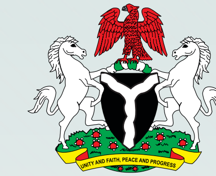
STANDARDS AND REGULATORY FRAMEWORK FOR PRIMARY HEALTH CARE PRACTICE IN NIGERIA

January 2023



NATIONAL PRIMARY HEALTH CARE
DEVELOPMENT AGENCY

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Foreword

Primary Health Care (PHC) is defined as "essential health care based on practical, scientifically sound, and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation, and at a cost that the community and country can afford to maintain at every stage of their development, in the spirit of self-reliance and self-determination.[1]

The delivery of PHC services is based on the premise that good quality services are non-negotiable and that consistent efforts must be made to achieve the same, irrespective of the geographic and other systemic challenges. This can only be achieved through the setting of health standards, which according to the World Health Organization (WHO), is a critical tool for strengthening health services management; and is essential to achieving the highest possible 'Quality of Care' within the resources available.[2] While efforts have been made over the last two decades to publish various guidelines and standard for PHC by the National Primary Health Care Development Agency (NPHCDA), these have been codified in numerous documents with virtually no cross referencing and many long-gone out of circulation. This has made the communication of standards non-effective, hindering the enforcement and practice of quality care delivery.

It is this precedence that informed the development of this document on 'standards, guidelines and regulation' to promote the application of standards for PHC in Nigeria. It was developed by harmonisation into a single document, of existing and anticipated standards, strategic approaches, best practices, praxis, and innovations that have over time yielded favourable outcomes within the context of Nigeria's PHC systems.

For the first time, this manual articulates a regulatory and accountability framework for practitioners, thus, making accountability possible. Furthermore, this manual effectively clarifies to readers, appropriate policies,

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[1]World Health Organization (WHO). Declaration of Alma Ata : International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978. Geneva: World Health Organization/ the United Nations Children's Fund. Available at: https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2 (Accessed: October 10, 2021).
[2] World Health Organization (WHO). Quality health services. Geneva: World Health Organization. 2020. Available at: https://www.who.int/news-room/fact-sheets/detail/quality-health-services. (Accessed: October 11, 2021).

documents, and manuals where more detailed information about the concepts presented may be accessed. It, therefore, serves as a veritable source of reference for institutions and practitioners, including public officials, private providers, civil society organizations (CSOs) and stakeholders at the community, local government, state, and national levels. It provides a snapshot of implementation strategies and elucidates roles and responsibilities. It is, however, noteworthy that the use of this manual does not negate in any way, the relevance of the various policies, programmatic and operational documents from which its contents were drawn.

It is my anticipation that this manual on standards will be a 'game-changer' in the primary health care landscape, serving as a social compass that elicits the voice of citizens, governing agencies, civil societies, and partners, while guiding public expectation for the delivery of quality primary health care services. I hope PHC actors particularly at State Primary Health Care Boards and LGA Health Authorities would make this manual a close practice companion and reinforce their commitment to quality service delivery.

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Abbreviations

ACSM	Advocacy Communication and Social Mobilization
BHCPF	Basic Health Care Provision Fund
BHSS	Basic Health Services Scheme
BMPHS	Basic Minimum Package of Health Services
CBHI	Community-Based Health Insurance
CBME	Community-Based Medical Education
CBN	Central Bank of Nigeria
CBO	Community Based Organisation
CCE	Cold Chain Equipment
CEFP	Community Engagement Focal Persons
CHEW	Community Health Extension Worker
CHIPS	Community Health Influencers, Promoters and Services
CHO	Community Health Officer
CRF	Consolidated Revenue Funds
CRISP	Community-Based Research, Innovative Training and Services Programme
CSO	Civil Society Organisation
DFF	Decentralized Facility Financing
DRF	Drugs Revolving Fund
EML	Essential Medicines List
EEL	Essential Equipment List
EMSS	Expanded Midwives Service Scheme (MSS)
EOC	Emergency Operations Centre
FCT	Federal Capital Territory
FGoN	Federal Government of Nigeria
FMC	Facility Management Committee
FMoH	Federal Ministry of Health
GIS	Geographic Information System
HSMB	Hospitals Service Management Board
HMIS	Health Management Information System
HMO	Health Maintenance Organisation

HRH	Human Resources for Health
ICC	Inter-Agency Coordination Committee
ISS	Integrated Supportive Supervision
JCHEW	Junior Community Health Extension Worker
LERICC	LGA Emergency Routine Immunisation Coordination Centre
LGA	Local Government Authority
LGHA	Local Government Health Authority
LGHA MT	Local Government Health Authority Management Team
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MDAs	Ministries Departments and Agencies
MNCH	Maternal New-Born and Child Health
MoU	Memorandum of Understanding
MPDSR	Maternal Perinatal Death Surveillance Response
MSP	Minimum Service Package
MSS	Midwives Service Scheme
NAFDAC	National Agency for Food and Drug Administration and Control
NBS	National Bureau of Statistics
NCH	National Council on Health
NEMCHIC	National Emergency Maternal and Child Health Intervention Centre
NERICC	National Emergency Routine Immunisation Coordination Centre
NGO	Non-Governmental Organisation
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NHREC	National Health Research Ethics Committee
NHRHP	National Human Resources for Health Policy
NIPRD	Nigeria Institute for Pharmaceutical Research and Development
NLWG	National Logistics Working Group
NPHCDA	National Primary Health Care Development Agency
NSCIP	Nigeria Supply Chain Integration Project
NSCS	National Strategic Cold Store
NSHDP II	National Strategic Health Development Plan II
NSHIP	Nigeria State Health Investment Project
NSIPSS	National Strategy for Immunization and PHC Systems Strengthening

ODK	Open Database Kits
OIC	Officer-In-Charge
PBF	Performance-Based Financing
PCN	Pharmacists Council of Nigeria
PHAID	Programmes for HIV/AIDS Integration and Decentralisation
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PHI	Private Health Insurance
PIU	Project Implementation Unit
PPP	Public-Private-Partnership
RBF	Result Based Financing
RMNCAH+N	Reproductive Maternal New-born Child and Adolescent Health + Nutrition
SERICC	State Emergency Routine Immunisation Coordination Centre
SDD	Solar Direct Drive
SDG	Sustainable Development Goal
SHIS	State Health Insurance Scheme
SLWG	State Logistics Working Group
SMoH	State Ministry of Health
SOML PforR	Save One Million Lives Programme for Results
SOP	Standard Operational Procedures
SPHCB	State primary Health Care Board
TA	Technical Assistance
TBA	Traditional Birth Attendant
TMT	Top Management Team
ToR	Terms of Reference
TSA	Treasury Single Account
TSP	Technical Support Programme
TSTS	National Task Shifting and Task Sharing
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nations Children's Fund
VDC	Village Development Committee
VHW	Village Health Worker

VVM	Vaccine Vial Monitor
WDC	Ward Development Committee
WHO	World Health Organisation
WHS	Ward Health System
WMHCP	Ward Minimum Health Care Package

Definition of Terms

Agency	This refers to the National Primary Health Care Development Agency (NPHCDA)
Community Engagement	This is a top bottom approach initiative by governments to provide the community members with the necessary tools to get involved in decision making.
Community Mobilization	A capacity building process through which community, individuals, groups, and organizations plan, carry out, and evaluate activities on a participatory and sustained basis to achieve an agreed upon goal.
Community Participation	A process by which individuals and families assume responsibility for their own health and that of their community and develop the capacity to contribute to their community's development. It ranges in degree from Co-Option, Compliance, Consulting, Cooperation, and Co-Learning to Collective Action.
Consolidated Revenue Fund	An account that is owned and managed by the Federal Government, where all its revenues are paid.
Empanelment	The act of assigning patients to individual care providers and care teams with sensitivity to patient and family preferences.
Essential medicines	Essential medicines are those that satisfy the priority health care needs of the population. They are selected with due regard to public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness.
Financial Catastrophe	High out-of-pocket payments for health services in the presence of low household financial capacity and an absence of prepayment mechanisms results in financial catastrophe. This high expenditure for health care results in households or individuals reducing or becoming unable to pay for necessities like food, clothing and even education of children.
Fiscal Space	The availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position. Usually, in creating fiscal space, additional resources can be made available for some form of meritorious government spending.
Health Outcome	A change in the health of an individual, group of people or a population that is attributable to an intervention of series of interventions. It can be measured in terms of health status, deaths, or disability adjusted life years (DALY). It also includes patient's satisfaction of patient's responsiveness to the health care system.

