The National Strategic Health Development Plan Framework (2009-2015)

NCH ADOPTED
July 2009

TWG- NSHDP/
HEALTH SECTOR
DEVELOPMENT TEAM

Foreword

'Health is Wealth' goes the popular saying and therefore in every country, the health sector is critical to social and economic development with ample evidence linking productivity to quality of health care. In Nigeria, the vision of becoming one of the leading 20 economies of the world by the year 2020 is closely tied to the development of its human capital through the health sector.

However, the health indicators in Nigeria have remained below country targets and internationally-set benchmarks including the MDGs, which have recorded very slow progress over the years. Currently, the health sector is characterized by lack of effective stewardship role of government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, mal-distribution of health work force and poor coordination amongst key players.

To address these, the federal government implemented the Health Sector Reform Program (HSRP) from 2004-2007, which addressed seven strategic thrusts revolving around government's stewardship role; management of the national health system; the burden of disease; mobilization and utilization of health resources; health service delivery; consumer awareness and community involvement; partnership, collaboration and coordination. The HSRP recorded a number of policy and legislative initiatives, notable among which are the National Health Policy review, the National Health Bill and strengthening the National Health Insurance Scheme. In addition, efforts were directed at strengthening disease programmes and improving the quality of care in tertiary health facilities. Despite these initiatives, much of the underlying weaknesses and constraints of the health sector persist.

Consequently, the Federal Ministry of Health has articulated this framework, as an overarching guide for the development of the National Strategic Health Development Plan (NSHDP) with its appropriate costing. The NSHDP would result from the harmonization of Federal, States' and local governments' health plans, thereafter serving as the basis for national ownership, resource mobilisation/allocation and mutual accountability by all stakeholders – government, development partners, civil society, private sector, communities, etc. The framework is based on the principles of the Four Ones: one health policy, one national plan, one budget, and one monitoring and evaluation framework for all levels of government. It also provides the template to concretize the health sector development component of the 7-point Agenda, Vision 2020 and a platform for achieving the MDGs.

Based on a multidimensional assessment of the health sector, the framework identifies eight priority areas for improving the national health systems with specific goals and strategic objectives. They are leadership and governance for health; health service delivery; human

resources for health; health financing; health information systems; community ownership and participation; partnerships for health development; and research for health.

I implore all stakeholders to use this framework to adequately harness the policy gaps and program interventions required to improve the performance of the health sector towards the delivery of quality, efficient and sustainable health care for all Nigerians.

Prof Babatunde Osotimehin OON
Honourable Minister of Health
May, 2009

THE DECLARATION

DECLARATION OF STAKEHOLDER COMMITMENT TOWARDS THE USE OF THE NSHDP FRAMEWORK FOR THE DEVELOPMENT OF A COSTED HEALTH PLAN AT ALL LEVELS

1. CONTEXT

We, the stakeholders involved in, or supporting the provision of health services in Nigeria with emphasis on primary health care;

1.1 Realising that health is a basic human right, subscribe to the achievement of the Millennium Development Goals (MDGs), the President's 7-Point Agenda, Vision 202020 and other national health development agenda;

1.2 Acknowledging global (International Health Partnership {IHP+} and others) and regional efforts (eg. Harmonization for Health in Africa {HHA}) aimed at strengthening partnerships for health;

1.3 Affirming our need to be responsive to the principles of the Paris Declaration on Aid Effectiveness in terms of:

- **Ownership**: where the federal, state and LGAs exercise effective leadership over health development policies and, as well as plans, coordinate health development efforts;
- **Alignment**: where health development partners base their overall development assistance on this Framework, its resultant National Strategic Health Development Plan (NSHDP), institutions and procedures;
- **Harmonisation:** where development partners effectively coordinate within the health development partner group to minimise the cost of delivering aid;
- **Managing for Results:** through which Nigeria and its health development partners work together to manage technical and financial resources towards achieving concrete results;
- **Mutual Accountability:** by which the Federal, State, LGAs, Development Partners and other stakeholders hold each other accountable for health development results;

1.4 Recognising that the Federal Ministry of Health (FMoH) has a broad mandate as the national coordinating authority on health;

1.5 Acknowledging that the National Council on Health, is the highest decision making body in the Nigerian health sector and would bring together different constituencies of stakeholders for innovation and participation in policy formulation and action within the NSHDP context, and

1.6 Recognising the National Health Management Information System (NHMIS) as the One Monitoring and Evaluation Framework, to track, monitor and evaluate the NSHDP.

2. PRINCIPLES

We the undersigned this … day of …… …….. declare our commitment to the following principles:

2.1 To strengthen capacity for active involvement of communities at all levels of health services delivery.

2.2 To provide support for equitable distribution of services and resources to those in greatest need based on evidence and to uphold the rights of consumers of health care, particularly vulnerable populations;

2.3 To provide voluntary and timely information to feed into the nationally agreed M&E framework to track, monitor and evaluate the national health system;

2.4 To work jointly towards complementarity between health and related sectors (water and sanitation, basic education, infrastructure, etc), expanding utilization and delivery options and coordinating technical assistance;

2.5 To work in a result-focused and transparent manner, while employing participatory approaches that involve representation of all stakeholders, not only within the context of prevention, but beyond; and

2.6 To ensure that health development partners are well coordinated to ensure the effectiveness of aid.

2.7 To support the Federal Ministry of Health in discharging its mandate as the coordinating authority for health in Nigeria.

3. UNDERTAKINGS

Bearing in mind that Nigeria is not on target towards meeting the health related MDGs, we therefore resolve to take immediate and relevant actions in addressing the complexities and challenges presented by the stagnating health status through the NSHDP Framework and as listed below, and build on these and other national, regional and global commitments for future health investments.

3.1 Promote the use of the NSHDP Framework for the development of the respective health plans for each tier of government;

3.2 Ensure that the health plans encompass cost-effective interventions that strengthen the delivery of basic health services and referral services including secondary and tertiary care, which include Integrated Maternal, Newborn and Child Health (IMNCH) strategies, malaria control, immunization, TB, HIV/AIDS, public private partnerships;
3.3 Ensure equitable distribution and management of the human resource for health through appropriate strategies including capacity building, incentives; and task delegation;
3.4 Ensure adequate funding for health services at all levels in the country to meet its commitment on the Abuja declaration of ensuring 15% of total national budget is allocated to health
3.5 Ensure that appropriate and broad based partnerships are built with the community and media to promote behavioural change towards improved health;
3.6 Engage all stakeholders under the leadership of the FMoH to update programmes and projects to promote compatibility with the NSHDP Framework;
3.7 Strive towards synchronized planning and review cycles in line with the annual review and planning systems in order to maximize the use of national capacities and competencies;
3.8 Promote data collection, through harmonized reporting procedures and timelines within the national NHMIS framework; strengthen information sharing and knowledge management mechanisms for better planning;
3.9 Ensure constituency representation in the various subcommittees of the National Council on Health to facilitate FMoH's task in effectively fulfilling its coordination role;
3.10 Create conducive environment for the advancement of science and research in Nigeria whilst adhering to highest ethical and scientific standards;

IN WITNESS WHEREOF, the undersigned, being duly authorized representatives of the parties hereto have signed this Declaration of Commitment on the day and year first above written.

Signed:

1. Honourable Minister of Health

2. All State Governors

3. Chair, Association of Local Governments of Nigeria (ALGON)

4. Representatives of Multilateral and Bilateral Development partners
   WHO
   UNICEF
   UNFPA
   UNDP
   WORLD BANK
   AfDB

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USAID
DFID
CIDA
EU
JICA

5. Representatives of Private Health Care Providers

6. Representatives of Professional Groups

7. Representatives of Civil Society Organisations (CSOs)

8. Representatives of the community (Chairman Traditional Rulers Council for each State)

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ACRONYMS

BCC	Behaviour Change Communication
CIDA	Canadian International Development Agency
CORPs	Community oriented resource persons
CPD	Continuing professional development
CSO	Community Service Organization
DFID	Department for International Development
DHS	Nigeria Demographic and Health Survey
DP	Development Partners
DPRS	Department of Planning, Research and Statistics
FCT	Federal Capital Territory
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GIS	Geographic Information System
GTZ	Gesellschaft für Technische Zusammenarbeit
HDCC	Health Data Consultative Committee
HF	Health Facility
HIS	Health Management Information System
HIV/AIDS	Human Immuno Deficiency Virus/Acquired Immune Deficiency Syndrome
HLM	High Level Ministerial Meeting on Health Research
HPCC	Health Partners Coordinating Committee
HRH	Human Resources for Health
HW	Health worker
IEC	Information, Education and Communication
IMCI	Integrated management of Childhood Illnesses
IMNCH	Integrated Maternal, Newborn and Child Health
IPC	Interpersonal Communication skills
ISS	Integrated supportive supervision
ITNs	Insecticide treated nets
JFA	Joint Funding Agreement
JICA	Japan International Development Agency
LGA	Local Government Area
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDAs	Ministries, Departments and Agencies
MDCN	Medical and Dental Council of Nigeria,
MDGs	Millennium Development Goals
MNCH	Maternal and Newborn Child Health
MRCN	Medical Research Council of Nigeria

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NAFDAC	National Agency for Food Drugs Administration and Control
NGOs	Non-Governmental Organizations
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Committee
NIMR	Nigerian Institute for Medical Research
NIPRD	National Institute for Pharmaceutical Research and Development
NMSP	National Malaria Strategic Plan
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHDPf	National Strategic Health Development Plan Framework
NSTDA	National Science and Technology Development Agency
NYSC	National Youth Service Corps
OAU	Organisation of African Unity
ODA	Oversea Development Assistance
OPS	Organised Private Sector
PEPFAR	President's Emergency Plan for AIDS Relief
PERs	Public Expenditure Reviews
PHC	Primary Health Care
PHCMIS	Primary Health Care Management Information System
PPP	Public Private Partnerships
QA	Quality Assurance
RDBs	Research data banks
SHAs	State Health Accounts
SMOH	State Ministry of Health
SWAPs	Sector-Wide Approaches
TB	Tuberculosis
TBAs	Traditional birth attendants
TWG	Technical Working Group
UN-System	United Nations-System
VAT	Value Added Tax
VHW	Village health workers
VOC	Vote-of-charge
WHO	World Health Organization

Executive Summary

Nigeria's overall health system performance was ranked 187th position among 191 member States by the World Health Organization (WHO) in 2000. Primary Health Care (PHC), which forms the bedrock of the national health system, remains in a prostrate state due to gross under funding, mismanagement and lack of capacity at the LGA level. The 2003 NDHS indicators demonstrating the performance of the health system indicate an immunization coverage of 23%; 6% of under-fives sleeping under insecticide treated nets (ITNs) with only a third of children with fever appropriately treated with antimalarials at home and less than half of deliveries attended to by skilled health personnel. It is noted that wide variations of these indicators exist in different geographical zones, states and rural/urban locations.

Recognizing that recent improvement in Nigeria's macroeconomic performance have not translated into discernable improvement in the health system and quality of life of Nigerians, the Federal Government's 7-Point Development Agenda has underscored human capital development as the bedrock of this national agenda with explicit reference to the health sector. Access to quality health care and prevention services are therefore considered vital for poverty reduction and economic growth, particularly as Nigeria is lagging behind in attaining the health-related MDGs.

In order to meet the challenges of achieving improved health status particularly for its poorest and most vulnerable population, the health system must be strengthened; proven cost-effective interventions must be scaled up and gains in health must be sustained and expanded. The Federal Ministry of Health (FMOH) appreciates that this can best be done within the context of a costed National Strategic Health Development Plan (NSHDP), which is aimed at providing an overarching framework for sustained health development in the country. The NSHDP is to be developed in accordance with extant national health policies and legislation, and international declarations and goals to which Nigeria is a signatory to, namely; MDGs, Ouagadougou Declaration on PHC and the Paris Declaration on Aid Effectiveness.

As a prelude to the development of the NSHDP, a generic Framework has been developed to serve as a guide to federal, states and LGAs in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians. It is expected therefore, that in using this Framework, the Federal, States and LGAs would respectively develop their respective costed plans through participatory approaches to reflect their context and prevailing issues. The end product being a harmonized National Strategic Health Development Plan with its appropriate costing will thereafter serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria. It would also stipulate requirements for future health investments towards achieving sustainable universal access and coverage within the planned period of 2009 - 2015.

Major steps adopted in the development of the NSHDP Framework included the conduct of 10 background studies; inauguration of a steering committee and technical working group comprising of government, development partners, CSOs, private sector, academicians and experts in development planning. Through the review of technical resource materials, wide consultations and participatory techniques, eight priority areas of concern to improve the Nigerian health system were identified namely: leadership and governance, service delivery, health financing, human resources for health, health information system, community participation and ownership, partnerships for health development and research for health. For each of the priority areas, this framework details the context, goals, strategic objectives, and recommended evidence-based and cost-effective interventions required to deliver improved performance of the health system and health outcomes for Nigerians.

Leadership and governance Frequent changes in leadership at all levels, corruption, lack of accountability and transparency characterize poor leadership systems and crises in governance structures in Nigeria's health system. Recommended interventions to address these include appropriate legislation and regulatory frameworks; generating federal, states and local government consensus through national and state councils on health; effective decentralization of decision making processes; intergovernmental and multi-sectoral collaboration and coordination of all stakeholders including Public-Private Partnership; strengthening stewardship role of government with proper accountability and transparency, and empowering the community and civil society as health sector watch dogs.

Health service delivery: is characterized by inequitable distribution of resources, decaying infrastructure, poor management of human resources for health, negative attitude of health care providers, weak referral systems; poor coverage with high impact cost-effective interventions, lack of integration and poor supportive supervision. Interventions recommended include strengthening health services management; implementing the ward minimum health care package; increased access to quality health services; rehabilitation of health infrastructure, sustainable procurement system for health commodity security; rational use of drugs; strengthening referral system; attitudinal reorientation through SERVICOM; institutionalizing staff motivation and establishing quality assurance mechanisms.

Human resource for health: There is a dearth in the quality, quantity and mix of health care workers with a skewed distribution towards urban and southern population, alongside the existence of multiple categories of health care providers from orthodox to traditional. Interventions recommended include implementation of the National Human Resource Policy; supporting lower levels to develop HRH plans; establishing a system of continuing professional development; addressing critical human resource shortages in some parts of the country; task shifting; and periodic curriculum reviews by the training institutions and regulatory bodies.

Financing for health: with a per capita health expenditure of $10 and about 70% Out-Of-Pocket Expenditure, health financing in Nigeria has remained unpredictable, insufficient and uncoordinated with limited attempts to provide safety nets for vulnerable populations towards achieving universal access to health care. Critical interventions recommended include increasing government allocation to health at all levels, expanding the NHIS coverage and regulatory functions, implementation of the community-based health insurance schemes, pooling funds using common basket approaches by all actors involved in financing health in Nigeria

Health information system (HIS): The existing gaps in the national HIS include non-adherence to reporting guidelines, poor availability and utilization of standardized tools, dearth of skills for interrogation of data, non-involvement of private providers, etc. Recommended interventions include modernization of the HIS; increased funding to HIS; capacity building at all levels for data collection and interpretation; availability of data collection tools at all levels; collaboration with the private sector; institution of sanctions for defaulters; harmonization of data collecting systems with key indicators; utilization of data to inform policy formulation and programming.

