addressed in a politically sensitive manner. It is advisable that the transformation committee or another such high level committee or person, for example the Commissioner for Health, drive this process. Exploring the option of collaborating with the National Health Insurance Scheme is also critical to leverage resources and enhance the role of free quality MCH services.

Challenges to allocation of resources - Buildings and Equipment

The MSP provides the framework for considering what each level of facility needs in terms of physical infrastructure and equipment. The MSP provides a basis for setting out a rational plan for improving and managing these, and will help managers resist pressures for facilities, vehicles and equipment that are not affordable and sustainable.

Many politicians are involved in constructing new buildings and procuring new equipment, which usually consume large resources as capital projects, without addressing the usefulness

and operational costs of such investments. The traction to place expensive capital projects based on political considerations rather than technical needs often distorts any health investment plans and renders investments useless to the host communities. This is a major challenge, which is entangled with political patronage at variance with good governance which promotes accountability, transparency and responsiveness as epitomised in MSP implementation. As mentioned previously, there is a need to address this and similar issues in a politically sensitive manner to avoid tearing the PHCUOR apart.

d) Necessary steps

STEP 1: *SPHCMB or SPHCDA adopts the MSP policy.* A key technical step is for the new SPHCMB or SPHCDA Board Management Team to adopt the MSP approach. To do this the Board Management Team needs to review current available tools and adopt/adapt a tool to suit its purposes. As noted, the NPHCDA is currently reviewing a set of three tools that states can consider using and the SPHCMB or SPHCDA and its Board Management Team will need training on the use of the tool or tools. This needs to be budgeted for and funds sourced from government or development partners.

STEP 2: *SPHCMB (or SPHCDA) utilizes the MSP approach to assist in the classification of facilities and the allocation of resources.* Once management capacity has been built in the use of the tools, the SPHCMB or SPHCDA should use the relevant tool in the classification of facilities and the allocation of current and future resources. With political elements in the classification of facilities, the SPHCMB or SPHCDA needs to work closely with the transformation committee. In addition, communication with other leaders and community structures is vital.

STEP 3: *Use of the MSP tool for developing free MCH services.* As noted, many state Governors have declared that MCH services are free at the point of service. However, this has not been costed in most states and the requisite resources are not necessarily available at facilities to provide free MCH services. The MSP tool allows for MCH services to be costed. Individual elements, for example Antenatal Care services, Emergency Obstetric Care services, Integrated Management of Childhood Illnesses services, can be costed and then combined to give a complete picture. This then allows states to introduce elements of the free MCH services in a sequential fashion dependent on budget availability. Eventually, the complete free MCH package can be provided.

e) Indicators

State adopts ward health system and MSP policy

State classification of health facilities aligned with NPHCDA guidelines on Minimum Standards is established

MSP utilized to guide investment plan

Theme 4: REPOSITIONING

Key questions

a) Overview

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

The Minimum Package of Services (addressed in Theme 3)

Human Resources (Theme 7)

Finance Sources and Structures (Theme 8)

Management

This Theme deals primarily with the management issues.

The Bill/Law and Regulations thereunder should specify the functions, roles and responsibilities of the new SPHCMB, SPHCDA or other governing body.

The Bill/Law and Regulations thereunder should also specify what functions, roles and responsibilities will be transferred from existing bodies, for example the SMOH or SMOLG. The Bill/Law and Regulations thereunder might also specify the categories of existing bodies to be closed down. Following through these responsibilities will require firm and sometimes difficult decisions about changes required in existing and new bodies, as well as clear policies and fair practice in managing circumstances of individual staff.

Even the best managed restructuring creates uncertainty and concern among personnel, and can impair functioning of existing and new management structures. It can also lead to resistance and blocking of changes.

Thus, it is critical that all management are conversant with and attuned to the relevant provisions in the new Bill/Law and Regulations and that they understand their functions, roles and responsibilities in relation to the new structures that the Law and Regulations create.

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

b) Options

Re-orientation and capacity development

Restructuring is only the beginning of the repositioning process. Political leaders and managers need to address two key activities:

winning the commitment of staff to new ways of working – re-orientation

learning new ways to do so – capacity building

States need to consider their options for the scope and levels of their re-orientation. They may choose to focus on particular groups of staff, such as senior managers and facility managers, whose support is most crucial for repositioning or include all health workers and perhaps even community structures, although different groups will require using different methods. The Bill/Law and Regulations need to be utilised to guide the re-orientation. Adequate time needs to be allocated to the process and facilitators need to encourage frank and open discussion.

Managers also need to plan how to build effective capacity among a large workforce. Commonly, the focus of capacity building programmes starts with managers, especially those managers in the new structures. They, in turn, will lead the managerial and technical development of staff throughout the PHC system.

c) Challenges

There are four key challenges that states need to consider as they deal with the repositioning.

Involvement of all stakeholders

Just as choices about governance engage a wide range of stakeholders, stakeholder involvement is essential in implementing the new structures, as defined in the Law and Regulations, and repositioning staff to operate the new structures effectively. It is especially critical that health workers on the ground, their professional bodies and local management structures are involved in the re-orientation. The process needs to cascade from state to LGA levels, as well as to facility and community levels. It is key that the SMOLGCA and any other state level body that has previously been involved in health care delivery be involved. Repositioning involves hard decisions, but failure to ensure that all health workers and community members understand and support repositioning can lead to poorly implemented systems, misunderstandings, resistance to change, and, ultimately, failure to improve service and of "Bringing PHC under One Roof"..

Funding

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

Nature of capacity building (CB) programme

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

Resistance to change

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

d) Necessary steps

STEP 1: *Repositioning of SMOH, State Hospital Management Board and other structures for their new functions and roles*. Passage and enactment of the Bill/Act, enactment of Regulations and creation of new structures with different arrangements, particularly for finance, human resource management and service provision, will require changes in and understanding of the roles and responsibilities of existing and new bodies and should be addressed sensitively at each stage and in each situation. It is critical to understand this and create the space and time for the bodies to adapt to new situations. All bodies, both old and new, will require responsive support throughout the repositioning process.