Local Government	Public administration at local level exercised through representative councils established by law, exercising specific powers within a defined geographical area. These powers give the Local Government substantial control over local affairs as well as the staff to direct the provision of services and implement projects, which complement the activities of the State and Federal Governments.
Medicines	Medicines, also termed drugs, include any substance or mixture of substances manufactured, sold, or advertised for use in the diagnosis, treatment, mitigation or prevention of any disease disorder, abnormal physical state, or the symptoms thereof, in man or in animals; restoring, correcting, or modifying organic functions in man or in animals; disinfection, or the control of vermin, insects or pests; or contraception (National Drug Policy, 2005).[3]
Process Quality of Care	The interaction between care givers and patients during which structural inputs from the healthcare system are transformed into health outcomes.
Structural Quality of Care	Stable, material characteristics (infrastructure, tools, technology) and the resources of the organizations that provide care and the financing of care (levels of funding, staffing, payment schemes, incentives).
Universal Health Coverage	A process that ensures all people have access to needed promotive, preventive, curative, and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services.
Vaccines	A biological preparation that improves immunity to a particular disease. A vaccine typically contains an agent that resembles a disease-causing microorganism and is often made from weakened or killed forms of the microbe, its toxins or one of its surface proteins. The agent stimulates the body's immune system to recognize the agent as foreign, destroy it, and "remember" it, so that the immune system can more easily recognize and destroy any of these microorganisms that it later encounters.
Vulnerable	This refers to the following categories of people (a) pregnant women, (b) children under five (5) years (c) the elderly >85 years, (d) the disabled, (e) the poor, and others falling within the group.

[3] Federal Ministry of Health, Nigeria. National Drug Policy, 2005. Abuja/Geneva: Federal Ministry of Health, Nigeria/World Health Organization, 2005. Available at: https://www.health.gov.ng/doc/DrugPolicy.pdf (Accessed: October 11, 2021).

Ward	An administrative division of a city that typically elects and is represented by a councillor or councillors.
Village Development Committee	This is the Development Committee for every health area. Every political ward should be divided into a minimum of two or a maximum of six health areas. Each health area will have its own Village Development Committee.

Introduction

Primary Health Care (PHC) is the foundation of, and an integral part of, Nigeria's health care system. For many citizens, it forms the entry point of individuals, families, and communities into the formal health care system. It is the level at which health promotion and education efforts are undertaken, short-term uncomplicated health issues resolved, and patients in need of more specialized services connected with secondary care. It is a cardinal channel for achieving universal health coverage (UHC) (See Box 1) and Sustainable Development Goal (SDG) 3.8. Primary health care in Nigeria has undergone several eras culminating in the current mix of programmes and policies.

Box 1: Universal Health Coverage (UHC)

UHC means that all individuals and communities receive quality health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. UHC is comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, and social inclusion and cohesion.

Achieving UHC is one of the targets the nations of the world set when adopting the Sustainable Development Goals in 2015. Countries that progress towards UHC will make progress towards the other health-related targets, and towards the other goals.

PHC Development in Nigeria

At the International Conference on Primary Health Care in Alma Ata (1978),[4] representatives of 134 governments, including Nigeria, adopted Primary Health Care as a tool to achieving 'Health for All' by the year 2000. This ushered in the phases of PHC development in Nigeria which started with the implementation of a Basic Health Services Scheme (BHSS) from 1975 –1980.[5] This system of primary care delivery involved the use of a comprehensive health centre as a hub to coordinate service delivery in up to 20 surrounding health clinics. The BHSS evolved into PHC (1980-1985) in line with the model propagated by the Alma Ata Declaration. This was followed by a PHC Development Period (1986-1990) that saw the adoption of PHC in 50 model LGAs in Nigeria funded and managed by the federal government. A national scale up then saw PHC expansion to all LGAs in Nigeria.

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[4] World Health Organization (WHO). Declaration of Alma Ata : International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September 1978. Geneva: World Health Organization/ the United Nations Children's Fund. Available at: https://cdn.who.int/media/docs/default-source/documents/almaata-declaration-en.pdf?sfvrsn=7b3c2167_2 (Accessed: October 10, 2021).

[5] Aregbeshola BS, Khan SM. Primary Health Care in Nigeria: 24 Years after Olikoye Ransome-Kuti's Leadership. Front. Public Health, 13 March 2017 | https://doi.org/10.3389/fpubh.2017.00048

A period of Decentralization started (1990-1998) with the devolution of responsibility of PHC implementation to the LGAs. This unfortunately led to significant fiscal and managerial gaps within the system resulting in a decline of infrastructure and services. The National Primary Health Care Development Agency (NPHCDA) was created during this phase to maintain some level of federal government support and oversight in PHC development.

A PHC Revival Period followed (1999-2008) ushering an era of integration and decentralization, with the establishment of the Ward Health System (WHS) in 2000.This period culminated with the merger of the previously verticalized National Programme on Immunization into the NPHCDA. A further period of revitalization of PHC has been on-going over the last decade (2009 to Date) with mixed outcomes (See Appendix 2 for details).

> ***"The current areas of focus for the NPHCDA are to eradicate polio, revitalize PHCs, strengthen routine immunization and enhance transparency and accountability in the agency."***
>
> **Dr Faisal Shuaib**

Institutional Arrangements

The establishment of the National Primary Health Care Development Agency (NPHCDA) in 1992 (NPHCDA Act 1992 CAP N69 LFN 2004) was one of the most important milestones in the evolution of Primary Health Care (PHC) in Nigeria. NPHCDA was set up to consolidate the gains of the PHC development era and entrench PHC as the cornerstone of Nigeria's health system. The Agency was mandated to achieve this through the provision of technical and programmatic support to State, LGAs, and other stakeholders in the development, planning, implementation, supervision, and monitoring of PHC practice in Nigeria.

The NPHCDA guides and oversees the development and management of PHC in Nigeria through its national headquarters in Abuja, statutorily headed by an Executive Director and Chief Executive Officer, who leads a team of departmental directors populated by primary health care specialists. *According to the Agency's Director, Dr Faisal Shuaib, the current areas of focus for the NPHCDA are to eradicate polio, revitalize PHCs, strengthen routine immunization and enhance transparency and accountability in the agency*. The Agency has zonal offices which are headed by Zonal Directors across Nigeria's six geopolitical zones and state offices led by State

Coordinators who alongside state-based zonal technical officers directly provide technical support to the States.

At the State level, implementation of PHC is led by the State Primary Health Care Boards (SPHCBs) headed by an Executive Secretary. The SPHCBs function in a decentralised manner through the Local Government Health Authorities (LGHAs) that are directly responsible for service delivery at the PHC facilities spread across Nigeria. The political wards are recognized as the community catchment area for PHC service organisation and delivery.

Primary Health Care Revitalisation

A major focus of the NPHCDA and its affiliates in recent years has been the drive to effectively revitalise PHC systems and processes. The goal of this revitalization is to ensure the establishment of at least one 'fully functional' PHC facility (Ward Health Centre) per political ward across Nigeria, from which services can also be purchased through a financing mechanism for Universal Health Coverage (UHC). This has led to a PHC revitalisation agenda that synergizes various programmes across the health system building blocks and service delivery interventions.

The PHC Revitalisation programme consists of the following thematic areas: governance, leadership and accountability, human resources for health; PHC infrastructure and equipment; commodities, tools, and supply chain; health financing for PHC, integrated PHC service delivery through fixed and outreach sessions; health information (facility and community data), and research. The various criteria used to assess the functionality of a PHC system are presented in Box 2.

Box 2: Criteria for Assessing the Functionality of a PHC System

Governance system through PHC Under One Roof (PHCUOR): The PHC should be managed by a functional Ward Development Committee (WDC) through the SPHCB.

Human Resources for Health: The health workers at PHCs should be adequate, skilled, motivated, have good attitude and be supervised (as specified in the ***Minimum Standards for PHC in Nigeria*****).**

Infrastructure and Equipment: The PHC should be easily accessible by road. It should have a signpost, be fenced, and have a security gate with a security man. It should be recently renovated with no leaky roof/ceiling or unkept floor and rooms. Rooms must be adequate at least for consultation, in-patient, out-patient, and delivery. The PHC should be connected to national grid, mast cells, solar or a generator. It should have a good water supply – pipe borne/borehole/well. Staff should be accommodated within the premises. Essential medical equipment, storage equipment for vaccines and other drugs, delivery kits and basic equipment for resuscitation should be available.

Basic Minimum Services: The PHC should operate a 24-hour service, weekends inclusive. The PHC must offer services as stipulated in the Minimum Service Package and boldly displayed at a notice board**.** The five minimum services must include communicable diseases; non-communicable diseases; maternal, new-born, child health and nutrition; health promotion/social mobilization and laboratory services.

Waste Management: The PHC should have a waste management plan including for waste recycling. It should have a functional incinerator. Toilet facilities (VIP, water closet) should be available.

Commodities and Logistic chain supply: Adequate stock of essential drugs and vaccines should be available with no stock outs. A cold chain system for vaccines should be maintained.

Hygiene and Sterilization: The PHC should be generally tidy and have dust bins placed inside and outside the facilities. WASH facilities placed in strategic locations in the PHC.

Administration, finance and account: The PHC should have a business plan with attached budget. It should be financed directly and must maintain basic accounting tools.

Two-way Referral system: To ensure a functional referral system, the following must be in place: available referral sheets, transportation plan, a functional ambulance, feedback response and a communication line with the referral centre.

M&E: Harmonized data tools should be available**.** It should have resources for data processing (collection, collation, analysis, interpretation, dissemination, and storage)**.** Data reporting should be complete and timely. All PHC data must be uploaded onto DHIS2.