Community participation and ownership: is central to the sustainability of the health system. Intervention to empower and engage the communities include using community-based organizations and kinship groups as platforms to promote community participation; implementation of bottom-top approach planning methods, implementation and monitoring; and demand creation through health promotion and behavioural change communication.

Partnerships for Health if properly harnessed would provide synergized efforts for improving the performance of the health system and addressing the social determinants of health. Interventions recommended include effective Public Private Partnerships; Inter- and intra-governmental collaboration; coordination mechanisms with health development partners, including multilaterals, bilateral and the civil society; equally partnerships with professional groups, traditional care providers and the community are critical.

Research for health is poorly coordinated and conducted in the country. Despite the existence of a national policy, implementation remains slow with limited funding. Interventions recommended include strengthening the capacity for research at all levels through training, increased funding and networking within and outside the country; formalization of a forum for interaction and coordination of health research; and formation of Institutional Review Boards (Ethical committees).

A section on Organization of services at the LGA level describes the practical operational measures required to improve service delivery within the LGAs.

The annexure to the Framework include the Methodology adopted by the Technical Working Group (TWG) in developing the Framework; the Planning Tool and Users Guide to aid the design of detailed Plans at Federal, State and LGA levels.

Chapter 1 Background

The centrality of health to national development and poverty reduction is self-evident, as improving health status and increasing life expectancy contribute to long term economic development. The legitimacy of any national health system depends on how best it serves the interest of the poorest and most vulnerable people, for which improvements in their health status gear towards the realization of poverty reduction goals. In the Nigerian context, current reviews show that the country is presently not on course to achieving the health Millennium Development Goals (MDGs) by 2015. This poses a major developmental challenge, which will impede and undermine development and economic growth.

The Federal Government of Nigeria recognizes that, in order to achieve the country health targets, inclusive of the health-related MDGs, particularly for its poorest and most vulnerable population, the health system should be strengthened, health services must be scaled-up and existing gains in the health sector must be sustained and expanded. These improvements can be achieved through the use of an evidence-based Framework to guide the development of a ***National Strategic Health Development Plan (NSHDP),*** *with appropriate costing.*

Vision
"To reduce the morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Nigerians".

Mission Statement
"To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the National Health System to be able to deliver effective, quality and affordable health.

The overarching goal of the NSHDP is *to significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system.*

1.1 Situation Analysis

1.1.1 Country Profile

The Federal Republic of Nigeria has an estimated population of 148 million (2008)[1], of which 49% are female and 51% male. The country operates a three-tiered governance structure – a

[1] National Planning Commission (2008) *Draft National Development Plan* Abuja: National Planning Commission

Federal Government, 36 semi-autonomous State Governments grouped into six geopolitical zones, the Federal Capital Territory and 774 Local Governments, with wide regional, socio-cultural, economic and geographical diversities existing across the country.

While subsistence agriculture is the predominant occupation, the national revenue is derived mainly from oil, accounting for 81% of export earnings and over 80% of government revenue[2]. States and LGAs revenue, contributing to funding for health care are largely dependent on allocations from the federal government as their internally generated revenues are low.

Nigeria has enjoyed a period of economic growth with the Gross Domestic Product rising from 2.5% in the 1990's to 6% during the period 2004 – 2007 with average annual inflation rates falling from 20.6% to 11.6% over the same period[3], though in recent times, the global economic recession has adversely affected the country's economy. With a GDP of over $181 billion[4], Nigeria has the potential of being a key player on the African continent, however in spite of her potentials; development shortfalls remain pervasive as evidenced by low earnings for individuals, poor social indicators and significant disparities by income, gender and location. It is also estimated that more than half of Nigerians (54.4% or 76 million) live in poverty with 70.8% of this living below the poverty line of less than $1 per day[5]. Furthermore, Poverty is found to be predominant in the rural areas than urban areas and deepens from the southern to the northern part of the country. Coupled with the above, the current global economic recession also continues to pose a risk to the availability of resources to the health sector.

1.1.2 The Health Care System

Nigeria operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with hardly any collaboration. Both the private and public sectors provide orthodox health care services in the country. In 2005, FMOH estimated a total of 23,640 health facilities in Nigeria of which 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary. 38% of these facilities are owned by the private sector, which provides 60% of health care in the country[6]. While 60% of the public primary health care facilities are located in the northern zones of the country, they are mainly health posts and dispensaries that provide only basic curative services. The Private Out-Of-Pocket-

[2] National Planning Commission (2008) *Draft National Development Plan* Abuja: National Planning Commission

[3] Central Bank of Nigeria (2008) *Annual Report* Abuja: Central Bank of Nigeria

[4] Central Bank of Nigeria (2007) *Annual report* Abuja: Central Bank of Nigeria

[5] United Nations Development Program (2007) Human Development Report

[6] Federal Ministry of Health (2005) *Inventory of Health Facilities in Nigeria* Abuja: Federal Ministry of Health

Expenditure (OOPE) in Nigeria accounts for over 70% of the estimated $10 per capita expenditure on health[7], limiting equitable access to quality health care.

The public health service is organized into primary, secondary and tertiary levels. While the Constitution is silent on the roles of the different levels of government in health services provision, the National Health Policy ascribes responsibilities for primary health care to local governments, secondary care to states and tertiary care to the federal level. At the same time, a number of parastatals, based at the federal level, for example, the National Primary Health Care Development Agency (NPHCDA) are currently engaged in primary health care services development and provision; the latter is evidently part of its mandate. Although national policies, formulated by the Federal Ministry of Health provide some level of standardization, each level is largely autonomous in the financing and management of services under its jurisdiction.

The health system is in a deplorable state with an overall health system performance ranking 187th out of 191 member States by the World Health Organization (WHO)[8]. Primary Health Care (PHC), which forms the bedrock of the national health system, is in a prostrate state because of poor political will, gross under funding, and lack of capacity at the LGA level, which the main implementing body.

The health system remains overstretched by a burgeoning population; physical facilities are decaying, equipment are obsolete and there is scarcity of skilled health professionals. In addition, the roles of stakeholders are misaligned and coordination systems are weak. These are further compounded by the dearth of data which renders evidence based planning, policy formulation and health systems management weak.

The very weak health system contributes to the limited coverage with proven cost-effective interventions. For example, immunization coverage is 23%[9]; only 12% of under-fives sleep under ITNs, 20% of children in urban areas and 14% resident in rural areas with fever are appropriately treated with antimalarials at home, contraceptive prevalence rate is 15% and only 39% of women deliver under the supervision of skilled attendants[9]. It is important to note that

[7] Federal Ministry of Health (2004) *Health Sector Reform Program: Strategic Thrusts and Log Framework* Abuja: Federal Ministry of Health

[8] WHO (2000) *World Health Report 2000: Health Systems - Improving Performance*. Geneva: World Health Organisation

[9] National Population Commission (2008) *National Demographic and Health Survey* Abuja: National Population Commission

wide regional variations exist for these indicators, with comparatively worse figures in the rural areas and in the northern part of the country.

1.1.3 Health Status Indicator The health status indicators for Nigeria are among the worst in the world. The life expectancy at birth is 49 years while the disability adjusted life expectancy at birth is 38.3years; vaccine-preventable diseases and infectious and parasitic diseases continue to exact their toll on health and survival of Nigerians, remaining the leading causes of morbidity and mortality. Nigeria has the highest number of HIV infected persons in the African continent and the fourth highest TB burden in the world. In the face of these, non communicable diseases are increasingly becoming public health problems, especially among the affluent urban population.

Even though only 2% of the global population is in Nigeria, the country, with an estimated infant mortality rate of 75 per 1000 live births, child mortality rate of 88 per 1,000 live births, under 5 mortality rate of 157 per 1,000 live births[10] and a maternal mortality ratio of 800 per 100,000 live births, contributes a disproportionate 10% to the global burden of maternal and also infant mortality[11]. Wide regional variations exist in infant and maternal mortality across the zones. Infant and child mortality in the North West and North East zones of the country are in general twice the rate in the southern zones while the maternal mortality in the North West and North East is 6 times and 9 times respectively the rate of 165/100, 000 recorded in the South West Zone[7].

[10] National Population Commission (2008) *National Demographic and Health Survey* Abuja: National Population Commission

[11] Federal Ministry of Health (2008) *Integrated Maternal, Newborn and Childhealth Strategy.* Federal Ministry of Health, Abuja

Chapter 2 Priority Areas of the Framework

Preamble

This generic Framework has been developed to serve as a guide to federal, state and LGAs in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians. It is expected therefore, that through the use of this Framework, the Federal, States and LGAs would respectively develop their respective costed plans through participatory approaches to reflect their context and prevailing issues. The end product being a harmonized National Strategic Health Development Plan with its appropriate costing will thereafter serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralization, equity, harmonization, alignment, and mutual accountability in Nigeria. It would also stipulate requirements for future health investments towards achieving sustainable universal access and coverage with a defined package of essential services within the planned period of 2009 - 2015.

Therefore, and as stated in the Declaration contained in this Framework, the Honourable Minister for Health urges all to '*promote the use of this NSHDP Framework for the development of the respective health plans for each tier of government*'

This generic framework discusses eight evidenced-based priority areas identified to improve the performance of the health sector, through a holistic approach at federal, state and LGA levels. They are: leadership and governance, service delivery, human resources for health, health financing, health information system, community participation and ownership, partnerships for health and research for health.

For each of these priority areas, the framework provides uniform guidance, specifying a goal with strategic objectives and corresponding recommended interventions for the States to consider. It is recognized that specific actions to deliver the different interventions, which in turn contribute to the attainment of strategic objectives and the goals may vary by level of government and from state to state and likewise for LGAs. Appendix ??? provides guidance on how to use this framework for the development of the health plans.

The aforementioned priority areas are presented in sections 2.1 to 2.8, with an introductory context.

2.1 PRIORITY AREA 1: LEADERSHIP AND GOVERNANCE FOR HEALTH

2.1.1 Context

Nigeria has adopted 5 successive national and over 24 sectoral health policies since 1960, when the country gained political independence. The first 4 policies were incorporated into various national development plans formulated between 1960 and 1985. The initial guiding philosophy of pre- 1985 policies was based on the assumption that improving the health of the population was essentially dependent upon the availability of health providers and access to health facilities[12].

In 1988 a PHC focused health policy was adopted by the Federation with the latest review in 2004. This policy was the first to provide direction hinged on the concepts and principles of primary health care (PHC) based on the evidence of the health needs and problems of the nation including the disease burden. Apart from a few places where health is mentioned, the current constitution of Nigeria (1999) is largely silent on matters concerning health.[13] Nonetheless, an overarching law – The National Health Bill (May 2008)[14] – which is currently in the process of being enacted attempts to clarify the structure, roles and responsibilities of the different levels of government.

The poor performance of the health system is not helped by the lack of clearly defined roles and responsibilities which results in duplication of efforts. This is compounded by inadequate political commitment especially at lower levels, poor coordination, lack of communication between various actors, lack of transparency and poor accountability. In addition, the private sector, a major contributor to health care delivery in the country, is poorly regulated due to weak capacity of State governments to set standards and ensure compliance. All these factors have led to the lack of strategic direction and an inefficient and ineffective health care delivery system. Nonetheless, there have been successive attempts including the Health Sector Reform Programme (2004-2007), and past health policies and programmes aimed at enhancing leadership and governance for health.

This priority area of the NSHDP Framework seeks to streamline and empower the Ministries of Health at the Federal and State levels as well as LGA Health Departments to reposition their organisational and management systems to provide the strategic and tactical leadership and governance for health. It equally recommends interventions to enhance mutual accountability and transparency in the use of health development resources, particularly through results-based management approaches.

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[12] Health Reform Foundation of Nigeria (2006) *Nigeria Health Review* Abuja: Health Reform Foundation of Nigeria

[13] 1999 Constitutions of the Federal Republic of Nigeria

[14] Draft Nigeria National Health Bill, May 2008

2.1.2 Conceptual Definitions

Stewardship: The WHO Health Report 2000 refers to stewardship as "function of a government responsible for the welfare of the population, and concerned about the trust and legitimacy with which its activities are viewed by the citizenry"[15] The concept of the stewardship role of government in health as stated above means: the way in which governments mobilize and spend revenues and make regulations and policies that deal with the issue of accountability and transparency in the health system, with specific regard to: (i) Oversight (ii) Financing (iii) Human and Physical Resources (Development and Utilization) (iv) Improvement of Performance (v) Promotion of the Health of the People (vi) Leverage of Health Program Implementation and Outcomes.

Governance: Governance for health is the exercise of economic, political and administrative authority to manage the country's health affairs at all levels – Federal, States and LGAs; as well as mechanisms, processes and institutions, through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations and mediate their differences[16]. It includes formulation of national health policy and health strategic plans (defining the vision and directions), exerting influence through regulations and advocacy, collecting and using information, and accountability[17].

Leadership: Leadership in health includes providing direction and the enabling environment for the various stakeholders to articulate the complex social processes which impact on the healthcare delivery system at their level in a participatory way, allowing people's viewpoints and assumptions about their local health system and economy to be brought to light, challenged and tested and jointly developing a mechanism for achieving positive change. It is imperative for strategic oversight to be provided through collaboration and coordination mechanisms across sectors within and outside government including civil society. Leadership will influence action on key health determinants and access to health services while ensuring accountability. Leadership ensures that policy formulation is deliberately structured and linked to programme planning, project selection and task implementation arising from a common shared vision.

2.1.3. Goal

Create and sustain an enabling environment for responsive health development in Nigeria

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[15] WHO (2000) *World Health Report 2000: Health Systems - Improving Performance*. Geneva: World Health Organization, Geneva.

[16] Governance For Sustainable Human Development: A UNDP Policy Document 10-12-2008

[17] Frame work for implementation of the Ouagadougou declaration on PHC and health system in Africa; 2008

2.1.4. Strategic Objectives.

2.1.4.1 To provide clear policy directions for health development

2.1.4.2 To facilitate legislation and a regulatory framework for health development

2.1.4.3 To strengthen accountability, transparency and responsiveness of the national health system

2.1.4.4 To enhance the performance of the national health system

2.1.5 Interventions

A description of the suggested activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

To provide clear policy directions for health development:

2.1.5.1 Improve Strategic Planning at Federal and State levels

In order to provide clear policy direction for health development in the country, the policy and strategic leadership of the FMoH will be strengthened through an integrated organisational change and development programme, which will incorporate the re-oreintation and strengthening of the human resource capacities. Increased emphasis will be placed on effective implementation of agreed plans and this will include advocacy at State level in support of policy development and implementation. The highest priority will be to support States in the development of evidence-based, costed, and prioritised strategic health plans for the sector. The development of strategic health plans will be undertaken in such a way as to optimize the contribution of the wider stakeholders at each level.