STEP 2: *Support for the repositioning process at LGA level.* After passage and enactment of the Bill/Act and the enactment of Regulations, it is important that LGAs and existing PHC departments, within state and local government levels, support the restructuring process. The management of human resources (HR), finance and service delivery will all change. The process will be far smoother if the LGAs have been part of the process from the beginning, their concerns are understood and they are allowed to play a full part in the repositioning activities.

STEP 3: *Orientation and team building of staff and community members for their new roles*. With the changing environment and the movement of staff, it is vital that all staff are oriented with respect to new structural arrangements and the roles and responsibilities of the different bodies. LGA and PHC health personnel and community members, especially ward development and facility health committees, will be key in each of these processes. The Bill/Law and the Regulations thereunder must be used to guide discussions and change.

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

time for participants to share challenges, successes and to discuss solutions

input from facilitators and experts tailored to the specific local context – this might be on human resources, health management information systems, drug supply or other areas.

technical support, facilitation and mentoring for team projects, innovations and assignments, providing direct improvements to services on the ground

e) Indicators

Roles and responsibilities of all structures established

Capacity building programme for managers functioning

Theme 5: PHC SYSTEMS DEVELOPMENT

Key questions

Is the structure of the PHC System in line with the principles of the 'three ones" (**one management, one plan and one M&E system)**
Has your State appointed an SPHCMB or SPHCDA Governing Board?
Has the SPHCMB or SPHCDA developed a Strategic Health Plan usually for five years and annual costed operational planning?
Has the SPHCMB or SPHCDA developed and implemented financial management policies?
Has the SPHCMB or SPHCDA developed and implemented Integrated Supportive Supervision policies and plans?
Has the SPHCMB or SPHCDA developed and implemented Performance Management policies and plans?

a) Overview

Governance and management systems need to reflect the needs of stakeholders (Theme 1), and to be implemented pursuant to legislation (Theme 2).

State legislation will establish the new structure, an SPHCMB, SPHCDA or equivalent with a number of elements. At each level there is a governing body, usually termed the Board and a Board Management Team. At state level, the governing body is composed of respected political, religious, traditional and technical leaders. The Board is required to meet on a regular basis and ensure the delivery of PHC services.. The head of the Board Management Team, termed Executive Secretary, Executive Director or functional equivalent, whose duties are defined by law, reports to the Board. Usually the Bill/Act requires the Governor to appoint the Executive Secretary, Executive Director or functional equivalent. The Board approves the strategic health plan and overall annual plan, including but not limited to a detailed budget, and oversees the development of and monitors the implementation of policy. Policies will cover all systems areas, including but not limited to finance, human resource, performance management, and supply chain management. Policies will be developed by the Board Management Team and approved by the Board. All policies need to be aligned with relevant national and state government policies. The Board Management Team is comprised of health and other professionals specified in the Bill/Law and regulations thereunder.

At sub-state levels, this structure can duplicate itself. There might be a governing body, again established by law. This can be called various names, for example Local Government Health Authority, Zonal Council or Area Health Committee. The relevant governing body oversees the functioning of its full-time management team at this level but usually has no role in policy development, which is reserved to the SPHCMB or SPHCDA Board. Sub-state structures also provide a link to the community within defined geographical boundaries.

Line function management resides with the full-time management teams. At the sub-state level the relevant management team oversees the functioning of the PHC facilities (and if the new structure integrates both PHC and SHC services, hospitals) within its geographical boundaries. In turn, the sub-state management team reports to and is managed by the Board Management Team.

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

b) Options

The structures that can be created at state and sub-state level vary enormously across the states and again reflect on the no-one-size-fits-all principle. The structures should be determined in the state Bill/Law and Regulations, with line function management clearly specified.

Policy development needs to be aligned with national and state policies follow the principles

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

a) Challenges

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

Appointment of inappropriate people

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

Lack of clear distinction between governing body and management team

Inherent in the design, as encapsulated in the Law and Regulations, is the need to clearly define the role of politicians and administrators. This is played out in the respective roles and functions

of the governing bodies and the management teams. For many years, this distinction has not been clear and has led to inappropriate interference in the functioning and management of the health services. Often this has had disastrous effects.

Thus, the new Law and Regulations must clarify the roles and responsibilities of the politicians, the state and sub-state governing bodies and related management structures. For example, the Law/Regulations should specify that the Governor is usually responsible for approving the appointment of the governing body and the Executive Secretary, Executive Director or functional equivalent of the Board and ensure that LGA chairmen are represented on the governing bodies. Line function management should rest with the full-time Board and sub-state management teams. The Board has the overall responsibility for policy development and approval and oversight of the Board and sub-state management teams. However, governing bodies are not entitled to become involved in the day-to-day management of the health service. That is entrusted to the Board Management Teams and sub-state management teams.

Gender imbalances in the governing bodies

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

b) Necessary steps

STEP 1: Ensure that the transformation committee drives the process of establishing the SPHCMB, SPHCDA or equivalent and Board and sub-state management teams to manage the new system. It is key that the appointment of the Board and sub-state governing bodies and the Board Management Teams and sub-state management teams follow a fair and transparent process, which is consonant with the political aspirations of the state. The transformation committee, which is a senior committee usually appointed by the Governor, should oversee the process. In addition, the transformation committee needs to communicate progress regularly to all stakeholders, notably including the Governor and Commissioner for Health.

STEP 2: Establish the SPHCMB, SPHCDA or equivalent and management teams to manage the new system. An essential requirement for effective integration is that existing PHC staff, including staff currently employed by an LGA, LGSC and/or SMOH, will all come under the management of the SPHCMB or SPHCDA and the decentralised structures that are created. Payment of staff will be through the SPHCMB or SPHCDA. Recruitment and equitable distribution of staff will be the responsibility of the SPHCMB or SPHCDA. Similarly, finances will fall under the SPHCMB or SPHCDA. This will entail consolidating health funds that currently fall under LGAs, the SMOH, the SMOLG and any other bodies. At this stage, with managerial control over finances and human resources, the SPHCMB or SPHCDA will be empowered to manage and provide health services. Usually, the health services provided will fall in line with the MSP adapted from federal level guidelines

STEP 3: Establishment of sub-state health authorities. As previously stated, there is no-one-size-fits-all approach. For example, in Jigawa there is the Gunduma Board and nine Gunduma