PHC Programme Documentation

Like the revitalization programme, numerous policy documents have been developed over the years detailing programme strategies and interventions to strengthen the PHC systems and to enhance its implementation. These strategies and interventions that have been initiated by the NPHCDA in collaboration with its partners over the years have led to remarkable outcomes, evolving with emerging evidence and changing with the socio-demographic landscape of Nigeria. More recently, these strategies include:

- Direct deployment of newly graduated midwives to underserved areas through the Midwives Service Scheme (MSS)
- Promotion of integrated PHC service delivery through the Ward Health Systems (WHS) approach, Programmes for HIV/AIDS Integration and Decentralisation (PHAID)
- Adoption of one Management, one Plan and one Monitoring and Evaluation principle through the Primary Health Care Under One Roof (PHCUOR) policy
- Establishment of a National Emergency Routine Immunisation Coordination Centre (NERICC)
- Establishment of the National Emergency Maternal and Child Health Intervention Centre (NEMCHIC)
- Harmonization of community health services and demand creation efforts through the Community Health Influencers, Promoters and Services (CHIPS) Programme
- Provision of effective technical support to the State through the Technical Support Programme (TSP)
- Implementation of an output-based financing in Nigeria State Health Investment Project (NSHIP).

The implementation of these and previous interventions by the NPHCDA especially along programmatic lines have been associated with the development of many different documents often with overlapping functions. These overlaps mirror the multiple, fragmented and poorly coordinated approaches driven by government and partners which have hitherto led to suboptimal outcomes and poor value for money. It is therefore imperative to harmonise the standards, guidelines, roles, and responsibilities related to the management and practice of PHC in Nigeria.

Purpose of the Document on Standards, Guidelines and Regulation

It is expected that this document would be a 'one-stop shop' for all enquiry as it relates to the practice of PHC in Nigeria. It is a guide for both implementers, civil society, partners, and all citizens who are the main

beneficiaries of the anticipated improvements in the quality-of-service delivery, the ultimate objective of this document. The document also serves as a reference guide and index to all other policy documents for PHC implementation, thereby facilitating the bridging of knowledge gaps and enhancing strategic alignment at all levels of PHC service delivery. This is expected to systematically transform the perspective of practitioners, and significantly leapfrog the quality-of-service delivery.

Furthermore, the document contains a section with an accountability framework, which is to be applied to all relevant levels of service delivery. This would serve as an instrument for assessing adherence to PHC standards across the country, evaluating performance and the basis for regulatory measures against defaulters, contributing significantly to the overall M&E framework for PHC. In addition, it is anticipated that in view of the rapidly changing implementation landscape, the document would benefit from periodic review or update. The authors recommend a review every 3 years to 5 years. These periodic reviews which are to be conducted by the NPHCDA would benefit from stakeholders' and partners' input, particularly as the frontiers of PHC implementation expands.

Guide Map for the Document

The document is articulated in three parts. Part 1 summaries the strategies and guidelines and communicates the standards. It is preceded by a glossary of technical terms and the introductory sections. Part 2 provides clarity on the roles and responsibilities of the various public institutions responsible for PHC delivery starting with the national (NPHCDA), the State Primary Health Care Board (SPHCBs), the Local Government Health Authorities (LGHAs), the PHC facilities and the communities. It also presents an accountability framework for every level of PHC practice. Part 3 highlights rewards for good practice and sanctions for poor performance/failures in expected actions, as applicable to every level.

Across the entire document, textboxes highlight critical innovations that are transformational for the implementation of PHC in Nigeria. The document concludes with a bibliography of reference materials as well as links to their sources, from which the document's content has been drawn and from where more detailed information may be sought. In addition, within each section, the material is arranged in a manner that allows a quick search to the various levels of operation, thus providing considerable timesaving and focus through its use. The contact for a knowledge management desk at

the NPHCDA is included on the last page to enable effective feedback on the document's content, should the need arise.

Part 1

Overview of PHC Strategies and Standards of PHC Practice in Nigeria

CHAPTER 1
LEADERSHIP AND GOVERNANCE

1.1 INTRODUCTION

Governance is recognised globally as one of the crucial crosscutting pre-requisites for success towards achieving Universal Health Coverage (UHC).[6] In Nigeria, it is seen as one of the pillars underpinning the success of PHC development. The organizational structure of the primary health care system is a function of how roles, power and responsibilities are assigned, controlled and coordinated and how information flows between different levels. This is a complex environment for which proper stewardship roles are required.

As a country made up of federating units, leadership is devolved to States and LGAs. The complexity of this devolution impacts on how the PHC system is managed and results that are achieved. Improving the governance and coordination both at the national and sub-national levels is key to the success of PHC in Nigeria. The Primary Health Care Under One Roof (PHCUOR) policy (Box 1.1) is the current thrust for PHC governance and by establishing SPHCBs sets the stage for decentralised authority, roles, and responsibilities as well as a stage for PHC financing such as the BHCPF. Such coherent and inclusive approach engenders the expansion of PHC as a pillar of UHC, ensuring the continuum of care and the provision of the Minimum service package.

Box 1.1 Primary Health Care Under One Roof (PHCUOR) Policy

In response to the multiplicity of primary healthcare responsibilities across state and local government departments, the PHCUOR policy was introduced by the NPHCDA and key stakeholders as a new governance reform to reduce fragmentation in PHC management and service delivery as well as to improve PHC implementation. It achieves this through its seven principles and nine pillars using the approach in improving PHC services.

The PHCUOR policy improves efficiency in use of resources to achieve better health outcomes, enhances transparency and accountability across all levels and increases access to more funding for PHC services. By establishing SPHCBs, all PHC activities are better coordinated through decentralized authority, responsibilities, and accountability.

[6] World Health Organization. Health Systems Governance for Universal Health Coverage: Action Plan. Department of Health Systems Governance and Financing. Geneva: World Health Organization. 2014. Available at: https://www.who.int/universal_health_coverage/plan_action-hsgov_uhc.pdf (Accessed: October 11, 2021).

1.2 POLICY

The Nigerian constitution places health on the residual legislative list thereby the states are semi-autonomous and receive policy guidance from the federal government. The National Health Act, 2014,[7] defines the organisation of the health care system, the service providers, the relationship between various tiers and provides the framework for standards and regulation of health services.

National Primary Health Care Development Agency (NPHCDA), a parastatal of the Federal Ministry of Health, was established by Decree 29 of 1992, which empowered it with the mandate to improve, amongst other things, the effectiveness of primary healthcare delivery across Nigeria.[8] The agency drives policy and central coordination of PHC, the sub-national levels, have significant levels of autonomy, including implementation. The harmonization of policies and strategies is of critical importance in ensuring good leadership and governance. This is guided by the National Health Policy which stipulates effective leadership that ensures adequate oversight and accountability for the delivery of quality health care and development at national and sub-national levels.

The National Primary Health Care Development Agency was designed, and implementation commenced in a unitary system, during the past military regime, where it was possible for decisions at the centre to be enforced by military fiat. However, with the advent of the three-tier federal system of government with exclusive and shared powers between the different levels, the constitution now guarantees autonomy for different tiers in the area in which it functions. This is demonstrated by the legislative lists in the 1999 Constitution which provides for the distribution of powers: the exclusive legislative list is allotted to the federal government; the concurrent legislative list is assigned to both federal and state governments and delineates areas in which both can legislate; and the residual legislative list is assigned to the states.[9,10] There are sixty-eight items in the exclusive legislative list, and twelve

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[7] Federal Republic of Nigeria. National Health Act, 2904. Federal Republic of Nigeria, Official Gazette No. 145, Vol. 101. Abuja: Nigeria. 2014. Available at: https://nigeriahealthwatch.com/wp-content/uploads/bsk-pdf-manager/2018/07/01_-Official-Gazette-of-the-National-Health-Act-FGN.pdf (Accessed: October 11, 2021).

[8] International Labour Organisation (ILO), Nigeria, National Primary Health Care Development Agency Decree 1992 (No. 29), 1992, https://www.ilo.org/dyn/natlex/natlex4.detail?p_isn=58758&p_lang=en

[9] Federal Republic of Nigeria, Constitution of the Federal Republic of Nigeria, 1999, Second Schedule, Parts 1 -3, available from: http://www.nigeria-law.org/ConstitutionOfTheFederalRepublicOfNigeria.htm#ExclusiveLegislativeList

in the concurrent list (see **Error! Reference source not found.**) of which health, unlike education, is excluded.