To facilitate legislation and a regulatory framework for health development

2.1.5.2 Strengthen Regulatory Functions of government

The private health sector is a major contributor to healthcare delivery in most parts of Nigeria and is often the first point of contact with the health system for the majority of people. Quality of service delivery is extremely variable and the capacity of State governments to set standards and ensure compliance needs to be strengthened. The FMoH will support the development of public/private partnership policies and plans in States in line with the national policy on PPP. States will also be offered opportunities for technical support on implementation of their

strategic plans to ensure that the regulatory function of government is strengthened and agreed quality standards are set, monitored, and delivered. The public sector (government) will also collaborate with the private sector to improve their health delivery system, for example through joint continuous professional development, supportive supervision and generation of public health information and intelligence. Arrangements under which State governments may wish to outsource some components of health service delivery to the private sector will be explored and supported.

Similarly, to strengthen regulatory framework through legislation, efforts will be channeled into reviewing, updating and enforcing Public Health Acts and Laws as well as revising and streamlining roles and responsibilities of regulatory institutions to align with the National Health Bill that is due to be passed into law. In this regard, the various tiers of government will prioritise the review of public health legislations to ensure that gaps are filled in areas which need improvement, and relevant laws enacted through National and State Assemblies. Review committees will be set up to review and align laws of regulatory bodies.

To strengthen accountability, transparency and responsiveness of the national health system;

2.1.5.3. Improve Accountability and Transparency

Demand for accountability, transparency and responsiveness of the national health system will be institutionalized through effective decentralization of the decision making process in the health sector. The FMoH will support the States and the LGAs to institute stakeholders' dialogue and feedback forum for enlisting input into health sector decision making. This will also involve creating platforms for interaction and collaboration with health sector advocacy groups, empowering beneficiary communities through sensitization to manage and oversee their health projects and programmes, as well as promoting the emergence of independent health sector 'watch dogs'. The FMoH will lead a process for improved access to information required for yearly joint review of the health sector and put such information in the public domain and on demand by stakeholders.

To enhance the performance of the national health system

2.1.5.4 Improving and maintaining Sectoral Information base to enhance performance

There is a need to deepen and expand the analytical work at both Federal and State Government levels, which is required to understand health sector performance and to drive improvements and reform. In conjunction with development partners a prioritised list of areas for further analytical work will be outsourced to Universities, private sector research firms and research institutes. An example is the Nigeria Demographic and Health Survey (DHS) which is conducted on a five

yearly cycle and presently outsourced to Macro International with funding from several donors. Linkage with the relevant activities in the research and health information system priority areas of this framework will contribute to achieving this intervention.

2.2 PRIORITY AREA 2: HEALTH SERVICE DELIVERY

2.2.1 Context

Health care services are activities geared towards the provision of a comprehensive package of integrated care to beneficiaries through the primary, secondary and tertiary levels. This includes increasing both demand and supply of services with the goal of expanding coverage for improving the health status of the citizenry. It is recognized that health care services in Nigeria are provided by a multiplicity of health care providers - public, private including for profit and not-for-profit, patent medicine vendors and the traditional health care providers.

Despite considerable investment in the health sector over the years, available evidence suggests that health services throughout Nigeria are delivered through a weak health care system. Consequently it is unable to provide basic, cost-effective services for the prevention and management of common health problems especially at the LGA and Ward levels. For example, the proportion of PHC facilities providing immunisation services range from 0.5% in the North-West zone to 90% in the South West and South East Zones. Also the capacity to provide basic emergency obstetric services is very limited as only 20% of facilities are able to provide this service[18]. This limited coverage of basic health services, which results from poor access to information and services results in under utilisation of services. For example, only 58% of women receive antenatal care from a professional, with coverage levels ranging from 31% to 87%, and deliveries under the supervision of a trained birth attendant ranging from 9.8% to 81.8%. The lowest figures are from the North East and North West zones[10.]

Availability and distribution of functional health facilities and other health infrastructure are variable across the country. And many new PHC facilities being built are wrongly sited. Majority of the public health facilities especially PHC centres are in a state of disrepair. Although every State currently has at least one tertiary health facility, nonetheless most are not functioning at optimal capacities in the provision of quality specialist care.

[18] FMOH/UNFPA study on essential obstetric care in Nigeria (2002-2003)

Most public health facilities across the country are poorly equipped as indicated in findings from a 2001 survey of public PHC facilities[19]. The report shows that only a quarter of health facilities had more than 50% of the minimum equipment package and 40% had less than a quarter. However, in the past few years a significant level of capital investment has been made to improve the medical equipment and infrastructure of a cohort of federal teaching hospitals and 350 model PHC facilities have been constructed and equipped.

The Essential Drugs Programme, including the first national essential drug list in the country was developed in 1988. The Bamako Initiative aimed at strengthening PHC through ensuring sustainable quality drug supply systems was re-invigorated in all LGAs in 1998 under the Petroleum Trust Fund. These initiatives are now moribund due to poor commitment to the establishment of systemic procurement systems for health commodities resulting in loss of confidence and decreased utilization of public sector health facilities due to drug stock-outs. One of the consequences of these is the proliferation of patent medicine vendors and drug hawkers which is compounding the problem of irrational drug use. In relation to this, the market is replete with substandard and fake drugs. However, there is a perception of increased confidence in the drug regulatory framework operated by NAFDAC in recent years.

Most services provided by private and public providers are clinic-based, with minimal outreach, home and community-based services. The services are fragmented, with many vertical disease control programs. Referral systems are weak and even tertiary facilities are used for provision of primary care thus diminishing the continuum of care and making the system inefficient. Also, despite the private sector delivering 60% of health care in the country, private-public partnership is very weak.

The NPHCDA has defined a ward health care minimum package for PHC, but dissemination and implementation remain very limited. At higher levels, except for a few disease control programs, like PMTCT, TB, Malaria, Family planning and Essential Obstetric care, there are no standard operating procedures and treatment protocols. These lead to provider-initiated rather than client-centered delivery of care.

Other confounding factors that further limit quality of care include dearth in the skills and, quantity of available human resources for health with poor attitude of health care providers. In addition the country is confronted with lack of emergency preparedness to respond to epidemics.

[19] Adeniyi. J, Ejembi CL, et al (2001) The Status of Primary Health Care in Nigeria: Report of a Needs Assessment Survey. National Primary Health Care Development Agency.

To improve the functionality, quality of care and utilization of services so as to positively impact the health status of the population, universal access to a package of cost-effective and evidence-based interventions is needed. This would of necessity require interventions that transform the way the health care system is resourced, organized, managed and services delivered

2.2.2 Goal
Revitalize integrated service delivery towards a quality, equitable and sustainable healthcare.

2.2.3 Strategic Objectives
2.2.3.1 To ensure universal access to an essential package of care
2.2.3.2 To increase access to health care services
2.2.3.3 To improve the quality of health care services
2.2.3.4 To increase demand for health care services
2.2.3.5 To provide financial access especially for the vulnerable groups

2.2.4 Interventions
A description of possible activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

To ensure universal access to an essential package of care

2.2.4.1 Essential Health Service Package
To provide package of essential care, there is a need to review, cost, disseminate and implement the minimum package of care in an integrated manner and also, strengthen specific communicable and non communicable disease control programmes. Standard Operating procedures (SOPs) and guidelines are to be made available for delivery of services at all levels

To increase access to health care services

2.2.4.2 Improve geographical equity and access to health services
Improving geographical equity and access to quality care will involve mapping of health facilities, establishing GIS for all health facilities in the country as well as developing criteria for siting of new health facilities at all levels. In addition there will be the need to upgrade and refurbish all substandard facilities especially at PHC level. In doing these, effort should be made to ensure adherence to guidelines that stipulate standards for access and linkages of the different levels of care. Guidelines for outreach services will be developed and implemented, budget lines

for the maintenance of health facilities provided and guidelines for task shifting established and implemented. The use of telemedicine will be strengthened.

2.2.4.3 Ensure availability of drugs and equipment at all levels

Another intervention to increase access to quality health care services will entail ensuring availability of drugs and equipment at all levels. This would involve a review of the essential drugs list and establishing a system to ensure procurement and distribution of essential drugs on a sustainable basis at all levels. Furthermore, there will be the need to develop/review an equipment list for different levels of health facilities in line with the essential package of care and ultimately procure and distribute equipment based on need.

2.2.4.4 Establish a system for the maintenance of health facilities and equipment at all levels

Availability of equipment is critical to service delivery. Therefore, there is a need to aadapt, disseminate and implement the National Health Equipment Policy; also create budget lines for the maintenance of equipment and furniture at all levels. The optimal performance and longevity of equipment will be assured by establishing medical equipment and hospital furniture maintenance workshops across the country as well as exploring public private partnership in maintenance of medical equipment and hospital furniture.

2.2.4.5 Strengthen referral system

Another key intervention is to strengthen referral systems. This can be done by mapping network linkages for two-way referral systems in line with national standards, with implementation guidelines for all cases such as emergency obstetric care, complicated malaria, road traffic accidents, etc; Transportation, communication and other logistics for referrals need to be put in place to ensure effective referrals and a system put in place to monitor referral outcomes.

2.2.4.6 Foster collaboration with the private sector

The private sector plays a key role in provision of health services in the country. Therefore, collaboration with the private sector health care providers will be fostered. Specific action to promote this will include the mapping of all categories of private health care providers by operational level and location, development of guidelines and standards for regulation of their practice and their registration. For the full potential of the private sector to be realised, guidelines for partnership, training and outsourcing of services will be developed. In addition joint

performance monitoring mechanism for the private sector will be developed and implemented. Also, the national policy on traditional medicine will be adapted and implemented at all levels.

2.2.4.7 Strengthen professional regulatory bodies and institutions

The need to standardise and regulate practice cannot be over emphasised. To this end regulatory bodies and institutions will be strengthened through the following potential actions: review, update and implement operational guidelines of all regulatory bodies at all levels and build capacity of regulatory staff to monitor compliance of providers to the regulatory guidelines. Budget lines are to be created and necessary resources provided. Regular monitoring exercises with appropriate documentation and feedback will be strengthened and regulators empowered through the provision of necessary security.

2.2.4.8 Develop and institutionalise quality assurance models

Another intervention is the development and institutionalisation of quality assuarance models. This will be done by reviewing available models and building consensus on the models to adopt. Furthermore, quality assurance training modules will be developed to build capacity of both public and private health care providers, training of trainers (TOT) conducted and cascaded to other health workers. Thereafter, quality assurance and improvement initiatives will be institutionalised and implemented at all levels. The quality of service delivery can be further assured by entrenching the ideals of SERVICOM at all levels of care. This will be achieved through the development of SERVICOM guidelines, building institutional capacity and training staff for its implementation at all levels. Strategies will be put in place for monitoring implementation of quality of care.

2.2.4.9 Institutionalize Health Management and Integrated Supportive Supervision (ISS) mechanisms

Integrated supportive supervision is an important strategy for ensuring that health workers are adequately supported in the process of providing health care services. This concept is predicated on the fact that many problems occur in the health facilities of which providers will not have immediate solutions. This helps in boosting the moral of the workers in their health facilities setting. To achieve comprehensive integrated supportive supervision the management capabilities of health managers and health teams especially at the LGA and Ward Levels will be strengthened through team building and leadership development programmes, institutionalization of comprehensive ISS at all levels, development of capacities of programme managers at all levels on the ISS mechanism; and development of ISS tools and guidelines specifying modalities and frequencies of the ISS visits at all levels.

To increase demand for health care services

2.2.4.10 Creating effective demand for services

In order to promote positive lifestyles for disease prevention and increase demand for health services, it is necessary to develop, disseminate and implement a national health promotion communication strategy based on the National Health Promotion Policy, and its corresponding adaptation to reflect local realities. To actualise the above intervention, budget lines for health promotion through Behavioural Change Communication will be provided at all levels and a programme monitoring and evaluation system put in place. *This intervention is further explored under Priority Area 7 of this framework.*

To provide financial access especially for the vulnerable groups

2.2.4.11 Improving financial access especially for the vulnerable groups

The costs associated with health care can be a barrier to accessing health services especially for the vulnerable groups. Models for financial protection for the vulnerable groups (e.g. Pregnant women, under fives, orphans and the aged) such as exemption schemes vouchers, health cards, pre payment schemes will be explored and existing financial protection schemes scaled up.
This intervention is further explored under Priority Area 4 of this framework.

2.3 PRIORITY AREA 3: HUMAN RESOURCES FOR HEALTH

2.3.1 Context

Human Resources for Health (HRH) comprise of trained health personnel in the public and private sector (doctors, nurses/midwives, pharmacists, relevant technicians, and community health workers e.t.c.), untrained informal health workers, including community-based health care providers e.g. herbalists, traditional birth attendants and volunteers, who play complementary roles in health care service delivery. Human Resources for Health (HRH) plays an important role in improving health system performance and should reflect the right number, mix, distribution and appropriate skills set (experience & qualifications) to provide the services required.

While Nigeria has one of the largest stocks of human resources for health in Africa, it is still inadequate to meet the country's needs. In 2006, an inventory of health care personnel indicated 39,210 doctors (0.3 doctors /1,000population), 124,629 nurses (1.03 nurses/1000 population), 88,796 midwives (0.67 midwives/1000 population), 2,482 Dentists (0.02 dentists/1000 population), and 12,072 Pharmacists (0.05 pharmacists/1000 population) for the year 2004[20].

[20] Health Reform Foundation of Nigeria (2007) *Nigerian Health Review* Abuja: Health Reform Foundation of Nigeria p.55

The planning and management of HRH still poses a major challenge to health development in the country as evidenced by absence of a human resource plan, especially at lower levels, lack of coordination, alignment and harmonization of HRH needs at all levels of government. In addition, dearth of skills, problems with HRH mix, poor motivation, differential conditions of service, remuneration and work environment; negative attitude to work and poor supervision are added challenges, some of which contribute to inequitable distribution to the disadvantage of lower levels of care, rural areas and northern parts of the country, and high attrition rates observed. Also, entry qualifications and the ceilings placed on enrolment to schools of midwifery and nursing by their regulating body are limitations to addressing the very critical HRH challenges in the some parts of the country.

There are presently 14 professional regulatory bodies charged with the responsibility of regulating and maintaining standards of training and practice for various health professionals. However, they are limited by weak structures and institutional capacities to carry out statutory functions of effective monitoring and accreditation of training institution programmes.