Councils, each covering two or three LGAs; and in Enugu there is the State Health Board, seven District Health Boards, each comprising two or three LGAs, 17 districts and 56 Local Health Authorities. The key principles for establishing lower level structures are:

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

c) Indicators

- Governing body and management structure fully functional at all levels
- PHC system established in line with the principle of ''three ones''
- Clear lines of accountability and communication established in the system

Theme 6: OPERATIONAL GUIDELINES

Key questions

Has your State established rules and constitution for its Board
Has your State drafted management policies and procedures for the functioning of the Board?
Has your State established HR, M&E, Accounting and other procedures/protocols?

a) Overview

States normally have well developed policies and procedures for human resource management, procurement/supply chain management (SCM), accounting/financial management and M&E. In most, if not all, of the new Bills/Laws and Regulations thereunder the creation of the new SPHCMB or SPHCDA is accompanied by statutory requirements for the SPHCMB or SPHCDA to develop specific policies, procedures and protocols related to these administrative areas. The Bill/Law and/or Regulations specify which entity is responsible for developing the policies, procedures and protocols and time frames within which they must be developed. It is critical for policies, procedures and protocols to be developed in written form and aligned with relevant national and state policies, protocols and procedures.

b) Options

One of the first tasks of the SPHCMB or SPHCDA Board Management Team is to review the new Law and Regulations thereunder and to extract all the tasks that need to be completed. Then the Board Management Team needs to embark on the development of required policies, protocols and procedures.

c) Challenges

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

Failure to develop and assent to Regulations

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

Failure to determine tasks required to fulfil the Law and Regulations

The new Law and Regulations thereunder can only set out a high level framework for governance and management. Fulfilling these depends on building effective systems, operational practice and guidelines.

In practice, few states, and the PHC Board management teams in those states, have reviewed its Law and Regulations thereunder and extracted the tasks that need to be completed within the prescribed time period.

Both Boards and Board Management Teams may lack experience in building new, successful institutions. Politicians and funders may underestimate the time, skills, funds and resources required to implement the changes required. Establishing a realistic plan for all operational procedures and guidelines is essential.

d) Necessary steps

STEP 1: Review the new Law and Regulations. It is essential for the SPHCMB or SPHCDA Board and Board Management Team to review the new Law and Regulations and extract the key tasks to be completed within specified time frames. Key tasks need to be compiled in an action list, inclusive of timelines and stating responsibility for various obligations. The Board and Board Management Team should track progress at each Board and Board Management Team meeting to ensure that timelines are met.

STEP 2: Agree on a plan and obtain the resources required. Without a realistic plan to establish operational procedures and guidelines, these will only be produced late, if at all.

STEP 3: Finalise the administrative procedures and distribute them to relevant personnel. Policies, protocols and procedures need to be finalised according to timelines noted in step 1. These need to be aligned with relevant national and state policies, protocols and procedures. Once completed, they should be distributed to all relevant health workers falling under the SPHCMB or SPHCDA. In addition, training and orientation on all new administrative procedures needs to be undertaken. This should be budgeted for and funds sourced either from government or development partners.

e) Indicators

- Costed plan and timetable for establishing procedures and operational guidelines
- Management policies and procedures established.
- Policies and procedures for HRM, procurement/SCM, accounting/financial management and M&E established

Theme 7: HUMAN RESOURCES

Key questions

Has your State established a high level HR Committee
Has your State established an HR department or unit with requisite staff and capacity?
Has your State compiled an accurate staff database, that is established a HR Information System (HRIS)?
Has your State developed staffing requirements and affordable norms for different facility types in the MSP?
Has your State developed Job Descriptions for facility staff and managers?

a) Overview

Human resource management is one of the fundamental challenges facing any new structure. There are four overriding and interlinked issues.

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

The second issue relates to the appointment of management staff at state and sub-state levels. Appointment of managers in the new state level structure is addressed under Theme 5 PHC Systems Development, with the centrality of the transformation committee in ensuring a fair and transparent process and that the right people are selected for the Board and Board Management Team. A similar approach needs to be followed for the selection and appointment of the sub-state governing body or bodies and management teams.

The third issue relates to the inherited problems of maldistribution of staff, ghost workers and imbalance between professional and non-professional cadres. This is an issue that has political undertones and again highlights the delicate dance between governance and systems that the SPHCMB or SPHCDA Board and the Board Management Team need to begin addressing immediately.

A fourth issue is that the state may suffer shortages of adequately trained professional staff, for example midwives, lab technicians and doctors. The lead-time to train and develop these staff makes it essential to plan how to train, attract and retain staff, particularly for less attractive postings.

b) Options

Adequate resources for planning and managing HR are critical for success. Budgeted funds will be needed for staffing or temporary support, and to manage data relating to many hundreds or thousands of posts and staff. States may want to establish a specialist HR function at an early stage as a critical component for driving repositioning and development.

In general, the best approach is to start by getting a clear cut audit of existing staff, preferably using a HRIS database. This will form the basis for much of the work that will flow from this Theme.

Movement of staff is a critical issue. Staff are accountable to those who manage and pay them. Thus, it is critical for the new SPHCMB or SPHCDA Board to manage and remunerate all PHC staff and where relevant, SHC staff. The data in the HRIS will establish the numbers and the types of staff available. But, there are other issues to consider. Some of the health functions, usually environmental health, will remain with LGAs and not be transferred to the new SPHCMB or SPHCDA Board. In addition, there might be an excess of non-professional staff, for example security staff and cleaners. All these might not be needed in the new SPHCMB or SPHCDA Board run facilities. They could be retained and redeployed by the LGAs. In addition, with the adoption of the MSP as addressed in Theme 4, the new SPHCMB or SPHCDA Board should have a clearer idea of the number and type of staff needed at each facility. All these will inform the need for staff in the new SPHCDB or SPHCDA run facilities. Thus, it is imperative for the new SPHCMB or SPHCDA to do all the groundwork and then negotiate with the old employing structures for the staff they need to run their facilities.

The SPHCMB or SPHCDA Board will oversee the selection and appointment processes of sub-state governing bodies and management teams. As at state level, job descriptions need to be developed and fair and transparent selection processes adopted. It is critical for the health systems transformation initiative, “Bringing PHC under One Roof”, for the right people to be chosen to fill positions. Thus care needs to be taken to ensure the right outcomes. Communication with state and LGA politicians and other community leaders and structures is vital.