Table 1: Concurrent legislative list

1. Allocation of revenue
2. Antiquities and monuments
3. Archives
4. Collection of taxes
5. Electoral law
6. Electric power
7. Exhibition of cinematography films
8. Industrial, commercial, or agricultural development
9. Scientific and technological research
10. Statistics
11. Trigonometrical, cadastral, and topographical surveys
12. Universities, technological and post primary education

Some policy commentators have argued that the States are empowered to legislate on all matters not identified in the exclusive, concurrent, or the local government lists.[11] These constitute the residual list and include among others, health services, rural development, and social welfare. Noteworthy is the constitutional provision in Section 17 (3d) which empowers the State to direct its policies towards strengthening social welfare including to ensure adequacy of medical and health facilities[12] – no similar powers have been delegated to the FG. This poor clarity has limited the constitutional role of the

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[10] Elaigwu, J.I., The Federal Republic of Nigeria, http://www.forumfed.org/libdocs/Global_Dialogue/Book_2/BK2-C08-ng-Elaigwu-en.htm

[11] Elaigwu, J.I., The Federal Republic of Nigeria, http://www.forumfed.org/libdocs/Global_Dialogue/Book_2/BK2-C08-ng-Elaigwu-en.htm

[12] Federal Republic of Nigeria, Constitution of the Federal Republic of Nigeria, 1999, Chapter 11, Section 17 (3), available from: http://www.nigeria-law.org/ConstitutionOfTheFederalRepublicOfNigeria.htm#ExclusiveLegislativeList

FG in the governance of health, including PHC. Whereas in practice, due to the fiscal and institutional constraints experienced by states, the FG has consistently played an active role in shaping health policies. This has led to conflicts where the identification of who is truly responsible, based on the constitution, for the governance of health and by extension PHC has become difficult.[13]

Nigeria is not alone in this push to secure the Federal Government's full involvement in legislating and administrating on health and related issues. For example, in May 2018, the Indian 15th Finance Group formed an advisory high-level committee which among other efforts, continues to advocate for the entire transfer of health (Public health and allied subjects, such as sanitation, hospitals and dispensaries) to the concurrent list.[14,15] Noteworthy, is that the prevention of infectious and contiguous diseases from one state to another, already exists under India's concurrent list. This may have contributed to critical health gains over the past few years – maternal mortality rate declined by about 70% from 398/100 000 live births (95% CI: 378-417) in 1997-98 to 99/100,000 (95% CI: 90-108) in 2020.[16] South Africa, like Nigeria, has a bicameral parliament with a constitution that includes health services within the functional areas of concurrent national and provincial legislative competence.[17] This provides legal backing for the central government to be significantly involved in agenda-setting, policy formulation, financing and monitoring of health service delivery leading to basic package of services almost universally available at the PHC facilities.[18]

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[13] In December 2021, the legality of the Federal Government’s involvement in primary health care was called into question and an ad hoc committee set up by the Federal House of Representatives to identify, interrogate and engage stakeholders on the constitutionality of FG’s participation in PHC.

[14] "Fifteenth Finance Commission constitutes a High Level Group to examine the strengths and weaknesses for enabling balanced expansion of Health Sector", May 2018, Press Information Bureau, Government of India, Available from: https://pib.gov.in/newsite/PrintRelease.aspx?relid=179524

[15] A high-level group set up to advise the Finance Group on "ways and means to" make effective use of the "existing financial resources and to" encourage "the state governments’ effort on" fulfilling "well-defined health parameters in India".

[16] Meh, C. et al., Trends in maternal mortality in India over two decades in nationally representative surveys, August 2021, Available from: https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.16888#:~:text=The%20MMR%20declined%20in%20India,%2D29%20years%20(58%25)., p. 550

[17] Mhlongo, L., A critical analysis of South Africa's system of government: from a disjunctive system to a synergistic system of government, 2020, Available from: http://www.scielo.org.za/scielo.php?script=sci_arttext&pid=S1682-58532020000200004, pp. 257-274

[18] WHO, Primary Health Care Systems (PRIMASYS): Case study from South Africa, 2017, Available from: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://apps.who.int/iris/bitstream/handle/10665/341145/WHO-HIS-HSR-17.38-eng.pdf?sequence=1, p.20

Therefore, moving health into the Concurrent list would provide the Federal Government with the legal backing and expanded flexibility to institute regulatory changes and reinforce the obligation of all stakeholders towards achieving a resilient PHC system. Also, individual state governments are encouraged to act on their own initiates until federal action is required. If the PHC system is left alone to the States and the Local governments, in the background of the current and possible future pandemics, they may not have sufficient technical and financial resources to address shocks to the system and build momentum in our journey to Universal Health Coverage. Hence, as it concerns PHC, cooperation between the three tiers of government (see **Figure 1**) – an advantage of concurrency – is the best approach for managing this critical component of the health system.

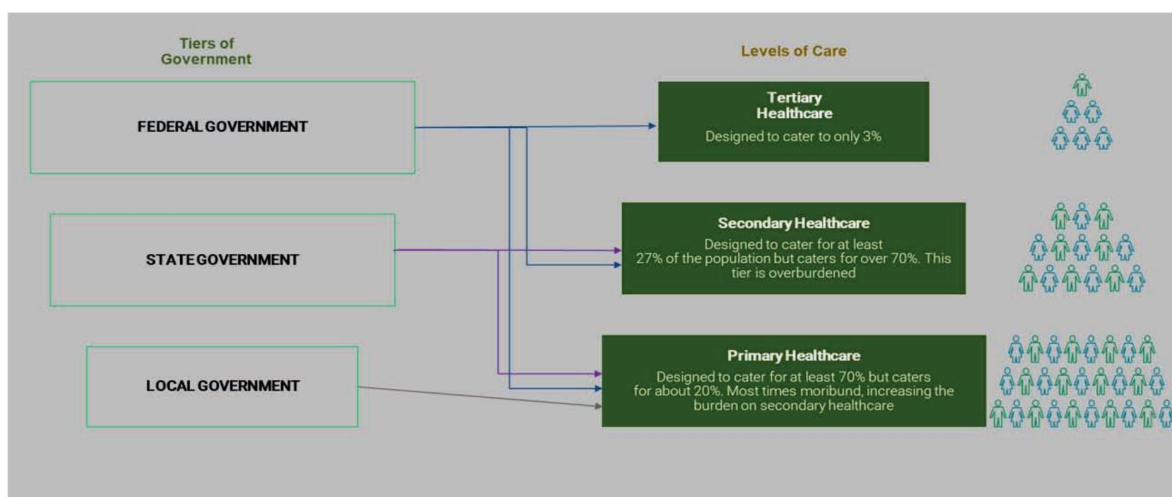

Figure 1: NPHCDA's framework for thinking about the relationship between the tiers of government and levels of health care[19]

Other important reasons for moving PHC to concurrent list includes:

Technical and financial capacity: Despite its limited spending on health,[20] the FG's contribution to the states continues to match and sometimes outstrip each state's individual allocation of budgetary resources to health. Also, the FG is technically better equipped to design effective health interventions because of its ownership of medical research institutions and

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[19] Adapted from FMoH, Second National Strategic Health Development Plan (NSHDP II) 2018 – 2022, January 2019, Available from: https://www.health.gov.ng/doc/NSHDP%20II%20Final.pdf , p. 6

[20] In the light of the 2001 Abuja declaration and the current revenue-sharing arrangement, where the federal government takes 52.68 percent, states get 26.72 percent while local governments get 20.60 percent of the revenue shared.

coordination bodies like the National Primary HealthCare Development Agency (NPHCDA), National Centre for Disease Control (NCDC), Nigerian Institute of Medical Research (NIMR), National Institute for Pharmaceutical Research and Development (NIPRD) dedicated to the management of health.

Based on its technical and financial capacity, the FG has implemented several interventions on health issues such as tuberculosis, polio and HIV-AIDS and encouraged state governments to support these schemes, thereby determining the last mile usage of the funds devolved. This has yielded positive outcomes such as Nigeria being certified wild polio virus-free on 25th August 2020, successful eradication of Ebola in 2014 and effective COVID-19 response (1.4 million people vaccinated in Phase 1) – a strong argument for concurrency which provides legal backing for the intervention of the federal government in all states of the country.[21] Therefore, the FG has assumed a more active role in designing health policies despite a lack of defined constitutional obligation. By limiting health to the jurisdiction of states, the Constitution ignores this reality. A situation that does not exactly strengthen the state. Although it is given the responsibility of health services, it is not adequately provided with the fiscal power or the institutional support to effectively make or implement policies. Given the above context, it may, therefore, be time to re-think the distribution of constitutional power with respect to PHC and adopt an approach whereby the FG can work collaboratively with the states in the spirit of ''cooperative federalism''.

Perspectives of credible international institutions: The WHO Constitution, adopted in its First World Health Assembly in 1948, declared as its objective the "attainment by all peoples of the highest possible level of health" and stated that "Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures".[22] Government in this instance refers to all the tiers and not just the sub-national structures. Nigeria has a record of aligning its policies to global best practices and tailoring same to local context. Therefore,

[21] Mackirdy, K.A., & Watts, R.L., New Federations: Experiments in the Commonwealth, 1966, Available from: https://www.semanticscholar.org/paper/New-Federations.-Experiments-in-the-Commonwealth-Mackirdy-Watts/c7501b1162dae1bfcd41e6a7e1b9777e16860dee, pp. 174-175

[22] WHO, Constitution of the World Health Organisation, July 1946 , Available from: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf?ua=1

adopting concurrency in health is in line with the country's historical trend of cross-cultivation of workable policies from other contexts.