To respond to the weak HRH performance, in 2006, the FMOH through a participatory approach developed a comprehensive National Human Resources for Health Policy[21] and its corresponding Strategic Plan for 2008 to 2012[22]. Interventions contained therein guide investments and decision making in the planning, management and development of human resources for health at the federal, state, LGA and institutional levels. The HRH policy and Strategic plans are therefore valuable tools in rationalizing production, distribution and utilization of health workforce in the country. It is also noted that currently, few States have adapted the National HRH policy.

2.3.2 Goal

Plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care.

2.3.3 Strategic Objectives

2.3.3.1 To formulate comprehensive policies and plans for HRH for health development

2.3.3.2 To provide a framework for objective analysis, implementation and monitoring of HRH performance

2.3.3.3 To strengthen the institutional frameworks for human resources management practices in the health sector

[21] Federal Ministry of Health. (2006) *National Human Resources for Health Policy*

[22] Federal Ministry of Health. (2008) *National Human Resources for Health Strategic Plan (2008 – 2012)*

2.3.3.4 To strengthen the capacity of training institutions to scale up the production of a critical mass of quality, multipurpose, multi skilled, gender sensitive and mid-level health workers

2.3.3.5 To improve organizational and performance-based management systems for human resources for health

2.3.3.6 To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

2.3.4 Interventions

A description of possible activities that can contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

To formulate comprehensive policies and plans for human resource for health development

2.3.4.1 Development and Institutionalization of the Human Resources Policy framework

States are to domesticate the National HRH Policy and Strategic Plan to guide human resource development at all levels. Policies on training and recruitment of health personnel are to be updated across the country to make them non-restrictive and ensure non-discriminatory processes irrespective of states of origin and/or gender. A policy framework to guide existence of private and public practitioners at all levels of health service delivery is to be developed; also develop and implement guidelines on task shifting and establish a fora for public-private practitioners to institutionalize HRH policy reviews, supervisory and monitoring frameworks.

To provide a framework for objective analysis, implementation and monitoring of HRH performance

2.3.4.2 Reappraisal of the principles of health workforce recruitment at all levels

Career pathways for all groups of health professionals critically needed to foster demand and supply creation in the health sector are to be developed and streamlined. To guide HRH planning, it is necessary to develop, introduce and utilize staffing norms based on workload, service availability and health sector priorities. It is also necessary to establish coordinating mechanisms for consistency in HRH planning and budgeting by Ministries of Health, Finance, Education, Civil Service Commission, Regulatory bodies, Private Sector Providers, NGOs in health, and other institutions. State and LGA capacities will be strengthened to access and implement federal government circulars, guidelines and policies related to HRH. Entry criteria

and admission quotas of prospective health care providers into training institutions are to be reviewed.

Strengthen the institutional framework for human resources management practices in the health sector

2.3.4.3 Establishment and strengthening of the HRH Units

HRH units will be created / strengthened at all levels to perform HRH functions. Training programmes in human resource for health planning and management at all levels will be established to enhance the HRH managers.

To strengthen the capacity of training institutions to scale up the production of a critical mass of multipurpose and mid-level health workers

2.3.4.4. Review and adaptation of relevant training programmes for the production of adequate number of community health oriented professionals based on national priorities

Training programmes of health related institutions in HRH will be reviewed in line with national priorities. Special training programmes aimed at producing adequate cadres of health professionals in critical areas of need will be designed and implemented. Similarly, training for community health workers and other cadres of supportive personnel will also be established or expanded. In addition, the national Midwives Service Scheme and the Community Midwifery Programme will be promoted. Furthermore, admission criteria for relevant disciplines in response to the HRH crisis in disadvantaged areas of the country will be reviewed, while adequate production of qualified health professionals through appropriate accreditation and regulatory bodies will be strengthened. Continuous assessments of training institutions and programmes will be institutionalised and curricula and programmes to reflect task shifting requirements will be developed and implemented. Regular review of functions and mandates of HRH regulatory bodies will be conducted and public private partnership in HRH development and management strengthened.

2.3.4.5 Strengthening of health workforce training capacity and output based on service demand

To set up and strengthen training institutions for production of health care providers there is need to provide minimum levels as well as ensure the periodic upgrading of teaching and learning materials, infrastructure and financial support as incentives for retention of staff. Quality assurance units and education review units are to be established in all training institutions with incentives for satisfactory performance. Training curricula of identified training institutions will be reviewed to reflect the disease burden situation of the country. Accreditation systems for training institutions to ensure professional standards of health personnel will be strengthened and

accreditation of eligible private sector health facilities to increase training opportunities for internship and post-basic training for all sector health professionals facilitated.

Human capital capacity building and continuing professional development (CPD) by government and healthcare provider institutions will be promoted and coordination with professional regulatory bodies to link sponsorship to bonding of healthcare providers to mitigate migration across states and outside the country established.

To improve organizational and performance-based management systems for human resources for health

2.3.4.6 Equitable distribution, right mix and retention of the right quality and quantity of HRH

To achieve the objective of recruitment, selection and deployment of competent and capable staff to reflect organizational objectives and needs, attention needs to be paid to deployment processes that are equitable in terms of mix, needs and geographical space. It is crucial to create a database of HRH, and to develop and provide job descriptions and specifications for all categories of health workers. Redeploy staff equitably between rural and urban areas and at the different levels of the health care system in relation to needs, paying attention to staff mix. States MoH are to collaborate with Federal institutions located in their states to leverage available human resource so as to expand service coverage and quality. Mandatory rotation of health workers to underserved rural areas, e. g through NYSC scheme for doctors, pharmacists and appropriate scheme for midwives and nurses is to be promoted. The National Health Bill makes provision for a primary healthcare fund from the federation account; 10% of this fund should be deployed equitably for HRH. Retention strategies including management of migration, through bilateral and multilateral agreements are to be developed and implemented to reverse and contain the crises. The pool of professionals in Diaspora and the capacities of retired trained health professionals will be leveraged to strengthen the human resource availability in the country and meet HRH gaps respectively. Use of intra or extra mural private practice services to improve services in underserved areas as well as provision of incentives for health workers in underserved areas will be instituted.

Mechanisms to minimize work place hazards through management of physical risks and mental stress, with full compliance with prevention and protection guidelines will be strengthened so as to create an enabling environment that motivates staff. Performance-based incentives will be established.

2.3.4.7 Establishment of mechanisms to strengthen and monitor performance of health workers at all levels

Routine re-orientation of health workforce on attitudinal change including training and retraining in Interpersonal Communication (IPC) skills and work ethics are to be conducted for the promotion of client satisfaction and improvement of quality of care. A system of recognition, reward and sanctions will be instituted. It is also vital to establish and institutionalize a framework for an integrated supportive supervision with adequate committed resources for all types and levels of care providers across public and private sectors. Mechanisms will be established to monitor health worker performance, including use of client feedback (exit interviews).

To foster partnerships and networks of stakeholders to harness contributions for human resource for health agenda

2.3.4.8 Strengthening communication, cooperation and collaboration between health professional associations and regulatory bodies on professional issues that have significant implications for the health system

The HRH policy (2007) states that government shall promote intra and inter-professional respect, harmony and team work among all disciplines of health care workers for optimum health service delivery. This can be achieved through establishing effective dialogue and complaints channels between management and staff of public and private sectors as well as HRH regulatory bodies and associations. Also, involvement of workers and professional groups in management teams, design and monitoring of services is proposed to enhance cooperation amongst all actors.

2.4 PRIORITY AREA 4: HEALTH FINANCING

2.4.1 Context

Poor utilisation of modern health services leading to poor health outcomes for majority of the citizens of Nigeria is not only influenced by lack of knowledge and negative perception but also by health care costs that include cost of services, travel to health facilities and opportunity costs. Poverty level is therefore a major factor responsible for individual and household decision making on utilization of health services.

The Commission for Macroeconomics and Health estimates a cost of about US$34 per person per year (per capita) to deliver an essential package of interventions to meet the Millennium

Development Goals (MDGs)[23]. In Nigeria the total per capita health expenditure is estimated at between $10 at average exchange rates with private out of pocket expenditure (OOPE) accounting for 70%[24]. It is also recognized that the poor spend a disproportionately higher percentage of disposable household income on healthcare and in the absence of social protection mechanisms (health insurance, social security or credible exemptions), this population face challenges of financial barriers to health care at the time of need. This no doubt deters the poor from seeking health care on time or deepens their impoverishment when they are compelled to make health expenditure.

African leaders at a special session of the OAU in Abuja in 2001, in consideration of the dismal situation of health care delivery with its poor level of funding recommended the allocation of 15% of total national budget to health. Though Nigeria committed to meeting this declaration, between 1999 and 2008 the average allocation to the health sector was recorded to be about 5% of the total national budget.

Currently, healthcare is financed in Nigeria from a mixture of budgetary allocations from the Federal, States and LGAs, private out-of-pocket expenditure, external development funding, grants from corporations and charities and a small but growing social health insurance contributions. Lately, many States have also commenced programmes aimed at protecting vulnerable groups from the financial risk of ill-health, such as free maternal and child health services. Nonetheless, in order to achieve the level of funding required for meeting the health needs of the whole population, the country has to put in place mechanisms for increased funding both in absolute terms and as a proportion of the total budget. In addition, there is a need to coordinate all the resources available to the sector from all sources. The Draft National Health Bill, when enacted into law will assure significant improvement in health care financing in the country as it earmarks 2% of the consolidated federal revenue for health, with a large proportion of it assigned for PHC.

In the recent past, a range of potential measures are being established, including the National Health Insurance Scheme (NHIS) that incorporates programmes covering formal sector workers; community-based health insurance; social health protection models targeted at the poor and vulnerable groups such as free maternal and child health (MCH) services, voucher schemes, health cards and exemptions; and private health insurance. However, none of these options have

[23] Commission for Macroeconomics and Health (2001) *Macroeconomics and Health: Investing in Health for Economic Development*. Geneva: World Health Organisation

[24] Federal Ministry of Health (2004) Health Sector Reform Program: Strategic Thrusts and Logframe

been scaled up to the point of providing adequate financial risk protection for majority of people in Nigeria[25].

2.4.2 Goal

Ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at LGA, State and Federal levels

2.4.3 Strategic Objectives

2.4.3.1 To develop and implement health financing strategies at Local, State and Federal levels consistent with the National Health Financing Policy

2.4.3.2 To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services

2.4.3.3 To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner

2.4.3.4 To ensure efficiency and equity in the allocation and use of health sector resources at all levels

2.4.4 Interventions

A description of some activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

To develop and implement health financing strategies at Local, State and Federal levels consistent with the National Health Financing Policy

2.4.4.1 Strategic Health Financing Plans

The first intervention of the health financing strategic framework is to develop and implement evidence-based, costed health financing strategic plans at LGA, State and Federal levels in line with the National Health Financing Policy. This will require the setting up of technical working groups for health financing at each tier of government and capacity building for the development and implementation of the Strategic Plans at all levels. There may be a need for the Federal Ministry of Health to provide technical assistance to support this process.

[25] National Health Insurance Scheme. (2008). *Blueprint for the Implementation of Social Health Insurance Programme in Nigeria*. Abuja: National Health Insurance Scheme

To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services

2.4.4.2 Strengthen System for Financial Risk Health Protection

A large proportion of the people in Nigeria have little protection against economic costs of catastrophic illness. States and LGAs will be supported to explore existing and innovative social health protection approaches – social health insurance, other pre-paid schemes, community-based health insurance schemes, etc - for sustainable health financing with protective measures against the financial risks associated with ill health. Technical support will be provided to States and LGAs to rapidly scale up successful approaches to achieve wider population coverage. The capacity of the NHIS needs to be strengthened to provide effective regulatory framework for social health Insurance and protection programmes in the country. This will require the review and amendment of the current law establishing the NHIS to provide the legislative backing for its regulatory authority.

To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner

2.4.4.3 Improving Financing of the Health Sector

The level of public sector finance available within Nigeria for funding health care at all levels – Federal, States and LGAs, is insufficient when compared with the scale of health needs. Mechanisms will be put in place to get governments at all levels to increase the allocation of public resources to the health sector (apportion 15% of total budget on health in line with Abuja Declaration) and to assist them in the effective and efficient use of these resources. States and LGAs will be supported by the FMoH to test and implement strategies for attracting alternative financial flows to the health sector and to share lessons learnt. Existing and potential financing strategies that will be considered include pre-payment schemes, and health insurance schemes, grants from the Federal Government, proportion of Value Added Tax (VAT), "sin tax" from alcohol and cigarette and donations from corporations and charities. Special funds for chronic and emerging diseases (e.g. mental health, cancers, diabetics etc.) may also need to be established. In all cases, the establishment of alternative financing sources will include careful consideration of the impact on poverty and gender and financing safety nets will be established to protect the interests of the poor and vulnerable groups.

2.4.4.4 Donor Coordination of Funding Mechanisms

The coordination of the activities of government and donor health programmes is relatively weak at both Federal and State levels in Nigeria. The FMoH in collaboration with Development Partners will conduct a detailed assessment of coordination structures and functions which exist in the country and appropriate models for more effective coordination will be established on a State by State basis and at the Federal level. Mechanisms for coordinating donor resources with

that of government for health development are expected to take the form of common basket funding through options such as joint funding agreements, sector-wide approaches (SWAps) and sectoral multi-donor budget support etc. The implementation of Paris declaration on aid effectiveness with a follow up of the Accra agenda will be promoted.

To ensure efficiency and equity in the allocation and use of health sector resources at all levels

2.4.4.5 Health Budget Execution, Monitoring and Reporting

Systems for monitoring budget execution at all levels are grossly inadequate more so with existing wide gaps between annual budgetary allocation and budget outturn. The FMoH will provide technical assistance to aid States and LGAs in developing costed, annual operational plans. Additional capacity will be built to ensure that proper internal recording and accounting of expenditures are maintained and that timely and detailed financial management reports are produced periodically. Credible mechanisms will be put in place to increase financial transparency through the development of National and State Health Accounts (NHA and SHAs) and Public Expenditure Reviews (PERs) and tracking of health budgets.

2.4.4.6 Strengthening Financial Management Skills

Competencies at all levels but especially at the State Ministries of Health and LGA Health Departments in critical areas such as budgeting, planning, accounting, auditing, monitoring and evaluation are in short supply. It will be very difficult to undertake effective transparent budgeting and management of the financial systems in the sector if practical steps are not taken to bridge the skills gap. Consequently, hands-on training and competency transfer will be conducted to enable the States and LGAs manage their financial management systems.

2.5 PRIORITY AREA 5: NATIONAL HEALTH INFORMATION SYSTEM

2.5.1 Context

In 1988, Decree 43 of the Federal Government of Nigeria created national M&E units to provide necessary mechanisms for tracking government budget and performance. This was followed by the establishment of Primary Health Care Management Information system (PHCMIS) in 1990 with a review in 2001. Equally, an integrated National Health Management Information System (NHMIS) was formally developed in Nigeria in 1993, following previous attempts at vertical data collection, collation and analysis systems. Recently in 2006, eventual harmonization of vertical M&E tools and systems culminated in the incorporation of key programmatic indicators in the health sector into the NHMIS and as captured in the current NHMIS Policy (2006). The NHMIS is equipped to improve data capture, storage analysis and report generation for health data in Nigeria. Also in existence is the National Bureau of Statistics which is backed by law and responsible for collecting as well as collating socio-economic indicators to inform decision making.