Maldistribution, ghost workers and the balance between types of staff are all highly charged political issues. The approach of developing the HRIS, using the MSP, classifying facilities correctly and determining the staff needs of each facility will assist the new SPHCMB or SPHCDA Board in logically determining staff needs. However, to address the political dimension it is important for the high profile transformation committee (or a similar HR committee) to drive the process. This committee also needs to liaise and communicate with the relevant politicians, including but not limited to the Governor, Commissioner for Health and LGA Chairmen, and communicate with other leaders and community structures.

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

c) Challenges

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

HR committee not senior enough

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

Technical steps not adequately followed

There is often a tendency to fast track the process. However, the key steps outlined below will need to be followed to ensure that the HR committee has all the requisite information to guide their deliberations and actions, and enough staff and resources to manage the process from the start. The establishment and capacity building of the HR department or unit must not be overlooked as this is the backbone for information gathering, collation and analysis which the HR committee will use to advocate around HR governance issues and to ensure that sound and established HR policies, plans and practices are developed and implemented.

Resistance to change

There will be health workers who, for a variety of reasons, will not want to move. There will be LGA chairmen who do not want to relinquish staff, again for a variety of reasons. As with other aspects of the transformation, the key actors driving the different processes need to be aware of this and make provision for this and related issues. Communication and advocacy are key tools in their armamentarium.

d) Necessary steps

STEP 1: Establishing a high profile HR committee. This is a key step. Most HR issues have governance and/or political dimensions. Simply adopting a technical approach will not suffice. Thus, the HR committee needs to be comprised of sufficiently high profile individuals with excellent links with state political actors. Preferably, each HR committee should be linked or aligned with the transformation committee. Each HR committee will require orientation and most likely training on such issues as the HRIS and the MSP. In addition, the HR Committee will need ongoing technical support. Again this needs to be budgeted for and funds sourced.

STEP 2: Establishing an HR department or unit and providing technical resource. HR requires strategic vision, management authority, technical expertise, administrative capacity and good information systems. The requirement depends on which HR functions are managed directly by the PHC Board. The HR Director, by whatever title, is essential to the management team. Planning and providing this function early is essential to the other steps.

STEP 3: Establishing an HRIS database of existing staff. It is critical that the new SPHCMB, SPHCDA or its equivalent establish the current HR situation and then link this to HR needs based on a MSP approach. To do this effectively, the SPHCMB or SPHCDA Board needs to utilize a HRIS. Currently, in some states a software tool called "HRPlanner" is being used for this process. States most likely will need external consultant assistance to develop this database and receive training to maintain it. Thus either funds need to be sourced from government or from interested development partners.

STEP 4: Using the MSP to determine HR needs at all facilities. This is a key technical step. The MSP addressed in Theme 3 should be used to classify all facilities and thus determine the mix and numbers of staff required for each facility. The MSP can then be loaded on the HRIS and used to negotiate the transfer of current existing staff and also to recruit additional new staff. The MSP should also be used for planning pre-service and in-service training needs, and discussions with training institutions.

STEP 5: Negotiating with previous employers, particularly LGAs, with respect to movement of staff. After the numbers have been crunched, the HR committee can negotiate with the previous employees concerning the number and types of staff to transfer to the new SPHCMB or SPHCDA run facilities. In the process, certain staff will remain with their previous employers and either be utilized to fulfill functions that are not transferred, for example environmental health, or redeployed within other departments. With the transfer of staff will come the transfer of funding to pay staff.

STEP 6: Selecting/appointing sub-state governing bodies and management teams. As previously noted, selecting and appointment of sub-state bodies and management teams will follow the selection/appointment of the state level Board and Board Management Team. The Board and Board Management Team will be responsible for the overall management of the process pursuant to state recruitment processes. It is critical that the process is fair and transparent and also seen to be fair and transparent. Thus job descriptions and selection processes need to be developed and shared widely.

STEP 7: Communicating widely the processes, changes and outcomes. Any change creates uncertainty and fear of the unknown. It is vital that all aspects of the change are communicated widely to the different stakeholders in the state.

e) Indicators

- High profile HR Committee in operation
- HR department/unit with HR director/unit head and team established
- Up-to-date information about existing staff available from HRIS
- Staff movement and redistribution within health facilities established in line with MSP
- Staff paid by new management body
- All key HRH functions reside with the new Board and management team

Theme 8: FINANCE SOURCES AND STRUCTURE

Key questions

Has your State released a PHC Board take-off grant?
Has your State established a dedicated budget process for planned PHC expenditure?
Does your State have a system for tracking the release of budgeted funds?
Has your State developed mechanisms for contributions from different role players?
Has your State set up a pooled fund for services/operations?

a) Overview

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

It is critical that the SPHCMB or SPHCDA Board develop systems and processes to ensure that plans are developed and costed; that these are included in the annual budgets of the SMOH and successfully defended; and that budget release is tracked. It is also critical to develop an effective M&E system and to provide for an independent annual audit to ensure the SPHCMB or SPHCDA Board can show state government how the money has been spent and with what effect and impact.

b) Options

Some states have adopted pooled funding mechanisms. This allows the state, LGAs and development partners to contribute to the management and running of services provided by the SPHCMB or SPHCDA Board. These funding mechanisms need adequate checks and balances to ensure that money is spent according to the detailed budget in the Annual Operational Plan.

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

Whatever options are chosen, it is critical that the SPHCMB or SPHCDA Board develop appropriate financial processes and procedures to cost plans, budget for activities and ensure that the money allocated is spent wisely in terms of the detailed budget in the Annual Operational Plan and that expenditure/releases from government is tracked and audited. This needs to be encapsulated in a financial manual developed by the Board Management Team and approved by the Board.

c) Challenges

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

Inadequate planning and budgeting processes

Most states have poor capacity when it comes to annual planning and budgeting. Plans are often rolled over from year to year. It is vital that the SPHCMB (or SPHCDA) develop the capacity for annual planning and budgeting, including the development of viable Annual Operational Plans.