Social role of government in health: The health sector is distinctive from other sectors, as market forces fail to address properly the health needs of populations, for various reasons, leaving governments – including the FG – with special responsibilities in PHC system development.

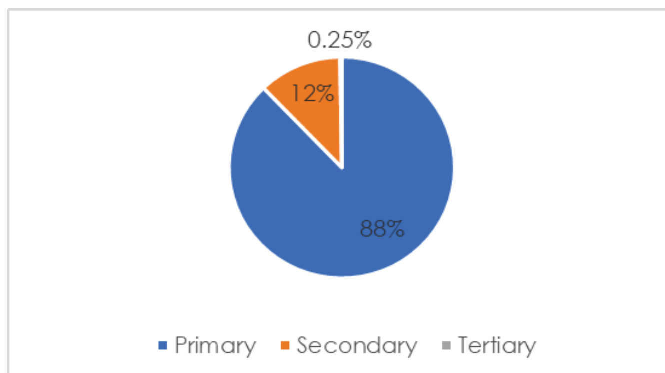

Figure 2: Distribution of health facilities across the three levels of

Equally important is that primary health facilities make up 88% of health facilities in Nigeria while secondary and tertiary health facilities make up 12% and 0.25%, respectively (see **Figure 2**).[23] There are more publicly owned than privately-owned health facilities (67% vs 33%). As a consequence of market failures, governments have an obligation to intervene in order to improve both equity and efficiency, to carry out important PHC functions and to supply vital public goods – vaccination services, essential drugs – which have a lot of bearing on PHC system development. Moreover, health is perceived globally, not merely as a market commodity, but as a basic human need and a social right, as stated in many constitutions of multilaterals and signed treaties. The federal governments, which levy taxes and benefit from natural resources, have social obligations to provide health security and to facilitate socioeconomic development, including development of the health system. The starting point should be a clear regulatory and financing role for the FG enshrined in the country's constitution.

Therefore, PHC – the first point of contact for individuals seeking healthcare – is the most critical component of Nigeria's health system and should not be left alone to the lowest tier of government – the Local Government. To further strengthen the foundation of Nigeria's health system, PHC should be transferred to the concurrent legislative list of the constitution. This will provide the constitutional mandate for the FG to continue to constructively

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[23] Makinde OA, Sule A, Ayankogbe O, Boone D., Distribution of health facilities in Nigeria: Implications and options for Universal Health Coverage, October 2018, Available from:

participate in the governance of PHC and promote cooperative federalism between the centre and the states.

1.3 STRATEGIC APPROACHES

Governance and coordination are a priority area of the National Strategic Health Development Plan II (NSHDP II), where it seeks to streamline and empower the Ministries of Health at the Federal and State levels as well as LGHAs 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.

Strategies to improve governance and coordination in PHC are focused on:

1. Establishment of coordination organs at national and sub-national levels, including:
    a. National Council on Health (NCH)
    b. Inter-Agency Coordination Committee (ICC)
    c. Health Partners Coordination Committee
    d. Top Management Team (TMT)
    e. State Council on Health
    f. Ward Development Committee (WDC)
2. Strengthening PHC management through PHCUOR policy
3. Improving coordination at the ward level through the Ward Health System Strategy (WHSS)

1.3.1 Establishment of coordination organs at national and sub-national levels

1.3.1.1 The National Council on Health (NCH)

The National Council on Health (NCH) is the highest policy making body in Nigeria on matters relating to health. It provides strategic oversight and guidance to the health sector, including for PHC. It is responsible for coordinating health services rendered by the different levels as may be necessary to establish a comprehensive national health system.

1.3.1.2 Inter-Agency Coordination Committee (ICC)

In order to strengthen coordination of partners in health, the (ICC), chaired by the Honourable Minister of Health, was established to provide an overarching supervisory architecture to the immunisation programme, with technical support provided by the core group. The ICC's responsibilities include coordinating decision-making and information across all

immunisation activities and programmes undertaken by the Federal Government of Nigeria (FGN) and its partners. Although the ICC was established to strengthen coordination for Routine Immunization (RI) activities, this approach to high level coordination is being expanded to other aspects of PHC.

1.3.1.3 Top Management Team (TMT)

The Top Management Team (TMT) of each department at NPHCDA serves as a coordinating mechanism within the Agency. At the SPHCB, the TMT also serves as a coordinating mechanism. The team will meet routinely based on established timetable. Sub-committees may be created to meet more frequently or as may be required.

1.3.2 Strengthening PHC management through Primary Health Care Under One Roof (PHCUOR) Policy

The NPHCDA in collaboration with key stakeholders introduced the Primary Health Care Under One Roof (PHCUOR) policy as part of a new governance reform designed to improve primary health care implementation at state and sub-state levels. It is a policy for the integration of all PHC services under one authority (the SPHCB) to reduce fragmentation in PHC management and service delivery. This is in line with the National Health Act and Sustainable Development Goal 3.8 (SDG3.8) to achieve UHC. Bringing "Primary Health Care Under One Roof (PHCUOR)" is modelled after the WHO guidelines for integrated district (LGA)-based service delivery which is based on the following key principles:

1. Integration of all PHC services delivered under one authority (SPHCB).
2. A single management body with adequate capacity to control services and resources especially human and financial resources.
3. Decentralized authority, responsibility, and accountability with an appropriate "span of control" at all levels.
4. Principles of "three ones": one management, one plan and one monitoring and evaluation (M&E) system.
5. An integrated supportive supervisory system managed from a single source.
6. An effective referral system between and across the different levels of care.
7. Enabling legislation and concomitant regulations which incorporate these key principles.

The implementation of PHCUOR at state and sub-state levels rests on nine (9) pillars which together will result in the desired improvement in quality and

increased access to the Minimum Service Package. Details on implementation steps can be found in the ***Implementation Guidelines for PHCUOR.***

1.3.3 Improving coordination at the ward level through the Ward Health System Strategy (WHSS)

The Ward Health System Strategy (WHSS) represents the current national strategic thrust for delivery of PHC services in Nigeria. The WHSS is designed to provide PHC services to a political ward which is a constituency from where an elected councillor can represent the political and socio-economic aspirations of the ward in the local government council. It centres around building the capacity of communities and harnessing grassroots political participation towards owning the health system that will be used to deliver services identified in the Minimum Service Package. It also helps in developing effective systems of financing thus making it as community based as possible.

The WHSS is based on the use of political wards as the catchment area to target PHC interventions. This system requires at least one functional PHC centre which provides integrated services to cover all PHC components, as well as serve as the upward referral facility in the ward. Other levels of PHC facilities are the health clinic and health post, the latter being the lowest level health facility in the ward. The PHC centre coordinates and supervises all the health services within the ward both at the facility and community levels.

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

All PHC facilities should have Facility Management Committees (FMCs) directly managing the health facilities. Each FMC for an individual facility should report to the WDC or VDC as applicable for coordination and support.

1.4 STANDARDS

1.4.1 National Level (NPHCDA)

NPHCDA gives support to the National Health Policy through monitoring of PHC plan, implementation, and provision of technical support. NPHCDA is to mobilize resources, nationally and internationally, for programme implementation, to conduct or commission studies on PHC issues, to monitor the development of the nation's PHC programme and conduct periodic evaluation of PHC. It is to provide advocacy and support for the orientation of health professionals towards PHC and to strengthen Schools of Health Technology. NPHCDA is to provide support to villages (the community health system) and conduct health system research. It is to promote PHC generally.

To be able to perform its functions effectively, NPHCDA has a Governing Board, an Executive Director, a small core of professional staff at its headquarters and six zonal offices namely South-West, South-East, South-South, North-East, North-West, and North-Central. The zonal office is headed by a Zonal Director who supervises State Coordinators and Zonal Technical Officers.

1.4.2 State Level (SPHCB)

The State PHC Board (SPHCB) is an administratively autonomous and self-accounting PHC entity established by law to manage PHC in the state as recommended by the 54th National Council on Health (NCH) through Resolution 29 and backed by the National Health Act of 2014. The SPHCB is established to drive PHC programmes in the state. As a result of this new role, State Ministries of Health (SMoH), State Ministries of Local Government and Local Government Service Commissions are repositioned by transferring all PHC programmes and functions to the SPHCBs.

The SPHCB consists of a governing board and a management team. The governing board shall be headed by a Chairman, while the management team is led by an Executive Secretary who is at a level of a permanent secretary and who is responsible for the day to day running of the SPHCB. Details on the operational procedure of the SPHCB can be found in the ***Implementation Guidelines for PHCUOR***

1.4.3 LGA Level (LGHA)

The LGA PHC department should transform into the Local Government Health Authority (LGHA) in line with the PHCUOR agenda. This is the body at the LG level responsible for coordinating and providing close supervision of PHC services at the facility and community levels. The LGHA consists of an

advisory committee and a management team both reporting to the Executive Secretary of the SPHCB on policy and implementation issues and day to day activities respectively.

The role of the Advisory Committee is to oversee and ensure the provision of PHC services in accordance with established standards, guidelines, and procedures. The Committee primarily advises the SPHCB and the LGHA Management Team, and should focus on policy, accountability, community participation/involvement, PHC financing and quality as well as access to PHC services.