A Health Data Consultative Committee (HDCC) comprising of government and partners was established at federal level to coordinate and harvest population based data and other data from surveys and with a mandate to meet quarterly and with similar structures at State and LGA level. To meet the resource requirement to strengthen the NHMIS, in 1995, the National Council on Health adopted a resolution to allocate funding to the NHMIS based on an identified vote-of-charge (VOC) consisting of 0.5% to 1.0% of the annual capital (health) budget.

The NHMIS/M&E remains weak and fragmented with numerous vertical programmes and systems, which are mostly donor driven. In addition, there are multiplicity of data collection tools, too many indicators, and reluctance of developmental partners and the vertical programmes which they support (including programmes within the FMoH), to utilise national tools. Furthermore, there is no national M&E policy, framework and plan and there is lack of integration between the NHMIS and M&E systems. Even though the private sector provides 60% of healthcare in the country, there is very limited capture of their data into the NHMIS. Other major problems include lack of forms; incomplete, untimely, and largely incorrect reporting of data; grossly inadequate capacity to analyse and utilise data for decision making at all levels; and poor feedback mechanisms.

2.5.2 Conceptual Definitions

Health Information System is defined as a set of components and procedures organized with the objective of generating information which will improve health care management decisions at all levels of the health system.

Monitoring and Evaluation: **Monitoring** is a systematic process of collection and analysis of data to track project implementation and use of the information in project management and decision making. **Evaluation** on the other hand is a systematic process of collecting and analyzing information to assess the *effectiveness* of the programme organization in the achievement of its stated goals.

Disease surveillance: The ongoing systematic collection, collation, analysis, and dissemination of information to all those people who need to take action for the prevention and control of disease. In Nigeria, the surveillance system in place Integrated Disease Surveillance and Response (IDSR) is for communicable diseases.

2.5.3 Goal

Provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care

2.5.4 Proposed Strategic Objectives

2.5.4.1 To improve data collection and transmission
2.5.4.2 To provide Infrastructural Support and ICT on Health Databases and Staff Training
2.5.4.3 To strengthen sub-systems in Health Information System
2.5.4.4 To Monitor and Evaluate the NHMIS
2.5.4.5 To strengthen analysis of data and dissemination of health information

2.5.5 Interventions

A description of key activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

To strengthen data collection using nationally standardised forms

2.5.5.1 Ensure availability of NHMIS tools at all health service delivery points at all levels

One key constraint to implementation of effective NHMIS is lack of tools for data collection. States and LGAs will make forms available by providing adequate budget and ensuring that funds are released for printing of the data collection forms. Moreover, the forms will be distributed to appropriate facilities to ensure their utilisation. Forms will be produced 6 monthly.

2.5.5.2 Periodic review of NHMIS data collection forms

NHMIS data collection forms will be reviewed periodically by FMOH in consultation with all stakeholders. The health managers at States and LGAs will create mechanisms to ensure regular feedback from the field on the appropriateness and user friendliness of data collection tools and establish mechanisms for annual review.

2.5.5.3 Coordinate data collection from vertical programmes

The Health Data Consultative Committee at Federal and State levels in collaboration with partners and other government agencies will be revitalised to streamline and strengthen data collection systems. The FMoH will integrate the current HIS with M&E system in the country to ensure coherence and complementarity. Linkages and harmonized data collection mechanism at State and LGA levels will be established and strengthened.

2.5.5.4 Build capacity of health workers for data management

Comprehensive training and re-training of service providers on data collection tools, analysis and utilisation of data for action in health programming and policy formulation will be conducted. Adequate monitoring systems at Federal and State levels to ensure data quality will be established, and recruitment of health information personnel, where grossly inadequate, to support the system will be undertaken.

2.5.5.5 Provide legal framework for activities of the NHMIS programme

In order to make data collection and utilisation mandatory, the draft National Health Bill proposes sanction of private care providers that fail to submit health data to the relevant health authorities. Mechanisms to enforce these sanctions will be put established. Additional legal framework for activities of the NHMIS programme will be put in place at State and LGA levels. Systemic advocacy will be embarked upon to policy makers to make them understand the value and usefulness of data as well as promulgate an enabling law and bye laws to make this mandatory. The FMoH and SMoH will spearhead this advocacy both to the top government functionaries as well as National and State Assembly. The vital registration system in the country will also be strengthened.

2.5.5.6 Improve coverage of data collection

In order to have good database the national data collection process and coverage will be improved. States will be encouraged to develop innovative strategies to collect data from all public and private health facilities and equally improve the collection of community based data. In addition, the National Population Commission will be supported to strengthen vital statistics of birth and death registration both by the federal and state government. This will only be feasible if there are adequate data collection tools and follow up on defaulting facilities.

2.5.5.7 Supportive supervision of data collection at all levels

Supportive supervision of data collection at all levels will be carried out and provision for adequate logistics for officials to supervise data collection at lower levels will be ensured.

To provide infrastructural support and ICT for health databases and staff training

2.5.5.8 Strengthen the use of Information technology in HIS

Use of information technology on HIS will be strengthened, and decentralized software-based systems for data collection and analysis will be promoted public-private partnerships in the management of data warehouses will be established as well as mechanisms to enhance the wide use of e-health data, such as through electronic Management Intelligence Information System, websites, Patient information system, etc.

2.5.5.9 Provision of HIS Minimum Package at the different levels (FMOH, SMOH, and LGA) of data management

An HIS Minimum Package at the different levels (FMoH, SMoH, and LGA) of data management will be defined. Subsequently, adequate and timely availability of the NHMIS Minimum Package at federal, state and LGA levels for data management, inclusive of basic infrastructure for data storage, analysis and transmission systems (computers, power supply, and internet) will be provided. Appropriate use of computers hardware systems will be monitored while acquisition systems for database software at all levels will also be deployed. Finally, capacity of relevant staff on the database will be built.

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To strengthen sub-systems in Health Information System

2.5.5.10 Strengthen Hospital Information System

The Federal and State ministries of health will establish and strengthen patient information systems as well as systems for mapping disease.

2.5.5.11 Strengthen Disease Surveillance

The Federal, State and LGAs will also ensure that regular reporting of notifiable diseases by all health facilities is carried out, as well as initiate and strengthen community based surveillance to strengthen disease Surveillance System.

To monitor and evaluate NHMIS

2.5.5.12 Establishment of monitoring protocol for NHMIS programme implementation at all levels in line with stated activities and expected outputs

Timely availability of logistics materials (vehicles or motorcycles) will be provided and use of NHMIS field monitoring instruments at all levels facilitated. HIS Quality Assurance (QA) manual (Handbook) will be used at each level of health care delivery, while quarterly HIS review meetings at LGA level, bi-annual review meetings at State level and annual meetings at National level instituted.

2.5.5.13 Strengthen data transmission

Institutional and human capacities for timely and complete transmission of data in line with relevant guidelines will be built.

To strengthen analysis of data and dissemination of health information

2.5.5.14 Institutionalize data analysis and dissemination at all levels

Institutional and human capacities for appropriate data analysis and dissemination of information and data to inform decision making and programming will be strengthened. Production of periodic health data bulletin and annual reports by Departments of Planning Research and Statistic at the Federal and States levels will be instituted.

2.6 PRIORITY AREA 6: COMMUNITY PARTICIPATION AND OWNERSHIP

2.6.1 Context

Traditional self help and community efforts in health development through community safety nets and other support mechanisms have been part of the history of communities in Nigeria. These efforts at community participation have however been limited in scope, organization and impact. Lack of clear policy framework to empower the community as the draft Community Development Policy is yet to be finalized may be contributory. National efforts at promoting community participation in health began with the introduction of PHC in the country in 1986. National guidelines were developed for PHC planning and implementation, including those for community participation. They included very prescriptive guidelines for setting up village health committees across the country with definitions of the size, composition and functions, which resulted in little or no efforts in the identification and strengthening of existing local social organizations, thereby pre-empting a crisis of legitimacy.

The introduction of PHC in the country also witnessed the development of training curricula for traditional birth attendant (TBAs) and village health workers (VHWs). The TBAs were to assist in home deliveries while the VHWs were to provide basic curative care and health education. While there were guidelines for linking this cadre of health care providers to the formal health sector, they were never implemented. The system for replenishing their health commodities were similarly not implemented as was the mechanism for their supervision, leading to the collapse of the programme. However, other programs have continued to train and support this cadre of workers, albeit on a limited scale. More recently, many programmes have successfully introduced the training programmes of different cadres of community-based health care providers like community drug distributors of ivermectin for onchocerciasis, community-based distribution agents for family planning commodities, vaccinators for polio eradication campaigns, community oriented resource persons (CORPs) for Integrated Management of Childhood Illness (IMCI), community volunteers for the community-based TB programme,

home-based care providers for home management of HIV/AIDS and role model mothers for home-based malaria treatment and control.

The Bamako Initiative (BI) which began in Nigeria in 1987 was a major effort to introduce the concept of community co-management and co-financing of essential drugs as a strategy for improving maternal and child health through the improvement of quality of services in PHC facilities. By 1998, the programme was scaled -up and consolidated through the PTF to cover all the LGAs in the country. A nationwide evaluation of BI by NPHCDA in 2001 showed a massive decapitalization of the funds and minimal evidence of community participation in the management of the drugs[26]. The introduction of the National Health Insurance Scheme has also opened another window of opportunity to foster community participation in health care through the community-based social health insurance scheme for the informal sector, which constitutes 70% of the population in the country. Currently, this sector pays for services through out-of-pocket expenditure; thus limiting access to health services.

There is minimal constructive engagement of communities in needs identification, planning and implementation of health programmes. To many, community participation was synonymous with provision of building for government to staff and provide curative services. Largely, communities remain reliant on government. Inadequate community participation has also resulted in inappropriate sitting of PHC facilities in inaccessible or unacceptable locations and also, gross underutilization of the services rendered.

2.6.2 Conceptual Definitions

Community Participation

Community participation has been defined as the process of enabling individuals, families and communities to take greater control over their health, on health promotion interventions to prevent disease, and take actions in the event of ill health on what to do and when and where to seek health care. It seeks to establish a partnership between government and local communities in the planning, implementation, utilization, monitoring and evaluation of services so that the community can benefit from increased self-reliance and social control over the infrastructure and technology of PHC. Community participation in health is therefore considered a fundamental human right as individuals and families have a right to participate in decisions affecting their health and are known as “right holders”. The Alma Ata declaration identified community participation as a key principle of PHC and central to the attainment of the goal of Health for All.

2.6.3. Goal

[26] National Primary Health Care Development Agency. (2001) *Evaluation of the Bamako Initiative.* NPHCDA, Abuja

Attain effective community participation in health development and management, as well as community ownership of sustainable health outcomes

2.6.4. Strategic Objectives

2.6.4.1. To strengthen community participation in health development
2.6.4.2. To empower communities with skills for positive health actions
2.6.4.3. To strengthen the community-health services linkages
2.6.4.4. To increase national capacity for integrated multi-sectoral health promotion
2.6.4.5. To strengthen evidence-based community participation and ownership efforts in health activities through researches

2.6.5 Interventions

A description of some activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

To strengthen community participation in health development

2.6.5.1 Provide an enabling policy framework for community participation

The importance of community participation in health outcomes is recognized by stakeholders. While there are guidelines for engaging communities, a policy that gives direction is lacking. There is the need to create an enabling policy environment to foster effective community participation in health actions through the appropriate revision of community participation section of the National Health Policy and finalization of the Community Development Policy.

2.6.5.2 Provide an enabling implementation framework for community participation

Communities have some level of organization which enables them carry out activities that protect their common interests and foster achievement of common goals. However, where available, the guidelines for establishing community structures for health development activities have been highly prescriptive. Therefore, existing guidelines for establishing community development are to be updated and adapted and participatory tools and approaches to enhance community involvement in planning, management, monitoring and evaluation of health interventions developed and utilised. There is need to establish inter-sectoral stakeholder committees involving community representatives at all levels so as to enhance collaboration.

To empower communities with skills for positive health actions

2.6.5.3 Building community capacity

To enable communities to actively participate in health actions, they need to be empowered with health knowledge and capacity in management, implementation, as well as basic interpretation of health data. The key roles and functions of community stakeholders and structures will be defined. To actualize the intervention, various processes will be followed, which starts with the development, upgrading or modification of existing participatory tools for mobilising communities in planning and management. Follow up actions to this will entail the identification and mapping out of key community stakeholders and resources with community assessment of capacity needs. Community development committees and community-based health care providers will be re-oriented on their roles and responsibilities and resources mobilized and allocated for funding for community level activities. Community dialogue between communities and government structures for maximum impact will be established and information, education and communication (IEC) activities and media used to enlighten and empower communities for positive action. Communities will be involved at all levels in program planning, implementation and monitoring of health activities.

To strengthen the community-health services linkages

2.6.5.4 Restructure and strengthen the linkages between the community and health services delivery points

Across the country, the isolated and piecemeal approach to community participation for health services (when they exist) has resulted in the fragmentation and limited success recorded for community participation efforts. A major intervention will be jumpstarted by a review and assessment of the level of linkages of the existing health delivery structures with the community. Technical guidance and support will be provided to community stakeholders for the development of guidelines for strengthening the community-health services linkage and there will be restructuring of health delivery structures to ensure adequate promotion of community participation in health development. In addition facilitation of exchange of experiences between community development committees will be promoted.

To increase national capacity for integrated multi-sectoral health promotion

2.6.5.5 Develop and implement multi-sectoral policies and actions that facilitates community involvement in health development

Community involvement in health development is hinged on the utilization of approved and acceptable approaches, people and systems. Advocacy to community gatekeepers to increase their awareness on community participation and health promotion will be undertaken and community health development programmes developed and implemented. Action plans to facilitate the development of health promotion capacities at community levels will be formulated

and support given to various levels to link health with other sectors using the health promotion guidelines.

To strengthen evidence-based community participation and ownership efforts in health activities through researches

2.6.5.6 To develop and implement systematic measurement of community involvement
The framework for measurement of community involvement efforts (methods, and impact, which showcases the various models that have been adopted, and opportunities to learn lessons) has been seriously lacking. Locally adapted models will be used to establish simple mechanisms to support communities to measure impact and document lessons learnt and best practices from specific community-level approaches, methods and initiatives and the findings from such efforts disseminated to enhance knowledge sharing amongst stakeholders.

2.7 PRIORITY AREA 7: PARTNERSHIPS FOR HEALTH

2.7.1 Context
Health is a multidimensional issue and government alone cannot meet the all the health needs of the people in Nigeria. Partnership with the private sector, non-governmental organisations, communities and development partners (donors) as well as other social and economic sectors is essential to deliver health services that can meet the needs of the population on a sustainable basis.