Lack of effective M&E and audit systems

If policy makers and politicians are not made aware of how allocated funds have been utilised and what differences the funds have made, they might not be prepared to be as generous in the future. The SPHCMB or SPHCDA Board needs to develop an effective M&E system with indicators showing outputs, outcomes and impact and an independent audit process. These are very powerful tools that are not utilised often enough.

Poor release of funds and budget tracking

Budgeted funds often go unreleased and thus unspent, resulting in the frustration of PHC development plans, including Annual Operational Plans. There are many causes for failure to spend agreed budgets. Regular reports of expenditure against budget highlight where expenditure is behind plan.

Little is done at state level to track budget releases and measure budget performance. The SPHCMB or SPHCDA Board needs to develop the capacity to track and measure, and to ensure that budget performance gets proper attention by the Board and Board Management Team.

Common causes for non-release of budgeted funds include over-projecting expected income; cash flow problems or reprioritisation of funds by Federal or State government; delays or failures in procurement; administrative weaknesses in processing purchases and payments; and internal delays in implementing work plans. Whatever the reason, prompt budget tracking is essential to identify and address the problem.

Procurement delays

Procurement systems are often weak, or may be poorly understood by new managers. Managers may need training to understand the steps and time required to order supplies and equipment.

d) Necessary steps

STEP 1: Develop the capacity to plan, budget and track release of funds. It is imperative for the SPHCMB or SPHCDA Board Management Team to have the capacity to plan, budget and track budget releases. This capacity will need to be built, most likely through external support and training. Funds for this need to be sourced from government or external development partners.

STEP 2: Create a planning and budgeting committee. This should be the engine house for this area of activity in the SPHCMB or SPHCDA Board. It is critical that competent and senior people are on this committee. The committee also needs to have connections to those in power, including the Governor and the Commissioner for Health, to ensure their concerns and deliberations can be aired. Again, the capacity of this committee will need to be built.

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

e) Indicators

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

Theme 9: OFFICE SET-UP

Key questions

Has your State selected SPHCMB or SPHCDA Board offices at State and Sub-State levels?
Has your State renovated and/or furnished PHC Board office space?
Has your State handed over the office space to PHC Board?
Has your State met work environment needs, for example vehicles, computers, internet, and other requirements?
Has your State selected SPHCMB or SPHCDA Board offices at State and Sub-State levels?

a) Overview

The Minimum Service Package in Theme 3 addresses practical needs of health facilities for buildings, equipment and supplies. It is also key that suitable offices are found for the state and sub-state level management teams. In addition, the tools of the trade, for example vehicles and computers, need to be made available to enable the SPHCMB or SPHCDA Board Management Teams to perform their duties. Most states have allocated a start-up grant to fast track this process and then allowed for the inclusion of costed plans to be included in the state budget for the upcoming year.

b) Options

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

c) Challenges

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

Inadequate funding released/ poor budget determination

Although funding could be released, this might be inadequate for the needs of the SPHCMB or SPHCDA Board and Board Management Team. It is important that the transformation committee, or whoever is discussing the amount to be released with the Governor, draws up a clear costed start up plan. This will help in the discussions with the Governor. Further, SMOH representatives need to be involved in this process.

Unsuitable offices selected

Selection of offices is key - both at state level and sub-state level. It is important that the transformation committee draw up clear criteria to guide the selection process and that these are then used by the team looking for offices. If not, there is a serious concern that inappropriate offices, for example offices that are too small or in an inappropriate location, will be chosen. This will make it difficult for the SPHCMB or SPHCDA Board and the sub-state management teams to function effectively.

Sub-state structures neglected

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

d) Necessary steps

STEP 1: Develop start up budget and plans. Development of the start-up budget, including an Annual Operational Plan with a detailed budget, is critical before the transformation committee approaches the Governor for the release of a start-up budget. Further, it is critical to ensure that realistic office costs and equipment costs are budgeted for at both state and sub-state levels.

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

e) Indicators

- Offices at all levels established

2. Supportive Steps at Federal Level

The entire PHC process will require high level advocacy to state governors, including clear messages on the need for and benefits of "Bringing PHC under One Roof". In addition, there needs to be, throughout the process, an extensive communication and advocacy campaign to keep all stakeholders informed of progress and issues/challenges.

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

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

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

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

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

agents required for this transformation. Thus, a carefully-planned advocacy campaign needs to be developed and implemented.

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

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

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

3. Indicators/Targets

It is key that a small set of indicators is developed that cover each of the nine Themes. For each indicator, targets can be established.

Development of targets will be a state-specific activity. Suggested indicators are offered below. For some indicators, targets are offered for three years, but, if necessary, a longer timeframe can be envisioned and the targets adapted. States need to agree on their own set of indicators and determine annual targets based on the context and stage of development in their state.

Some Themes depend on previous Themes being completed. For example it will be necessary for the Law to be signed before money can be released or staff moved. This complex web of issues needs to be taken into consideration when developing state-specific targets.

Indicator	Target Y1	Target Y2	Target Y3
Governance and Ownership			
Design of PHC Board and structures at sub- state and facilities levels agreed with key stakeholders, including but not limited to community representatives			
Law and Regulations reflect agreed design of PHC Board and structures at sub-state and facilities levels			
Governance processes widely explained and understood	Criteria for selection of community members agreed	Representative community members elected to all governing bodies, including Board and state sub-structures	Community members trained on expected roles and responsibilities
Legislation			
Technical committee established	Committee established and comprised of senior government and stakeholder representatives	Committee functional and leading transformation	
Bill passed into Law	Bill drafted	Bill approved by state Houses, at which point it becomes a Law	Law assented to by Governor, at which time it comes into effect
Regulations passed	Regulations drafted	Regulations approved by technical committee and submitted to Commissioner of Health or Governor, as required by relevant state law	Regulations assented to by Commissioner for Health or Governor, as required by relevant state law
Stakeholders aware of and satisfied with the PHC Board, structures at sub - state and facilities levels, and management arrangements			
Minimum Service Package (MSP)			
State adopts ward health system and MSP policy			
State classification of health facilities aligned with NPHCDA guidelines on Minimum Standards is established			
MSP utilized to guide investment plan	MSP used to classify all facilities	MSP used to determine resource requirements for all facilities	Government & development partners use MSP to guide resource allocation
Repositioning			
Roles and responsibilities of each Board, Board Management Team and state sub-structures established	Written document on roles and responsibilities extracted from the Law and Regulations	All staff from all health structures orientated on new roles and responsibilities	Handover of roles and responsibilities complete