The LGHA Management Team (LGHA MT) is the operational arm of the LGHA and is under the leadership of the LGA Health Secretary. In States where there are enacted public health laws, the Medical Officer of Health could double as the LG Health Secretary. The team is responsible for overall planning, budgeting, and management of LGHA resources for effective implementation, supervision, monitoring, and coordination of PHC activities in the LGA.

1.4.4 Ward, Village and Health Facility Levels

Structurally, every ward shall have a WDC. The recommended guidelines for the composition, functions, and Terms of Reference (ToR) of the WDCs can be found in the ***Ward Health System Strategy (WHSS)*** document and should be followed. At the village/community level, a Village Development Committee (VDC) should be established. The Chairpersons of the VDCs in the ward are members of the WDC and represent their respective VDCs bringing health facility problems that are beyond the capacity of the health facility to the WDC. All identified problems at the ward level should be taken to the LGHAs for interventions and necessary actions. The members of the various committees are participating on a voluntary and merit basis and apart from transport and refreshment allowances are not entitled to additional compensation.

A Facility Management Committee (FMC) should be established for individual PHC facility (excluding the health post). The FMC shall consist of the following members:

1. WDC (or VDC) Chairman or his or her representative as Chairman
2. All unit heads in the facility (Maternity, pharmacy, laboratory, consultation, immunization etc)
3. Account Officer of the facility
4. Officer-In-Charge (OIC) of the facility as Secretary

Details of their functions, ToR and job descriptions of FMC are found in the ***Ward Health System Strategy (WHSS)*** document.

CHAPTER 2
HEALTH FINANCING

2.1 INTRODUCTION

The World Health Organisation's health systems building blocks,[24] identify health financing as one of the key pillars of a functional health system. Finances are among the most important resources of health services and are critical to the achievement of UHC. Adequate and sustainable financial resources are essential in ensuring successful implementation of PHC in Nigeria. Available revenue needs to be collected, pooled, and effectively deployed through effective strategic purchasing approaches to achieve optimum utilisation of scarce resources for health service delivery. Fairness in financing is about funds availability, reduction of out-of-pocket expenditure and ensuring equity, effectiveness and efficiency in allocation and use of raised resources.[25]

2.2 POLICY

The National Health Act of 2014,[7] places the responsibility of funding PHC on the Federal, State and Local Governments. At the Federal level, funding for PHC is primarily reflected in the annual budget estimates of the NPHCDA. However, funds for PHC can also be identified in budgets for other Ministries, Departments and Agencies (MDAs). Such appropriations include resources for vaccine procurement, cold chain system, construction or renovation of health facilities, medicines and commodities, implementation of monitoring and evaluation strategies, and personnel and operations costs.

Although the fiscal space for PHC is often much smaller, state budgets mirror the National budget, and also include resources for funding specific programmes such as RMNCAEH+N, Malaria, Tuberculosis and HIV/AIDS. With the adoption of the PHCUOR policy across the country, PHC funds at the State level are increasingly captured within the budgets for SPHCBs. Personnel costs for health workers in PHC facilities have also been appropriated through the SPHCBs rather than the LGAs; in states that have

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[24] World Health Organization (WHO). Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies. Geneva, Switzerland: World Health Organization. 2010.
[25] World Health Organization (WHO). Health financing. Available at: https://www.who.int/health-topics/health-financing#tab=tab_1.(Accessed: October 11, 2021). Geneva, Switzerland: World Health Organization. 2021.

made progress with PHCOUR implementation. However, LGAs still provide funding support to health facilities for operations in some States.

Due to the inadequacy of public funding for PHC in Nigeria, PHC service delivery also depends on other sources of funding recognized by the National Health Financing Policy. Additional sources to government funding of PHC include out-of-pocket expenditure, prepaid financing mechanisms as well as development funding.

a. Federal Government funding: At the Federal level, funding for PHC is primarily reflected in the annual budget estimates of the NPHCDA. However, funds for PHC can also be identified in budgets for other Ministries, Departments and Agencies (MDAs). Such appropriations include resources for vaccine procurement, cold chain system, construction or renovation of health facilities, medicines and commodities, implementation of monitoring and evaluation strategies as well as personnel and operations costs.
b. State Government funding: Although the fiscal space for PHC is often much smaller, State budgets mirror the National budget, and also include resources for funding specific programmes such as RMNCAEH+N, Malaria, Tuberculosis and HIV/AIDS. With the adoption of the PHCUOR policy across the country, PHC funds at the State level are increasingly captured within the budgets for SPHCBs. Personnel costs for health workers in PHC facilities have also been appropriated through the SPHCBs rather than the LGAs; in States that have made progress with PHCOUR implementation. However, LGAs still provide funding support to health facilities for operations in some States.
c. Out-of-Pocket Expenditure: In Nigeria, private expenditure accounts for about 71.5%,[26] which is unacceptably high. Most households make out-of-pocket expenditures to use health services, which exacerbates the financial risk to households. In some states, fee waivers in form of exemptions have been tested whereby vulnerable population groups are exempted from payments. In some cases, conditional cash transfers have been implemented to mitigate the impact of health expenditures on households.
d. Prepaid financing: The 2006 National Health Financing Policy recognises the potential of prepaid financing mechanisms to improve financial access to PHC service and to achieve reduction in catastrophic household spending on health. The Nigerian government

[26] Federal Ministry of Health. National Health Accounts 2017. Technical Report. April 2019. Abuja/Geneva/Brussels: Federal Ministry of Health, Abuja, Nigeria/European Union/World Health Organization. Available at: https://www.health.gov.ng/doc/FINAL-VERSION-NHA-2017.pdf (Accessed: October 10, 2021).

established the National Health Insurance Scheme (NHIS) Act of 1999 with the aim of improving access to healthcare and reducing the financial burden of out-of-pocket payment for health care services. Through the NHIS, several prepayment strategies have been promoted. These include the Formal Sector Social Health Insurance Scheme and Community Health Insurance Schemes. The private sector has also provided coverage through Private Health Insurance offered by Health Maintenance Organisations (HMOs), while Non-Governmental Organisations (NGOs) and communities have also piloted Community Based Health Insurance (CBHI) schemes in local communities in Nigeria.

e. Donor Financing: Non-governmental organisations, donors or partners have formed an important source of PHC financing through grants, loans, and donations. They finance health programmes directly as well as through government organs and NGOs. In some States, basket funds have been experimented through explicit MoUs to finance mutually agreed priorities and programmes of Government.

In other to provide more sustainable funding for PHC, the National Health Act of 2014 provides for the allocation of not less than 1% of Federal Government's Consolidated Revenue Funds (CRF) and contributions from partners, into a Basic Health Care Provision Fund (BHCPF). This fund will be deployed through government platforms to provide a pre-defined Basic Minimum Package of Health Services (BMPHS) for all Nigerians at the PHC level.

The National Health Policy 2016 also seeks to develop and implement mechanisms to drive relationships between Ministries of Health and Ministries of Finance for increased budgetary allocation to health at all levels, especially for the implementation of the BHCPF etc. The policy also recognises the existence of various strategies aimed at promoting the availability of, and accountability for the use of limited resources for PHC. These include the use of Decentralized Facility Financing (DFF) and the Performance-Based Financing (PBF) approach, implemented through the Nigeria State Health Investment Project (NSHIP) and Saving One Million Lives Programme for Results (SOML PforR). These strategies have provided additional financing for PHC at various levels, while emphasizing delivery on results. DFF has been adopted as the policy approach for the implementation of the BHCPF. The ***BHCPF Operations Manual*** provides comprehensive guidance on the implementation of the Fund.

At the State level, the PHCUOR policy recognizes the importance of establishing a financial management system for PHC implementation. SPHCBs are to develop systems and processes to ensure that plans are developed and costed, that these are included in the annual budgets of the SMoH and successfully defended, and that budget release is tracked. It is also critical to develop an effective M&E system and to provide for an independent annual audit to promote accountability for resources provided to SPHCBs for PHC. The benefits of establishing a finance management system for the implementation of PHCUOR, the implementation steps, and indicators for success are available in the ***Implementation Guidelines for PHCUOR***.

2.3 STRATEGIC APPROACHES

Over the years, strategies for PHC financing have been fragmented and poorly coordinated, resulting to significant inefficiencies. Funding for interventions implemented by government agencies, development partners and NGOs are often not aligned, resulting in duplications and poor value for the inadequate funds available for PHC. While several strategies are still in place, the BHCPF and the National Strategy for Immunisation and PHC Systems Strengthening (NSIPSS) represent bold attempts to provide more coordinated and sustainable PHC funding. Existing strategies to promote PHC financing are presented below.