Private for profit Health Care Providers
There is a growing, but poorly regulated, private sector and a plethora of private sector providers ranging from private hospitals, clinics, to pharmaceutical stores, patent medicine stores and traditional healers used increasingly by growing numbers of people to access health services. Most of such facilities are unregistered; employ unqualified health workers and dispense counterfeit drugs despite the regulatory framework provided by the National Agency for Food and Drugs Administration and Control (NAFDAC).[27] It has been shown that there is a higher utilization of the private sector health facilities than public ones in Nigeria[28]. Perceived better quality care was identified as a factor and despite the high costs, the poor represent a significant

[27] NAFDAC Baseline Study of the Nigeria Medicines Situation conducted in 2005 by the World Health Organisation, and funded by the UK Department for International Development (DFID)

[28] Health Reform Foundation of Nigeria (2007) *Nigeria Health Review* Abuja: Health Reform Foundation of Nigeria

proportion of beneficiaries of varied forms of private health care, although effectively priced out of the health care market.

Private Not for Profit

There are thousands of active non-governmental organisations providing not for profit health care in Nigeria with a significant proportion from faith-based organizations. Their services are generally perceived to be of better quality and more accessible to the poor, however, unlike other African countries, in Nigeria, this sub-sector has received little government and external support Judicious and focused support to this sub-sector could in areas of need secure improved health benefits to the poor and the vulnerable.

Health Development Partners (DP)

The coordination of international and national based health development partners including Multilaterals, Bilaterals, NGOs, etc is the responsibility of the Departments of Planning and Planning Commissions at federal and state levels. Within the health sector, there currently exists some coordinating mechanism such as inter-agency coordinating committee (ICC) for immunization, Country Coordinating Mechanism (CCM) for the Global Fund and the Roll Back Malaria (RBM) partnership, Health Partners Coordination Committee and Health Systems Forum. However, there has been a lack of a harmonized framework for coordination between the FMOH and health development partners. As a result, effective coordination has been poor with donors working separately through various departments and agencies within the sector. The lack of an overarching framework specifying priority needs has allowed for donor driven aid deployed inefficiently and inequitably with the programmes not aligned or harmonized with government plans.

The Health Sector Reform Programme (2004 – 2007) in recognition of this captured improved donor coordination as essential to increasing the effectiveness of aid resources. There is some work in progress in the development of a Joint Funding Agreement (JFA) under the guidance of Federal government agencies such as NACA. The increasing focus on implementing the principles of the Paris Declaration on Aid Effectiveness towards achieving the MDGs is a propelling force to improve harmonization amongst donors and the subsequent alignment to national priorities.

Other Sectoral Ministries, Department and Agencies (MDA)

PHC recognizes inter-sectoral collaboration as one of its key principles; however, effort to establish this has been very limited. Presently, there is little or no inter-sectoral collaboration with key relevant Ministries such as Finance (adequate budgetary allocation and prompt release of funds); Education (school health and health promotion, girl-child education); Agriculture (food security, adequate and proper nutrition); Water Resources (adequate and safe, clean water);

Environment (pollution and vector control); Industry (production of critical inputs such as food and drugs and occupational health); Planning Commissions (Economic development and Poverty Reduction Strategies) to mention a few. For a holistic approach to health, all sectors must be mobilized through good governance, strong political will and commitment to galvanize all stakeholders towards a common purpose – better health for all.

Professional groups

Health care is a labour intensive sector dominated by various professionals that necessarily have to work in collaboration with one another and with all health authorities. Health professionals and health workers require strong, integrated health systems at both national and local levels to support the delivery of universal care and services. Proven, affordable interventions implemented in collaboration with professional groups within an integrated network of care, from community to referral centers have recorded success. Throughout the cycle of life, individuals and communities rely on health professionals to not only save lives, but to maintain and promote well being. These professionals groups include those for Doctors (Nigerian Medical Association and its affiliates), Nurses and Midwives (NANNM), Pharmacists (PSN), Community Health Workers (ACHPN), Medical Lab Scientists, anesthetists and other professional bodies. Health professional associations and societies therefore have vital roles to play in ensuring that health professionals are well equipped to deliver their important roles in improving health outcomes. Failure of cooperation among these professional groups to achieve broader health sector objectives such as better patient outcome has in part contributed to the poor performance of the health system.

Communities

Significant healthcare is undertaken by households at the family and community levels and households are also the main consumers of health care at facility level. Health facilities are located in communities and are expected to respond to their needs. However, there is poor engagement of the community by State and LGA health authorities. 'Community empowerment' has been an overused word that has become a mere rhetoric for health planners. Community/Village Health Committees where in existence have very limited role in determining the course of events as they affect the health of the community. Consequently, duty bearers (health authorities) are presently not accountable to the right holders (the community) resulting in lack of ownership by the communities.

2.7.2 Goal

Enhance harmonized implementation of essential health services in line with national health policy goals.

2.7.3 Strategic Objectives

2.7.3.1 To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector by 2011.

2.7.4 Interventions

A description of some activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector.

2.7.4.1 Public Private Partnerships (PPP)

While the private sector is the major provider of health care provision in the country, public-private partnership remains weak. Public-private partnership in health should not be seen as privatization, which involves complete transfer of public assets to private owners. The existing national PPP policy for the country will be updated with a view to leveraging technical and financial resources alongside improved management approaches for improved delivery of health care services. Strategies for implementing PPP initiatives in line with this national policy will be developed and PPP units at all levels to promote, oversee and monitor PPP initiatives will be established. Mechanisms for engaging the private sector – such as contracting or out-sourcing, leases, concessions, social marketing, franchising mechanism and provision incentives (e.g health commodities, or technical support at no cost) will be undertaken. In addition, other options that encourage the private sector set up health facilities in rural and under-served areas will be explored. Also, joint monitoring visits by public and private care providers with adequate feedback are to be established.

2.7.4.2 Coordination of Development Partners

At present most of the activities of international development agencies are not coordinated with that of the country health programmes. A framework for the harmonization and alignment of development partner's support will be institutionalized at all levels. One key activity will be the establishment of *Development Partners Forum* comprising only health development partners at Federal and State levels as single entry points for engaging with partners. The Health Partners Coordinating Committee (HPCC) as a government coordinating body with all other health development partners will be strengthened and similar mechanisms will be established at state level. In addition, mechanisms for resource coordination through common basket funding models such as Joint funding Agreement, Sector Wide Approaches, and sectoral multi-donor budget support will be established.

2.7.4.3 Inter-Sectoral Collaboration

In order for the country to attain the level of health status required, other social and economic sectors, other than health, have to take specific actions within their spheres of influence that would synergize the key health specific actions that could in turn bring about health gains for the entire population. To facilitate this, an inter-sectoral ministerial forum at all levels to facilitate inter-sectoral collaboration, involving all relevant MDAs directly engaged in the implementation of specific health programmes – such as Environment in Malaria control and prevention, Agriculture in nutrition programmes, Water Resources in control of water borne or related diseases, Women Affairs in Maternal, Newborn and Child Health, and Information in Behaviour Change Communication (BCC) programmes will be established.

2.7.4.4 Engaging Professional Groups

The following suggested activities would ensure that the concept of team-based collaborative work approach is entrenched in order to achieve better integration of care and prevent fragmentation of in service delivery: (i) Promote effective partnership with professional groups through jointly setting standards of training by health institutions, subsequent practice and professional competency assessments; (ii) engage professional groups in planning, implementation, monitoring and evaluation of health plans and programmes; (iii) Promote effective communication to facilitate relationships between professional groups and Ministries of Health; (iv) strengthen collaboration between government and professional groups to advocate for increased coverage of essential interventions, particularly increased funding; (v) convene public lectures through a coordinated approach by professional associations to enhance the provision of skilled care by health professionals; (vi) Promote linkages with academic institutions to undertake research, education and monitoring through existing networks; and (vii) influence regulation and legislation to allow for competency-based practice by all types of health professionals according to the principles of "continuum of care".

2.7.4.5 Engaging Communities

One pre-requisite for citizen's empowerment is improved availability of information, in a form that is accessible and useful. Suggested activities to achieve this intervention include: (i) Improve availability of information to communities, in a form that is readily accessible and useful through proper culturally appropriate and gender sensitive dissemination channels; (ii) Information packages for community consumption should include rights of beneficiaries, means of accessing care at health facilities and minimum standards of quality health services; (iii) develop indicators on health system performance at States, LGAs and facilities to improve transparency and accountability of the government to its citizens; (iv) institute mechanisms for competition between States, LGAs and facilities for satisfactory performance in delivery of community

support programmes for health; (v) establish and empower Health Service Charters at all levels, with Civil Society Organisations, traditional and religious institutions to promote the concept of citizen's rights and entitlement to quality, accessible basic health services; and (vi) build the capacity of communities to prevent and manage priority health conditions through appropriate self-mediated mechanisms such as Behaviour Change Communication (BCC), Social marketing, Public Awareness Campaign, Information, Education and Communication resources (IEC), etc.

2.7.4.6 Traditional health practitioners

Despite the availability of modern medical care and improvement in literacy levels, many people still patronize the services of traditional health care providers. This may not be unconnected with the belief system inherent in the country. While many traditional medical approaches may seem to be useful, many others are of no effect and some may indeed be harmful. Therefore, there is a need to find out what works and what does not and find ways in which both approaches can be integrated where necessary. The following are some suggested activities for working with traditional health practitioners: (i) Seek to have better understanding of traditional health practices and support research activities to gain more insight and evaluate them; (ii) organise traditional medicine practitioners into bodies/organisations that are easy to regulate and actually regulate their practice; (iii) adopt traditional practices and technologies of proven value into State health care system and discourage those that are harmful; (iv) train traditional health practitioners to improve their skills, to know their limitations and ensure their use of the referral system; (v) where applicable seek the cooperation of traditional practitioners in promoting health programmes in such priority areas as nutrition, environmental sanitation, personal hygiene, immunisation and family planning; and (vi) discourage traditional health practitioners from advertising themselves and making false claims in the public media.

2.8 PRIORITY AREA 8: RESEARCH FOR HEALTH

2.8.1 Context

Over the years successive government have introduced various initiatives to promote research for health in Nigeria. In particular, the Medical Research Council of Nigeria (MRCN) was established by Decree No 1 of 1972 and inaugurated in January 1973. In 1977 the National Science and Technology Development Agency (NSTDA) was established. The Nigeria Institute for Medical Research (NIMR) was initially an agency under the NSTDA, which transmuted into the Federal Ministry of Science and Technology until it was transferred to the FMOH. In 1988, the reorganization of civil service by Federal Government for effective, efficient and productive service created the Department of Planning, Research and Statistics (DPRS) in all ministries.One

of the responsibilities of the department is to co-ordinate research activities as well as spear-head planning. Consequently, there is now a Department of Planning and Research at the Ministries of Health at the Federal and State government levels. To conduct research in the area of Pharmaceutical commodities, the National Institute for Pharmaceutical Research was established under the oversight of the Federal Ministry of Health. A draft National Health Research Policy as well as National Health Research Priorities were produced in 2001, both document have been reviewed and merged in 2006. A Country report on status of health research was also produced by the FMOH in 2006.

Funding for health research in Nigeria is meager with evidence indicating at most 0.08% of health expenditure at the federal level with hardly any funding at lower levels. This is contrary to the 2% allocation to research for health prescribed by African Health Ministers and agreed to by the National Council on Health. The paucity of these allocations to the Health Sector had affected the quality and depth of health research in particular[29]. There is also an internationally accepted guideline that Donor agencies provide 5% of Aid to research.

Potential researchers are produced annually from the various tertiary institutions with high attrition rates resulting from lack of mentorship programmes and weak enabling environment in the country to sustain their research interests. It is important to note that the present trend in the communication of health research findings is that of translating or 'repackaging' technical or scientific information into a more user friendly format that will increase the uptake of the research. The National Research and Knowledge Enterprise Committee of the Federal Ministry of Health require strengthening to translate and summarise research findings for use by policy makers, implementing partners or local communities. Even where such findings have been carefully documented and published, dissemination of such findings has been very poor at all levels, explaining the weak impact of research at all levels.

The factors responsible for the inadequacies in health research in Nigeria are lack of coordination in research, lack of regular fora to discuss health research, poor linkage between research and policy, as well as between international and national research agenda. Equally contributory are inadequate research priority setting, dearth of research infrastructure, sub-optimal capacity building strategies, ineffectual documentation and publication. The National Ethical Research committee though in place at the Federal level; there is poor adherence to ethical guidelines in medical research resulting possibly from absence of ethical review boards in most states and higher institutions. Also, monitoring and evaluation of research is limited and researchers are not adequately motivated.

29 The10/90 Report on Health Research 2003-2004. Global Forum for Health, 2006

There is currently no legal framework mandating a depository of researches and output of databases in the country. Linking research for health with policies and decision making on health care in a country is imperative to provide decision-makers with empirically-based and scientifically-valid information on service delivery.

2.8.2 Conceptual Definition

Research for health is defined as the generation of knowledge that can be used to promote, restore, maintain, protect monitor or conduct surveillance of health of populations. Health research is the systematic generation of new knowledge in the field of medical, natural, social, economic and behavioral science and its use to improve the health of individuals or Group.

2.8.3. Goal:

Utilize research to inform policy, programming, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform.

2.8.4. Strategic Objectives.

2.8.4.1 To strengthen the stewardship role of governments at all levels for research, and knowledge management systems

2.8.4.2 To build institutional capacities to promote, undertake and utilise research for evidence-based policy making and programming in health at all levels

2.8.4.3 To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)

2.8.4.4 To develop, implement and institutionalize health research communication strategies at all levels

2.8.5 Interventions

Some possible activities that could contribute to the achievement of each specific objective and intervention are presented below for consideration at Federal, State and LGA levels. It is expected that the identification of appropriate activities would be based on the stewardship role and mandate of each level.

To strengthen the stewardship role of governments at all levels for research and knowledge management systems

2.8.5.1 Finalise Health Research Policy at Federal level and develop health research policies and strategies at state and LGA levels.

There is need to finalize the National Health Research Policy at Federal level and develop states' health research policy. In addition health research strategies will be developed at all levels. These interventions can be facilitated by convening Technical working groups to finalise or develop health research policies and strategies at all levels. There will also be the establishment of Health research steering committees at all levels to shepherd research activities at all levels.

2.8.5.2 Establish and or strengthen mechanisms for health research at all levels

The capacities of health research divisions and units at all levels to coordinate and encourage research efforts are to be strengthened, linking researchers and creating communities of practice. Departments of Planning Research and Statistics (DPRS) at all levels are also to be similarly strengthened in addition to the creation of active research units in FMOH, SMOH and LGA to undertake operations research and other research-related activities.The coordinated implementation of the Essential National Health Research (ENHR) guidelines are to be ensured.