Indicator	Target Y1	Target Y2	Target Y3
Capacity building programme for managers functioning	Work-based CB programme designed	At least one module conducted	A minimum of two modules conducted
Systems Development			
Each state's Board, Board Management Teams and structures fully functional at all levels	All members of each Board and each Board Management Team appointed	Roles and responsibilities between each Board and each Board Management Team clearly delineated	Each Board and each Board Management Team fully functional
PHC system established in line with the principle of ''three ones''			
Clear lines of accountability and communication established in the system			
Operational Guidelines			
Costed plan and timetable for establishing procedures and operational guidelines			
Management policies and procedures established			
Policies and procedures for HRM, procurement/SCM, accounting/financial management and M&E established	Policies and procedures drafted	Policies and procedures approved by relevant person	Policies and procedures implemented
Human Resources			
Staff paid by SPHCMB or SPHCDA Board	Based on HRIS and MSP, staff identified for transfer	Negotiations with 'old' structures leading to transfer of all identified staff	Staff paid by new management structure
HRIS fully established	Audit of existing staff completed	HRIS populated and reports fed to HR committee	Procedures to update HRIS established
Staff movement and redistribution within health facilities established in line with MSP			
High profile HR Committee in operation			
HR department/unit with HR director/unit head and team established			
Funding Sources and Structure			
PHC take-off grant released	Costed plan developed for take-off period	PHC take-off grant released	
Annual costed plan developed and approved by each Board	Planning and budgeting committee established by each Board	Annual SPHCMB or SPHCDA Board(or equivalent) Annual Operational Plan, including detailed budget, developed by Board and submitted to Commissioner of Health	Annual Operational Plan, with detailed budget, incorporated into overall annual state health plan and five Strategic Health Plan amended as required
Budget performance over 90%	Budget performance over 60%	Budget performance over 75%	Budget performance over 90%
Office Set-up			
Offices at all levels established	Costed plan for office establishment developed	Budget released for office setup	Offices at state and sub-state levels fully functional

4. Acronyms

CB	Capacity Building
FMOH	Federal Ministry of Health
HR	Human Resources
HRIS	HR Information System
LGA	Local Government Authority
LGSC	Local Government Service Commission
MCH	Mother and Child Health
M&E	Monitoring and Evaluation
MOF	Ministry of Finance
MOJ	Ministry of Justice
MOLG	Ministry of Local Government
MOWA	Ministry of Woman's Affairs
MSP	Minimum Service Package
NHIS	National Health Insurance Scheme
NPHCDA	National PHC Development Agency
PHC	Primary Health Care
PHCUOR	PHC under One Roof
SCM	Supply Chain Management
SHC	Secondary Health Care
SMOH	State Ministry of Health
SPHCDA	State PHC Development Agency
SPHCDB	State PHC Development Board

Annex 1: Checklist for Monitoring Progress

The assessment checklist was utilised by the NPHCDA to do an assessment of the status of each state in late 2012 with respect to "Bringing PHC under One Roof

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

Annex 2: Monitoring Progress at State Level

The assessment checklist was utilised to do an assessment of the status of each state in late 2012 with respect to “Bringing PHC under One Roof”. Each component was colour coded:

- Green indicates compliance or task completed
- Yellow indicates task initiated and more than 50% complete
- Amber indicates task initiated but less than 50% complete
- Red indicates noncompliance or task not started

On the following pages

- 2012 Assessment Tool shows progress in each state.
- The Score Card for Implementation of PHC under One Roof– selected states compares performance between seven sample states. This provides a snapshot of where the different states are and can be used to track progress over time.

The Assessment Tool and Score Card provided more than one column for the Finance Theme.