2.3.1 Strategies to increase the fiscal space for PHC

2.3.1.1 Basic Health Care Provision Fund

The National Health Act of 2014 provides for the allocation of not less than 1% of the CRF to fund selected priority health services under the BHCPF. Forty–five per cent of the fund goes through the NPHCDA gateway to states who meet certain conditions including counterpart funding for strengthening the provision of the BMPHS. The NHIS gateway also provides for BMPHS to be provided to citizens in eligible primary and secondary health care facilities based on an approved business plan. The National Health Act 2014 specifies that for any state or local government to qualify for a block grant, such state or local government shall contribute not less than 25% of the total cost of projects respectively, as their commitment in the execution of such projects. This serves as an incentive to mobilise funds for State projects. Box 2.1 presents a summary of sustainable PHC financing through the NPHCDA gateway of the BHCPF.

Box 2.1 Sustainable PHC financing through the NPHCDA gateway of the BHCPF

The Basic Health Care Provision Fund (BHCPF) is funded by the FGoN, International Development Partners and other sources. It sets the country on a trajectory towards achieving UHC by increasing the fiscal space with the aim of increasing access to quality PHC services to all Nigerians especially the poor and the vulnerable.

The NPHCDA is responsible for the 'NPHCDA Gateway' (i.e., 45% of the Fund), providing funding through the SPHCBs to eligible public PHCs (as Direct Facility Financing) to cover health facility operational costs.

The Fund is expected to cover 36+1 States of the Federation, through annual disbursements to states from the federal and quarterly disbursements to health facilities from the states. Individual state launches have been ongoing since the presidential launch of the Fund in January 2019.

States who meet a basic readiness score get their first annual disbursement allocation from the Federal. So far, 15+1 States have received their first disbursement to commence State level start-up activities. State level trainings aimed at building the capacity of health workers on the operationalization of the Fund are currently on-going in 4 States. Giving a time frame to this will provide more clarity.

This dedicated funding mechanism, demand and supply side financing with enhanced coordination, robust governance and accountability framework makes the BHCPF a unique and sustainable way of implementing PHC in Nigeria.

2.3.1.2 Nigeria Strategy for Immunization and PHC System Strengthening (NSIPSS)

Financing for vaccine procurement and first tier logistics for traditional routine vaccines in Nigeria comes from the Federal Government through a mix of budget and loans. GAVI has funded new vaccines for routine immunisation and SIAs. State and LGA financing are usually for operations (mostly integrated with other service areas) at their different levels. The World Bank Vaccine Financing Assessment showed that vaccine financing has grown about three-fold over the last decade, mostly due to GAVI catalytic funding with a 40:60 government: GAVI split between 2014 and 2016.

2.3.1.3 Saving One Million Lives Programme for Results (SOML PforR)

The SOML PforR is a Federal Government of Nigeria Maternal and Child Health programme supported by the World Bank, which provides incentives based on achievement of results (health outcome) and helps to drive institutional processes needed to achieve these results. The programme also

seeks to catalyse change in the way health business is done by focusing on results and governance. It is financed by a US$500 million International Development Association (IDA) credit to the Federal Republic of Nigeria over a period of 4 years from 2016 to 2020.

2.3.2 Strategies for Efficient financing mechanisms

2.3.2.1 Results-Based Financing (RBF)

The Nigeria State Health Investment Project (NSHIP) piloted in 8 States of the Federation from 2011 to 2020, provided an opportunity to test alternative financing strategies for the health sector, through two components of Results-Based Financing (RBF) namely Performance-Based Financing (PBF) and Decentralised Facility Financing (DFF). PBF in health is an instrument that links health financing to determined results, with payment made only upon verification that pre-determined results have been delivered. This approach to health financing aims at changing the incentive environment, accountability, and governance mechanisms at the State, LGA and health facility levels.

There is strong evidence which shows that linking financing to results produces better outcomes in terms of improved performance of service demand and supply as well as making health systems more accountable by shifting the focus from inputs to results. Box 2.2. describes changes in NSHIP implementation over the years, project impact, and lessons learned.

Box 2.2 How NSHIP is changing the face of PHC in Nigeria

Since December 2011, the FGoN, in partnership with the World Bank has implemented Performance-Based Financing, (a type of RBF), in health through the Nigeria State Health Investment Project. The project started with a small pilot in 3 States, (1 LGA per State), covering a population of approximately 600,000 and has rapidly scaled-up to 8 States across 3 regions of the country covering a population of over 24 million (approximately 11% of the country's population).

Project Impact and Lessons Learnt

Implementation of NSHIP has led to significant transformation in PHC practice within the 8 implementing States. Impact evaluation data collected in 2014 (February-April) and 2017 (August - October) showed that in the three pilot States, NSHIP was more cost effective and had important impact on the coverage and structural quality of maternal and child health services covering more than nine million people in three States than the controls in Nigeria.

Practical and significant impact was recorded on the quantity of key MCH services. Compared to control, NSHIP increased fully immunized child (FIC) coverage, Penta 3 coverage, ANC visits, number of curative consultations for children under 5, skilled birth attendance and outreach services. Additionally, NSHIP improved both structural and technical (process) quality of care compared to the control. NSHIP also significantly reduced out-of-pocket (OOP) expenditures.

The results indicate that providing operating budgets to health facilities, autonomy to spend the funds on their perceived priorities, strengthened supervision using a quality scorecard as well as strengthened management and governance contributed to success.

These results have greatly influenced decisions on how PHC should be practiced in Nigeria, specifically through the update of the Decentralised Facility Financing (DFF) in the operationalization of the NPHCDA gateway of the Basic Health Care Provision Fund.

Source: NSHIP Team

2.3.2.2 Decentralised Facility Financing (DFF)

DFF strategy is a health financing mechanism in which health facilities receive enhanced autonomy and once per quarter lump-sum cash transfer into their bank accounts. This PHC financing strategy has been adopted by the government to disburse the BHCPF through the NPHCDA gateway. This strategy supports facilities to identify and fund their priority needs based on approved business plans for effective operation and provision of quality care. The BHCPF through the NPHCDA gateway allocates 20% to provide essential drugs, vaccines, and consumables for eligible PHC facilities; 15% for

the provision and maintenance of facilities, equipment, and transport for eligible PHC facilities; and 10% to be used for the development of human resources for PHC. Beyond the 1% CRF, States shall provide counterpart funding which will further increase the funds available for PHC strengthening.

2.4 STANDARDS

Standards for financial management in the PHC system is essential for the success of UHC. The procedures for contracting PHC facilities, continued participation in the BHCPF implementation, provider payment as well as definition and costing of benefit package are fully outlined in the ***BHCPF Operations Manual***.

2.4.1 Financial Technical Working Group (TWG)

The TWG shall be established both at the State and LGA levels with specific ToR. They provide financial oversight and ensure efficient utilization of funds and resources towards strengthening PHC programmes. They receive and review reports of quarterly internal and annual external audit exercises and ensure that financial statements are shared with all stakeholders.

2.4.2 Provisional Accreditation of PHCs

A participating facility is designated as the beneficiary PHC of the ward in consultation with the WDC. The PHC shall meet the provisional "kick off" criteria for PHC accreditation as detailed in the BHCPF manual. This provisional accreditation will last for one year.

2.4.3 Renewal of Accreditation.

A participating facility must obtain annual facility licensure (Certificate of Standard) issued by the SMoH or other designated government body. Participating PHC facilities must be certified initially and must maintain the standard for continuous participation in BHCPF implementation.

Other criteria include the following:

i. Each accreditation shall be limited to 3years, within which a health facility license can be suspended or withdrawn based on beneficiary feedback, complaints, and provider performance.
ii. PHC facilities must provide all data/ financial reports to the NPHCDA through the SPHCBs.
iii. PHC facilities must possess valid current licenses of personnel, and registration with regulatory bodies.
iv. There must be evidence of internal quality improvement system and demonstration of incremental quality improvement as outlined in the BHCPF manual.

2.4.4 Funds Access

Each participating PHC facility must open an account with a commercial bank. The signatories to the account shall be in line with BHCPF manual and PHCUOR guidelines. Other types of facilities like health posts or health clinics will receive operational funds. All health facilities must develop quarterly business plans that outline all planned expenditures approved by the SPHCB.

2.4.5 Funds Disbursements

i. Funds are to be transferred electronically in the correct amount and in a timely fashion to PHC facilities according to guidelines.
ii. Funds to state boards will be domiciled at the Central Bank of Nigeria (CBN) Treasury Single Account (TSA).
iii. BHCPF funds received by public health facilities used appropriately.
iv. Verification that services paid for under the NHIS gateway provided.
v. NPHCDA shall provide to the National Steering Committee that all participating States have made a budgetary provision for PHC in their annual budget/appropriation for the disbursement year and such provisions have been released into the State's BHCPF account at the CBN.
vi. Actual cost of services to patients.
vii. Patient satisfaction through feedback mechanisms.

2.4.6 Financial Data Verification

i. Statement of accounts to ascertain the date of receipt of funds from the Fund (Federal Level).
ii. Payment vouchers for evidence of disbursement of funds to facilities no later than one month following the SPHCBs receipt of the first tranche of funds from Federal level.
iii. Quarterly reports of utilization data for key indicators including outpatient visits (including for children under-five), antenatal visits, skilled deliveries, postnatal visits, and immunization.
iv. PHC facility Verification visit Reports (details in the BHCPF guideline).
v. Household verification visits and phone calls.
vi. Annual National Health Facility survey.