2.8.5.3 Institutionalize processes for setting health research agenda and priorities

Currently there are no systematic mechanisms for setting health research agenda at all levels. Research agenda are mostly driven by availability of research grants from outside the country. To redress this trend, functional institutional structures for research are to be established and or strengthened. The health research agenda will be expanded to include broad and multidimensional determinants of health and ensure cross-linkages with areas beyond traditional boundaries and categories. Guidelines for collaborative health research agenda are to be developed at all levels.

2.8.5.4 Promote cooperation and collaboration between Ministries of Health and LGA health authorities with Universities, communities, CSOs, OPS, NIMR, NIPRD, Development partners and other sectors

For research to thrive and to be used to inform health development efforts, strong links will be established between the users of research such as policy makers and the producers of research such as universities. Hence, governments at all levels will establish a forum of health research officers at the FMOH and SMOH plus LGA. There will be annual convening of multi-stakeholders forum to identify research priorities and harmonize research efforts. Governments at all levels will have to support the development of collaborative research proposals and their implementation between governments and public and private health research organisations.

2.8.5.5 Mobilisation of adequate financial resources to support health research at all levels

Lack of adequate financial resources is a major bane of health research. To address this and) in line with the recommendation of African governments, at least 2% of health budget will be

allocated for health research at all levels. Similarly funds for health research will be deployed in a targeted manner while expanding beneficiaries of funding to researchers from both public and non-public health research organizations and individuals. Opportunities for accessing funds from bilateral and multilateral organizations, research funding agencies and through north-south and south-south collaboration will be explored. To attract additional funds, a credible and transparent independent national research funding agency will be established.

2.8.5.6 Establish ethical standards and practice codes for health research at all levels

In order to respond effectively in this regard, health research ethical mechanisms, guidelines and ethical review committees at federal and state levels will be established and or strengthened. Relatedly, similar mechanisms in tertiary health and education institutions will be strengthened as well as monitoring and evaluation system to regulate research and use of research findings at all levels also established.

To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels

2.8.5.7 Strengthen identified health research institutions at all levels

Most of the research institutions in Nigeria are weak and do not produce research outputs that are relevant for policy making. To mitigate this, Governments at all levels should strengthen identified health research institutions identified by inventory of all public and private institutions and organizations undertaking health research. Periodic capacity assessment of health research organizations and institutions will be conducted. Governments at all levels and development partners in conjunction with health research organizations/institutions are to develop and implement measures to address identified research capacity gaps and weaknesses. The development and implementation of resource mobilization strategies targeting the private sector, foundations and individuals for health research are to be ensured.

2.8.5.8 Create a critical mass of health researchers at all levels

Adequate and qualified human resources for health research are required at all levels to produce high quality and relevant research outputs. In this regard a critical mass of researchers in conjunction with training institutions will be created while developing appropriate training interventions for research, based on the identified needs at all level. Governments will regularly provide competitive research grants for prospective researchers while motivating increased PhD training in health in tertiary institutions through award of PhD studentship scholarships.

2.8.5.9 Develop transparent approaches for using research findings to aid evidence-based policy making at all levels

To achieve evidence-based policy formulation, mechanisms for translating research findings into policies will be evolved. Further to this, close liaison and linkages between research users (e.g. policy makers, development partners) and researchers will be established. A wide range of actors including research producers will be involved in policy-making consultations.

2.8.5.10 Undertake research on critical areas already identified in different forums

To immediately strengthen the health system, systematical researches on a number of topical areas such as estimating the burden of different diseases biennially, undertaking biennial Human Resources for Health studies; studies on health system governance (HSG); biennial studies on health delivery systems; studies on financial risk protection, equity, efficiency and value of different health financing mechanisms biennially, etc as may be determined by policy makers and other key stakeholders will be undertaken.

To develop a comprehensive repository for health research at all levels (including both public and non-public sectors)

2.8.5.11 Develop strategies for getting research findings into strategies and practices

Deliberate efforts will be made to utilize research outputs in the short to medium term to improve strategies and practices in the health sector by establishing getting research into strategies (GRISP) units at all levels and instituting bi-annual Health Research-Policy forums at all levels.

2.8.5.12 Enshrine mechanisms to ensure that funded researches produce new knowledge required to improve the health system

This will entail conducting needs assessment to identify required health research gaps at all levels as well as undertaking operations research by all government Health Ministries, Departments and Agencies at all levels. Public and non-public research organizations/institutes will be contracted to collaborate with government in the conduct of operations research thereby addressing gaps in research capacity in government institutions.

To develop, implement and institutionalize health research communication strategies at all levels

2.8.5.13 Create a framework for sharing research knowledge and its applications:

Knowledge is power and health system program implementation should not wallow in ignorance in the face of research evidence. However, the research outputs must be communicated to large audiences for them to be meaningful. Doing this will in addition to publishing the research findings in academic journals, involve the development of a framework for sharing research knowledge at all levels. Annual health conferences, seminars and workshops at Federal and State

levels on key thematic areas (financing, human resources, MDGs, health research, etc) will be convened. Also, opportunities for international collaboration on national research agenda, both in terms of ensuring research findings from Nigeria are published and presented in other countries and that Nigerians receive research updates from other countries will be pursued. Participation in international conferences on health and mainstream best practices at National, State and LGAs will be ensured.

2.8.5.14 Establish channels for sharing of research findings between researchers, policy makers and development practitioners

Governments and donors will develop the capacity of researchers to effectively produce policy briefs targeted at informing policy-makers, as well as the broad scientific and non-scientific audiences. Also an inventory of national journals according to areas of focus will be conducted. This is in addition to selection of national journals to be supported on the basis of their ability to address issues related to Essential National Health Research (ENHR) principles. Governments and donors will support the publication of high quality national journals, following a review of editorial boards, establishing appropriate linkages between editors of national journals and reputable publishers (especially online, free web-based access publishers) and international collaborators, to improve the quality of national journals. Wide dissemination of selected national journals to all stakeholders at federal, state and LGA levels will be vigorously pursued.

Chapter 3: ORGANIZATION OF SERVICES AT THE LGA LEVEL

The National Health Bill establishes the National Health System which include - (a) the Federal Ministry of Health; (b) the State Ministries of Health in every State and the Federal Capital Territory; c) parastatals under the federal and state ministries of health; (d) all local government health authorities; (e) the ward health committees; (f) the village health committees; (g) the private health care providers; and (h) traditional and alternative health care providers.

As such the health services are organized in the following manner

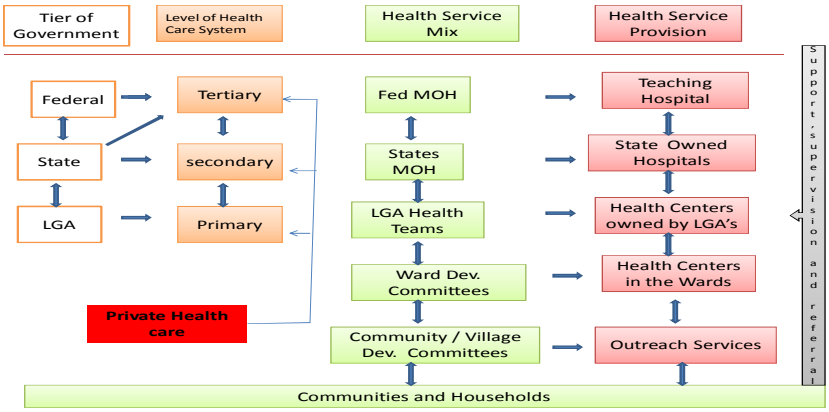

Fig 1: Levels of Health care in Nigeria

3.1Strengthening the LGA Health Systems

(i) Provide comprehensive care in an integrated manner to the population of the LGA; and (ii) LGA Health team to organize and undertake core activities through the Ward minimum Health Care Package at the household and community level in collaboration with existing Ward health system structures

3.2 Planning for delivery of health services

(i) LGA HMT should prepare operational plans annually in line with the National and State strategic health plan and based on the health situation analysis in the LGA, wards and communities; (ii) the health situation analysis should address issues related to the operationality of the LGA health system, availability and utilization of health services, gaps in access to and quality of care and availability of human, financial and logistic resources; and (iii) Set targets in line with national and state strategic health plans to provide benchmarks for regular monitoring to assess the level of the implementation of plans.

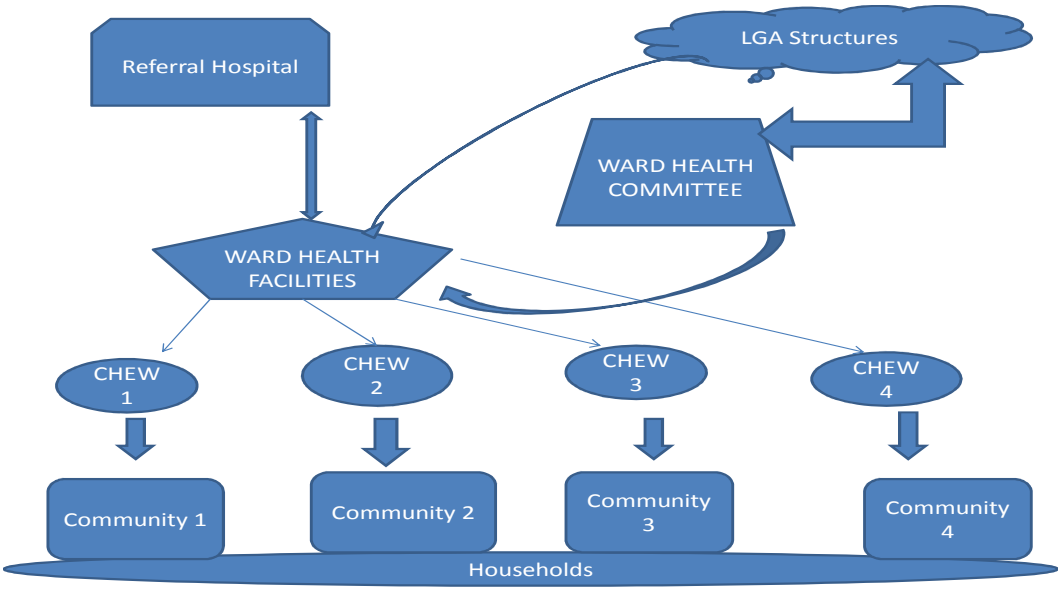

Fig 1: LGA Health Services

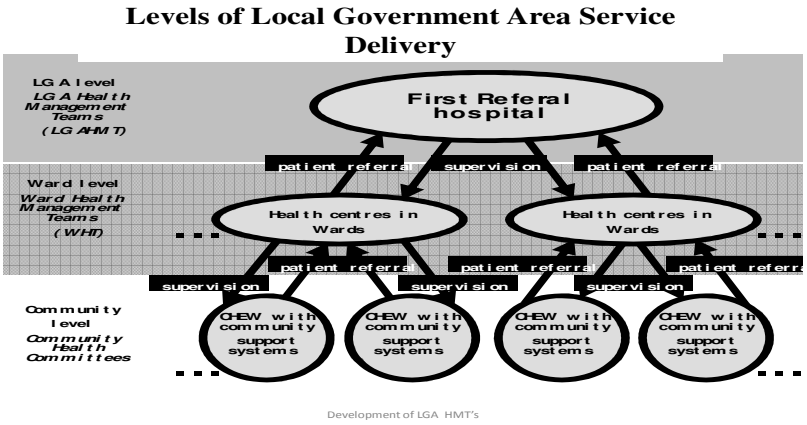

Fig 2: Organizing Health Service Delivery at the LGA, Ward and Community Levels

3.3 Mobilizing required resources to operationalise LGA Plans

(i) Establish a coordinated approach to mobilize resources from Federal and State governments, development partners, LGA-based organizations such as NGOs and other actors, including the private sector; (ii) accord high priority to financing health at the local level by increasing the allocation to the LGA from the national health budget (at least 70% out of the pledged 15% of national budget reference Abuja Declaration); (iii) institutionalize a balanced distribution of resources (personnel, equipment and financial) between primary, secondary and tertiary care levels at the LGA level; (iv) LGAs should estimate the level of required resources to provide essential health services; and (v) equitably allocate and distribute resources to health facilities and communities within the LGA in line with set targets.

3.4 Management of LGA health Systems to improve performance of health services

(i) Implement operational plans at LGA level; (ii) strengthen health provision and management structures; (iii) build capacity for planning, monitoring, evaluation and reporting at all levels; (iv) provide technical and management support from higher to lower levels; (v) build partnerships and improve coordination; (vi) institute integrated financial management systems at LGA level to justify fiscal decentralization in line with administrative devolution of the health sector; (viii) LGAs should ensure availability and use of proper functional accounting procedures and preparation of monthly returns for utilization of budgetary allocations; (ix) focus on availability and competence of managers, improve the work environment for staff, and ensure integrated in-service training to improve on HRH capacities at LGA; (x) establish effective stock management systems for health commodities to ensure routine inventory, uninterrupted availability, rational use and prevention of shortages/stock-outs in all health facilities and communities; (xi) develop a maintenance plan for essential medical equipment at LGAs; and (xii) build LGA capacities to institutionalize proactive evaluation and renovation of infrastructure.

3.5 Scaling Up implementation of Comprehensive integrated essential health services

(i) Scale up essential health interventions to achieve universal coverage and contribute towards attainment of MDGs through effective collaboration of all actors at all levels of the health system; (ii) strengthen integration at health facility and community levels; (iii) target vulnerable communities and groups, including the poor, women, children, and people in conflict and post-conflict situations and remote areas; (iv) build LGA capacities on target setting for expected coverage by health facility and community; (v) based on the set targets, design microplans to increase availability, accessibility, utilization and coverage of essential health services; (vi) involve communities in microp-lanning to scale up utilization of services; (vii) The LGAHMT should involve the private sector in a contractual arrangement to institutionalize sustainable public private partnerships that ensure protection of vulnerable populations during utilization of the services offered by the private institutions; and (viii) LGAs should create an enabling environment for sharing best practices in the implementation of health interventions among

different public and private health facilities and communities, with the objective of expansion.

3.6 Increasing use of evidence from health information and operational research

(i) LGAs should develop an operational research plan covering locally-determined implementation issues, research agenda and training of potential researchers; (ii) mobilize resources for research and publication; and (iii) use and disseminate research results locally to improve implementation and decision-making.