a) 2012 Assessment Tool

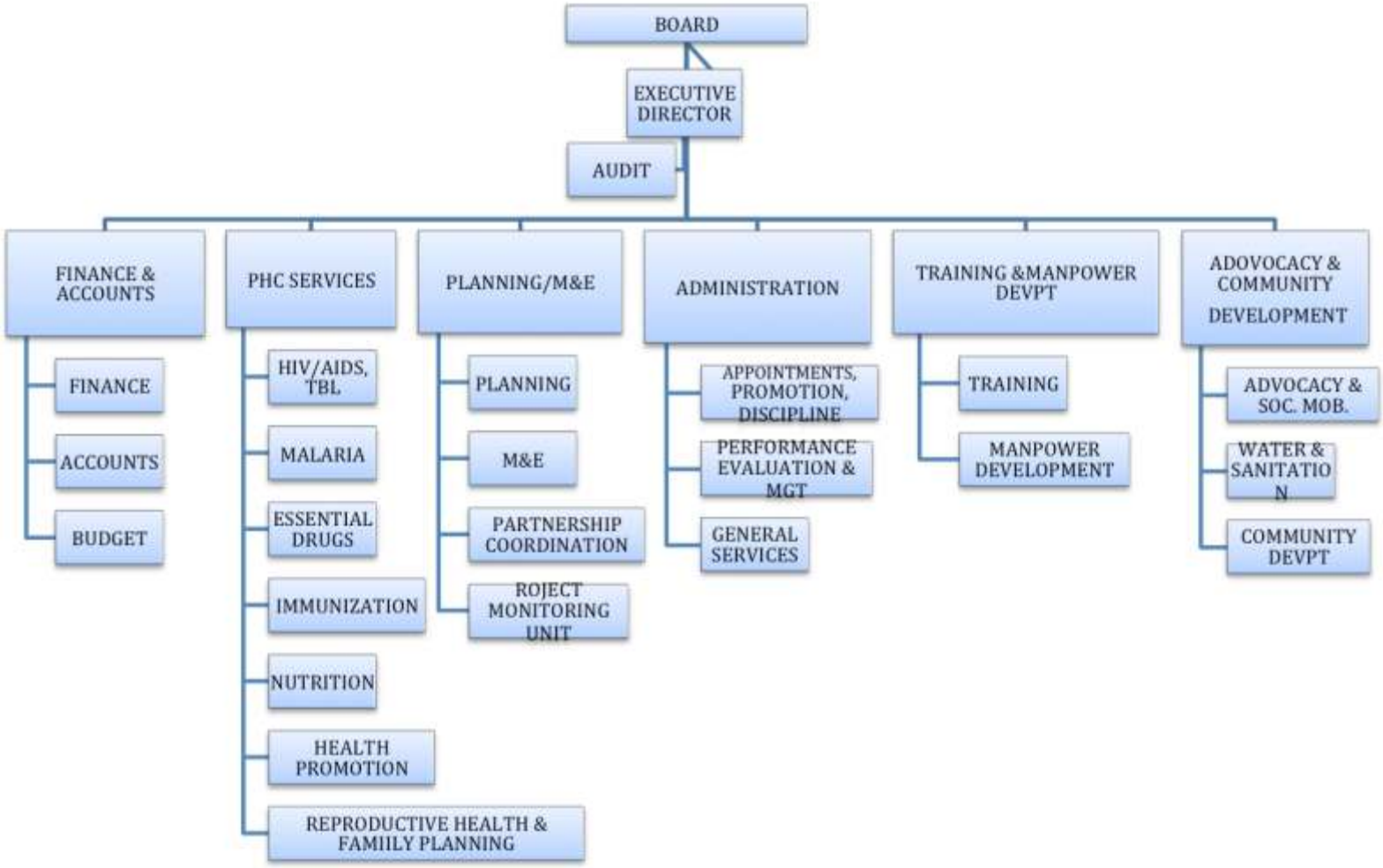
GOVERNANCE AND OWNERSHIP	LEGISLATION	MINIMUM SERVICE PACKAGE	REPOSITION-ING	SYSTEM DEVELOP-MENT	OPERATIONAL GUIDELINES	HUMAN RESOURCES	FUNDING STRUCTURE	SOURCES OF FINANCE		OFFICE SET-UP
Community representation on Board	Gazetted	Facility assessment and investment for MSP	Capacity of managers built for new tasks	SPHCMB or SPHCDApolicies are developed	SPHCMB or SPHCDAProcedures and protocols implemented	PHC staff deployed to HFs	Pooled and integrated into state budget	State, LGs +Donors	15% or >	Equipped offices handed over to management
Shared responsibilities for PHC	Passed	MSP resource gaps monitored	Managers re-oriented in new structures	Board has set up Agency ????	SPHCMB or SPHCDAProcedures and Protocols drafted	Staff database developed	Pooled funds from all sources	State and LGs	10 – 15%	Office space furnished/ equipped
Community PHC awareness	Drafted	MSP articulated for different HF types	New roles and responsibilities defined	SPHCMB or SPHCDA Board appointed	SPHCMB or SPHCDA Board policy and procedures in place	Staff distribution plan developed/ costed	SPHCMB or SPHCDA budget line	State Only	>5-10%	Space/offices identified
No community involvement	No Bill	No MSP	No repositioning undertaken	No PHC Board appointed	No Board rules	No PHC HR Plan	None of the above	No State Funding	5% or <	No space identified

b) Score Card for Implementation of "Bringing PHC under One Roof" – selected states 2012

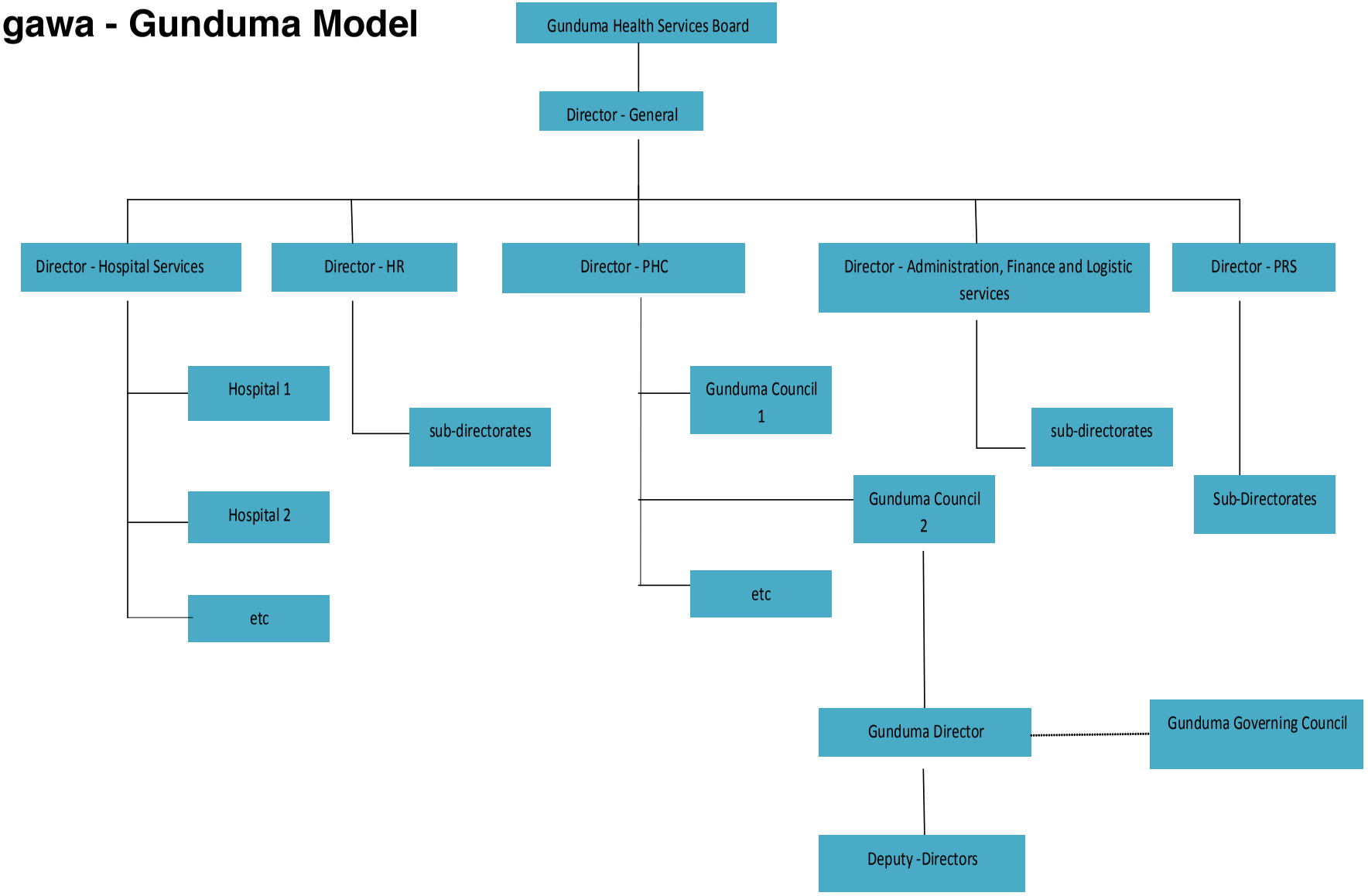
STATES	ENTITY	GOVERN-ANCE AND OWNERSHIP	LEGISLAT-ION	MINIMUM SERVICE PACKAGE	REPOSIT-IONING	SYSTEM DEVELOP-MENT	OPERAT-IONAL GUIDELINES	HUMAN RESOURC-ES	% state budget allocated to Health	Sources of finance	FUNDING STRUCTURE	OFFICE SET-UP	COMMENTS
State 1	SPHCMB or SPHCDA		2012										No PHC pooled fund, Law passed butSPHCMB or SPHCDA not yet functional
State 2	SPHCMB or SPHCDA		2005										No PHC pooled fund, Law passed butSPHCMB or SPHCDA not yet functional
State 3	District Health System		2009										No PHC pooled fund, SPHCMB or SPHCDA is functional but may be underfunded
State 4	District health System		2007										Basket fund for entire District Health System not PHC alone. SPHCMB or SPHCDA is functional
State 5	---												No State PHCMB or SPHCDA Bill drafted
State 6	SPHCMB or SPHCDA												No PHC pooled fund, SPHCMB or SPHCDA is functional
State 7	SPHCMB or SPHCDA		2010										Has pooled fund and SPHCMB or SPHCDA is fully functional