3.7 Supervision, monitoring and evaluation

(i) Institute effective supervision of the implementation of operational plans in the LGA to ensure that planned activities are properly implemented; (ii) establish/strengthen monitoring and evaluation systems to track progress and changes, as well as correct negative practices or gaps in service availability, coverage, human resources, financing, information systems, and leadership and governance; (iii) examine the functionality and adequacy of monitoring and evaluation systems through the completeness, regularity and quality of reports as well as the level of use in improving the performance of local health systems; (iv) LGAs should develop monitoring frameworks based on set targets, using coverage and other performance indicators to clarify type of data, sources, analysis and periodicity of review; (v) Data should be disaggregated by geography, gender, age and income level for targeting those in greatest need; (vi) Each level of service within the LGA health system should have a role and responsibility in monitoring and evaluation of their plans; (vii) LGAHMT should take the overall responsibility to guide and provide support to lower levels to undertake their monitoring and evaluation activities; and (viii) the health facility staff and/or community health workers should provide support to communities in monitoring activities undertaken at community level.

Annexes

I. Bibliography

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II. NSHDP FRAMEWORK AND METHODOLOGY FOR DEVELOPING THE PLAN USING THE FRAMEWORK

The framework is presented as a spreadsheet with four levels of detail which follow the layout below:

Goals	BASELINE YEAR 2009	RISKS AND ASSUMPTIONS	Stakeholder/ Responsibility
Strategic Objectives	Targets		
Interventions	Indicators		
Activities	None		

1. Goals

There are eight goals. These are intended to be the **national focal priority areas** for the period 2009 to 2015. All health care service providers are therefore provided with a clear set of national goals to which the nation will strive.

Since the goals are stated at a national level and for a long time period they provide the common direction in which the leadership is taking the health system and it services. It is not expected that the goals need to be added to by States and LGAs

2. Strategic Objectives

For each Goal there are one or more Strategic Objectives. These are intended to elaborate the national focal priority areas for the period 2009 to 2015 and provide all health service providers with a common focus.

Strategic Objectives are also stated at a macro level and also for a long time period and try to concretise the goals. They have clear high-level (national) targets stated so that all service providers understand what the plan is aiming to achieve.

The targets are stated very broadly and can be viewed as realistic medium- to long-term challenges to all role-players.

3. Interventions

For each Strategic Objective there are a number of interventions. The interventions provide more details on the major identified strategies that the leadership believes will take the provision of health services in a positive direction.

There are clear high-level, national, indicators stated for each strategy. The efforts of all service providers collectively should make it possible to achieve the stated indicators. These indicators need to be SMART (specific, measurable, achievable, realistic, time-bound) to be of any use. It can be a costly burden to monitor and evaluate services and progress towards

the stated improvement. It is therefore important to remember that these 'indicators' are the few measurable pointers that represent a broad set of inputs, processes, outputs and outcomes, some of which are very difficult to measure. They are not a means in themselves but purely the chosen set of measurements that indicate progress or otherwise.

Health care access, service provision, infrastructure, personnel and other resources are not evenly or equitably distributed in the country. Therefore the emphasis that one administration (State or LGA) places on the Strategic Objectives will differ. It is therefore expected that the strategic objectives may be added to by States and LGAs, some may not be appropriate and may be ignored at local levels, or the national indicators may be modified by individual providers to make them realistic in their local context.

Up to this point, the document is a 'Framework' and has no plan of how it will be implemented. The last level is the 'Plan' of how to implement and is a statement of what is to be done.

4. Proposed activities and actions

Actions are unique to each service provider. It is expected that the collective set of all of the actions and activities embarked on by the individual providers across the country will contribute to the achievement of the indicators and targets for the country.

These actions and activities must be very practical, achievable and affordable. This is not an opportunity to provide a 'wish-list'. It is rather the list of quantifiable steps and actions chosen by the management of each health provider because they are practical and affordable and will achieve the stated strategy. Actions are usually stated for only the current year. They must be very practical and must answer the question '**how** will the strategies be achieved?'

Actions and activities must be allocated resources and therefore costed so that a budget can be provided. Every year a new set of actions and activities is listed but the Goals, Strategic Objectives and Strategies usually remain for the term of the plan, unless there is very good reason to amend them. Every action or activity **must** be allocated a responsible person (not a group or a committee of people). It may be useful to list the stakeholders that will be involved in achieving a strategy as a whole.

It is not necessary to list indicators for every activity or action but there is no harm in providing them as statements by which to measure progress.

5. Risks and assumptions

All strategies have risks and for all strategies the management make assumptions where there is insufficient information available. Risks and assumptions are 'red lights' that warn of the potential constraints to achieving strategies. They can sometimes be managed if they are identified early.

6. Timeframes

As has been stated activities and actions are usually only for the current year. However some may be recurrent activities (like scheduled quarterly or annual meetings). The framework has a timeframe stated in quarters which looks like this:

Y	Y	M	M	D	D
Y	Y	M	M	D	D

Y	Y	M	M	D	D
Y	Y	M	M	D	D

Timeframe in quarters																											
YEAR 1 (2009)				YEAR 2 (2010)				YEAR 3 (2011)				YEAR 4 (2012)				YEAR 5 (2013)				YEAR 6 (2014)				YEAR 7 (2015)			
Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4

Not all actions and activities can happen at the same time. Some are dependent on the commencement or completion of others. The preparatory actions must be attended to before the concluding actions. It is important to show the sequence of the actions and activities to ensure that resources are available when needed.

7. Budgeting

As has been mentioned, actions and activities must be allocated resources and therefore costed so that a budget can be provided. Once the Framework is completed and understood at sufficient pilot sites phase 2, budgeting, can be considered.

III. Methodology

The process used in the development of the NSHDP is shown in diagram 1. The schematic diagrams reflect the stages for the development of the NSHDP and its framework and are described below:

1. The first step in the development of the NSHDP was the commissioning of 11 background studies on key areas of the health sector so as to provide a critical assessment and analysis of key national issues in these domains, namely Review of HSRP, Governance for Health, Burden of Disease, Social determinants of health, Partnerships for Health Development, Macroeconomics and health financing, Human resource for Health, Health Information and M&E Systems, Health infrastructure and commodities, and Research for Health.

2. A 20 member Technical Working Group was commissioned by the Honorable Minister of Health to support the development of the NSHDP Framework and Plan. Invited to the meeting to inaugurate the TWG, were all the States' Commissioners for Health and Development Partners who were presented with the Health Agenda of the FMOH and the proposed agenda for the development of the NSHDP, to which they made inputs.

3. Using the background documents, other national and international documents and declarations the draft NSHDP Framework was developed. The following process was adopted in the development of the first draft of the NSHDP Framework:
    a. Identification and harmonization of priority areas of concern from the Health Agenda of the FMOH that gives its strategic thrusts, the 2008 Ouagadougou Declaration that gives the African regional direction for health development on the continent and the common ground, an outcome from the Nigeria's stakeholders conference titled 'Securing a better health future: transforming Nigeria's health care system', using the Future Search methodology, that held March 2008.
    b. Eight priority areas were identified through this process, namely: leadership and governance, service delivery, health financing, human resources for health, health

information system, community participation and ownership, partnerships for health development and research for health

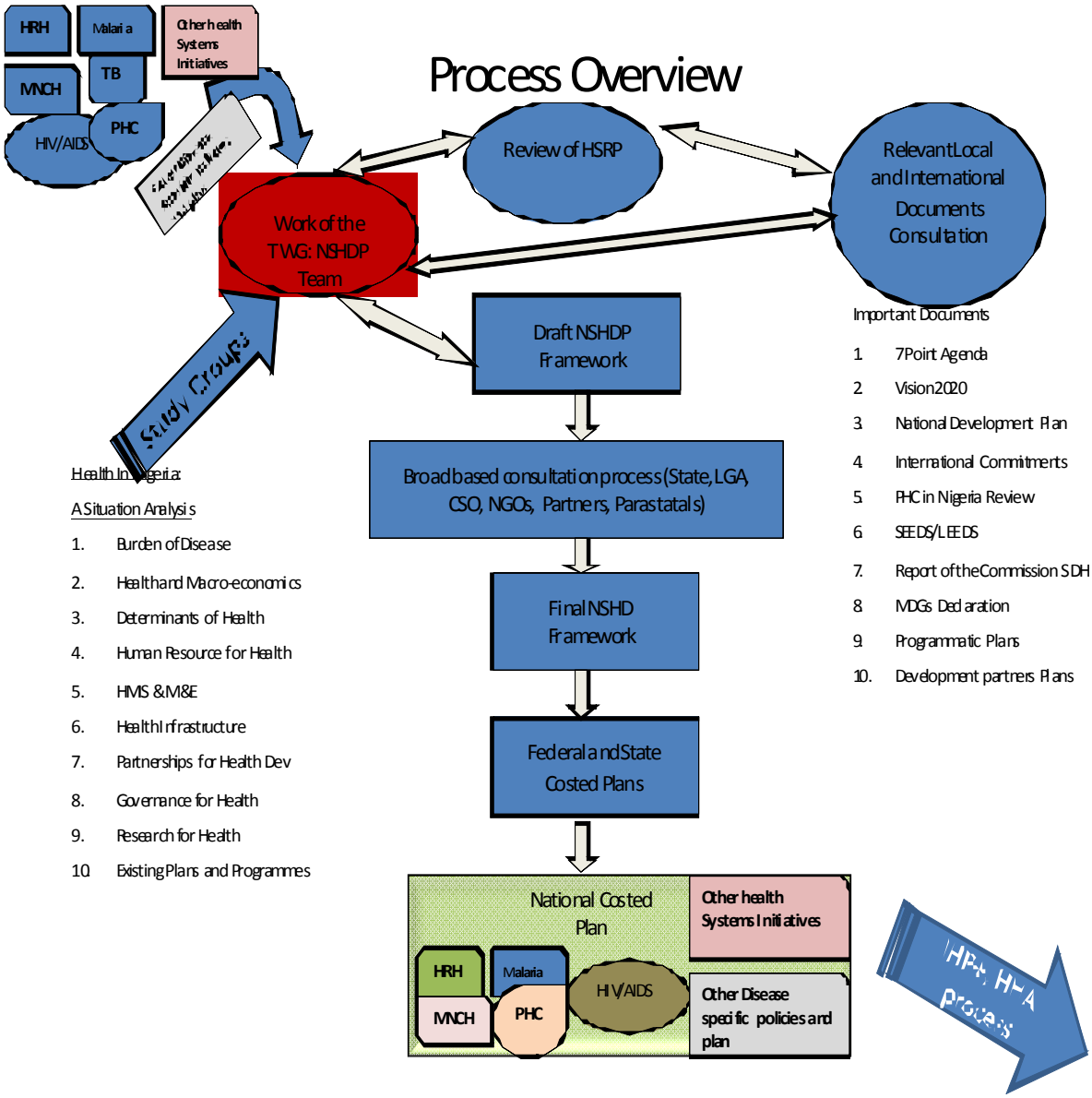
c. Identification of priority areas goals, strategic objectives, interventions and potential actions, and using these as the basis for the development of the NSHDP Framework.

4. Finalization of the NSHDP Framework from wide-stakeholder consultations involving key actors at Federal, State and LGAs;

5. Using the NSHDP Framework as a reference guide for the development of costed Federal, State and LGA health Plans; and

6. Collation of the Federal, States' and LGA health plans into the costed NSHDP

Diagram 1: NSHDP DEVELOPMENT PROCESS



IV. NATIONAL STRATEGIC HEALTH DEVELOPMENT PLAN FRAMEWORK

Table1: Strategic Goals and Strategic Objectives of the NSHDP Framework	
Goal: To improve the health status of Nigerians through the development of a strengthened, coordinated, reinvigorated and sustainable health care delivery system	
Leadership & Governance	**Goal:** To create and sustain an enabling environment for the development and delivery of quality health care in Nigeria **Strategic Objectives** • To provide clear policy directions for health development • Facilitate legislation and a regulatory framework for health development • To strengthen accountability, transparency and responsiveness of the national health system • To enhance the performance of the national health system
Health Service Delivery	**Goal:** To revitalize integrated service delivery towards a quality, equitable and sustainable access to healthcare. **Strategic Objectives** • To provide an essential package of care • To increase access to health care services • To improve the quality of health care services • To increase demand for health care services • To improve financial access for basic health services especially for the poor and vulnerable
Human Resources for Health	**Goal:** The goal is to plan and implement strategies to address the human resources for health needs in order to enhance its availability as well as ensure equity and quality of health care. **Strategic Objectives** • To formulate comprehensive policies and plans for health workforce development within the context of National health policies and strategies • To provide a framework for objective analysis, implementation and monitoring of measures aimed at addressing the HRH crisis in the country • Strengthen the institutional framework for human resources management practices in the health sector • To strengthen the capacity of training institutions to scale up the production of the health workforce which will include training a critical mass of multipurpose and mid-level health workers who will deliver promotive, preventive and curative health care

	• To improve system for management and performance of the health workforce; to improve recruitment, utilization, retention, task shifting and performance • To foster partnership and networks for stakeholders for joint ownership and harnessing contributions of all for the health workforce agenda
Health Financing	**Goal:** To ensure that adequate and sustainable funds are available and allocated for accessible, affordable, efficient and equitable health care provision and consumption at LGA, State and Federal levels. **Strategic Objectives** • To develop and implement health financing strategies at Local, State and Federal levels consistent with the National Health Financing Policy • To ensure that people are protected from financial catastrophe and impoverishment as a result of using health services • To secure a level of funding needed to achieve desired health development goals and objectives at all levels in a sustainable manner • To ensure efficiency and equity in the allocation and use of health sector resources at all levels
Health Information Systems	**Goal:** To provide an effective National Health Management Information System (NHMIS) by all the governments of the Federation to be used as a management tool for informed decision-making at all levels and improved health care **Strategic Objectives** • To strengthen data collection using developed forms • To provide Infrastructural Support and Computerization of Health Databases and Staff Training • To strengthen sub-systems in Health Information System • To Monitor and Evaluate the NHMIS • To strengthen analysis of data and dissemination of health information
Community participation and Ownership	**Goal:** To attain effective community participation in health development **Strategic Objectives** • To strengthen community participation in health development • To empower communities to play their roles • To strengthen the community-health services inter-phase • To increase national capacity for integrated multi-sectoral health promotion

	• To increase research based strengthening of community participation
Partnerships for Health	**Goal:** To enhance harmonized implementation of essential health services in line with national health policy goals. **Strategic Objectives** • To ensure that collaborative mechanisms are put in place for involving all partners in the development and sustenance of the health sector.
Research for Health	**Goal:** To utilize research to generate knowledge to inform policy, improve health, achieve nationally and internationally health-related development goals and contribute to the global knowledge platform. **Strategic Objectives.** • To strengthen the stewardship role of governments at all levels for research, and knowledge management systems • To build institutional capacities to promote, undertake and utilise research for evidence-based policy making in health at all levels • To develop mechanisms for getting research findings from the public and non-public sectors into strategies and practices at all levels • To develop, implement and institutionalize health research communication strategies at all levels

V. TECHINICAL WORKING GROUP (TWG) MEMBERS

1. Dr. Clara L. Ejembi Chairperson
2. Dr. Catherine Adegoke
3. Dr. T. Akande
4. Dr. Tarry Asoka
5. Prof. Eric Eboh
6. Demas Butera PATHS 2
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