Annex 3: Examples of State Organograms

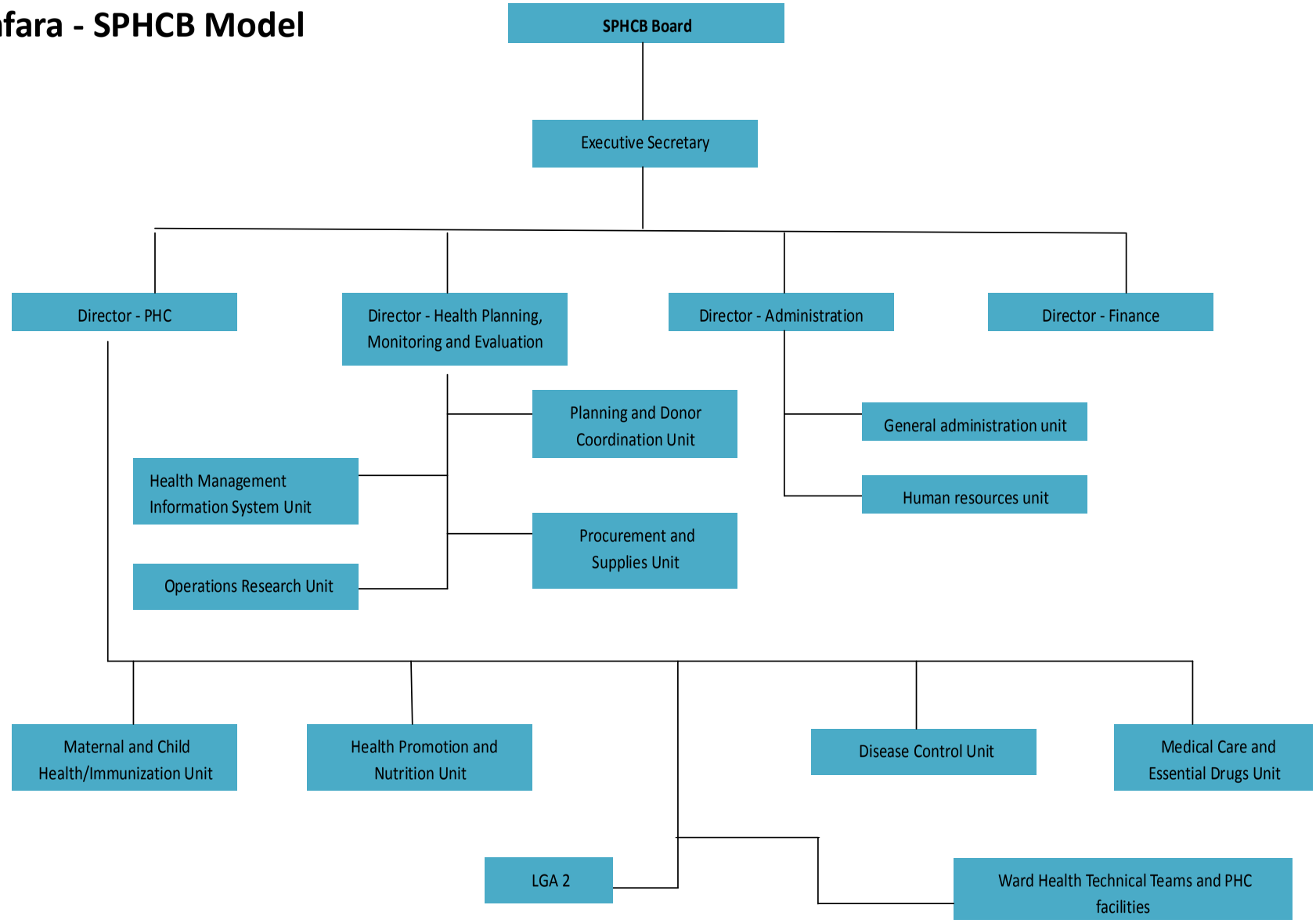
Following the principle of “No one size fits all', PHC Boards need to identify their own organisational structure. The following examples are offered as possible approaches.



Jigawa - Gunduma Model



Zamfara - SPHCB Model



NATIONAL PRIMARY HEALTH CARE
DEVELOPMENT AGENCY
Partnership for Service