CHAPTER 3
PHC MANAGERIAL AND SUPPORT SYSTEMS

3.1 INTRODUCTION

One of the principles of the PHCUOR policy is that decentralized authority, responsibility, and accountability with an appropriate span of control is established at all levels. This confers clear managerial responsibilities to heads of PHC facilities.

Management is the process of mobilizing and deploying resources for the efficient provision of effective health services for the community. It involves continuous decision-making and problem-solving (after problem identification and analysis), and the sequential processes of planning, implementation, and evaluation.

The head of a PHC facility functions as a manager of resources- manpower, materials, money, and time. The following functions apply to PHC management:

- Planning: This is setting objectives & choosing alternative courses of action towards their attainment.
- Organizing: This is ensuring order in the deployment of resources.
- Staffing: This is ensuring that positions on the organizational chart are filled with adequate number of staffs, with appropriate skills & attitudes.
- Leading: This is motivating personnel to work with sustained zeal towards organizational objectives.
- Controlling: It is carrying out surveillance to ensure that the work is done according to plan.
- Evaluating: This is assessing progress towards predetermined objectives.

Management and health intervention provision extends beyond the health sector. Several programmes and projects that affect the health status of the people are situated in different Ministries, Departments and Agencies (MDAs), e.g., agriculture, water resources, education, works and housing, so a major part of the duty of the Officer-In Charge (OIC) is inter-sectoral collaboration.

3.2 POLICY

With the passage of the National Health Act 2014, more managerial responsibilities and effective oversight are required from the managerial structures at the facility level, and the accountability structures at the ward level, respectively.

The OIC of the health facility serves as the manager and is responsible for the day-to-day running of activities. The OIC of the health facility is a member of the WDC and the FMC. These committees provide oversight and support to the facility. The PHC Centre coordinates and supervises all the health services within the ward both at the facility and community levels.

3.3 STRATEGIC APPROACHES

The OIC of health facilities are responsible for the management of resources (including man, material, money, and minutes). They also work with the WDC to mobilize financial resources from various sources and with the FMC to ensure the prudent and efficient use of available resources.

The PHC facilities receive operational funds from the LGHAs and SPHCBs. With the implementation of the BHCPF, health facility managers are required to manage additional funds from the BHCPF grant in the form of DFF from the Federal Government. DFF health facilities have enhanced managerial autonomy and once per quarter, receive a lump-sum cash transfer into their health facility bank accounts. Health facilities can use the income from the DFF grant on eligible items and activities needed to increase service provision and improve quality. They are also empowered to make decisions on the medicines, commodities and equipment needed to provide health services for beneficiaries.

Additionally, the OIC, together with the FMC shall ensure that the staff carry out their duties based on their job descriptions and SOPs as provided by the Human Resource Committee of the SPHCB in line with the PHCUOR initiative.

3.4 STANDARDS

3.4.1 PHC Facility Planning

The FMC, together with support from the WDC and technical advice from the LGHA Management Team, draws up a business plan every quarter. The SPHCB approves this plan. The business plan is used by the health facility management to explain the various targets and strategies it has devised to improve the coverage of good quality services. The business plan is meant as an aid for the health facility management to focus their problem-solving skills on the required service delivery performance.

3.4.2 PHC Facility Financial Management

Financial management at the PHC level is governed by expectations from the implementation of the National Health Act where PHCs across the

country will be expected to receive DFF grants to meet their operational costs and serve as primary providers for State Health Insurance Schemes (SHIS).

To ensure transparency and accountability at facility level, financial management would essentially include the following:

- Opening of a commercial bank account: All PHC facilities are required to open account where the OIC and a member of the WDC will be co-signatories. Financing from all sources – government, partners, insurance etc – is expected to be pooled in this account for PHC.
- Develop a quarterly business plan, based on available and expected financial resources, to be submitted to the LGHA and which should be approved by the SPHCB.
- Each PHC facility would constitute a quality improvement team consisting of the OIC, a member of WDC and other health staff who will prepare quarterly business plans. Where numbers do not allow, the FMC described above can serve as this.
- Similarly, on a quarterly basis, facilities shall provide a statement of account on total amounts received into the bank account, source(s) of funds and expenditure.
- PHC facilities shall be required to produce and submit income and expenditure statements for monies received from various sources to the SPHCB through the LGHA at the end of each quarter and of the financial year.

Details of this financial management processes, tools and capacity building are contained in the ***BHCPF operations manual*** and the ***NPHCDA gateway handbook*** for PHC workers.

3.4.3 PHC Facility Human Resource Management

The FMC shall monthly appraise the performance of their staff, using an individual performance evaluation framework (Appendix 5) to manage individual effort and reward good performance. This evaluation is based on the staff job descriptions and SOPs as provided by the Human Resource Committee of the SPHCB in line with the PHCUOR policy.

3.4.3 PHC Facility Coordination and Collaboration

Coordination is the organization and integration of activities, responsibilities, as well as structures to ensure that the available resources are used efficiently in pursuit of specified objectives while collaboration occurs when

two or more parties work jointly towards a common goal. The FMC collaborates with the WDC/VDC in activities such as mobilising resources for the health facility. They also collaborate with other stakeholders and partners for better PHC practice.

The FMC reports to the VDC or WDC as applicable for coordination and support. All identified problems at the ward level are taken to the LGHA for intervention and necessary action. Membership of the committees is on voluntary and merit basis.

3.4.4 PHC Facility Procurement

All procurement of consumables, equipment, essential medicines, and such items for the functionality of the facility as approved in the business plan shall be carried out by the health facility through a simple shopping method.

They can select a vendor from the state list of accredited vendors for the supply of essential medicines and commodities.

For maintenance of the health facility infrastructure and equipment, the FMC can hire local artisans for services.

All transactions shall be made through bank transfers and monitored through bank statements by the LGHA and the SPHCB.

CHAPTER 4
HEALTH SERVICE DELIVERY AND QUALITY OF CARE

4.1 INTRODUCTION

To achieve UHC, individuals and households need to have access to a comprehensive set of health services (often called a benefit package, health care package, service package) which is delivered at the right quality. At the Primary Health Care (PHC) level, these services should be informed by evidence from local health needs, guided by clear policies, and delivered at health facilities, outreaches and sometimes, directly to households.

4.1.1 Health Service Delivery

As part of efforts to guide the availability of services at PHC facilities, and in furtherance to the Revised Ward Health System Strategy, the NPHCDA has determined an essential service package to be delivered at each PHC level.

The Essential Service Package (ESP) is a total package of services that includes all health interventions and/or services, that address priority health and health related problems in a political ward resulting in substantial health gains and at low cost.

In defining this package, several considerations were made; disease patterns, economic considerations (e.g., cost of services) and proportion of population affected or benefiting from health services.
However, in line with current realities the ESP is further broken down into smaller packages defined by the PHC level.

- o Outreach Pack- Health Outreach Post
- o Minimum Pack- Primary Health Care Centre Level 1
- o Intermediate Pack- Primary Health Care Centre Level 2
- o Optimum Pack- Primary Health Care Centre Level 3

The ESP includes the following health interventions:

- Reproductive, Maternal, Newborn, Child, Adolescent and Elderly Health plus Nutrition (RMNCAEH+N)
- Prevention and Control of Communicable Diseases (malaria, STIs/HIV/AIDS, hepatitis, TB/leprosy, NTDs)
- Prevention and Control of Non-Communicable Diseases (NCDs)

- Emergency Medical Services
- Public Health Emergencies, including outbreaks
- Health Promotion
- Social Determinants of Health

Details of the services offered for each of the interventions can be found in the ***Revised Ward Health System Strategy*** document.

In a bid to improve coverage across the country, various health interventions also provide packages of services which are sub-sets of the MSP. These are either programme based i.e., implemented for a specific time frame e.g., the Minimum Package of Activities delivered by the Nigerian State Health Investment Project or insurance based i.e., a benefit package such as the Basic Minimum Package of Health Services delivered by the Basic Health Care Provision Fund and delivered through the NHIS gateway.

Clinical governance is a strategy for attaining quality of care.

Its various components

include

- Education and training
- Clinical audit
- Clinical effectiveness
- Research and development
- Openness
- Risk management
- Information management
- Engaged leadership

4.1.2 Clinical Governance and Quality of Care (QoC)

Clinical governance is a "framework through which health facilities are made accountable for continuously improving the quality of their clinical services and ensuring high standards of patient care by creating a facilitative environment in which excellence will flourish". It ensures that everyone who passes through the health system is well cared for and is a vital component of 21st-century medical care. Where properly instituted, it raises patient satisfaction, improves collaborative relationships and efficiency within and across clinical teams, increases job satisfaction for health workers, improves clinical outcomes and significantly reduces adverse events.

Clinical governance is a key strategy for attaining Quality of Care (QoC) which is defined by the Institute of Medicine (IOM) as "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". Standardizing care is a critical step in improving quality as it reduces variations among providers and enable measurements.

Although current focus is on quantity of care i.e., incremental population coverage, without concurrent improvements and focus on quality, the

impact on burden of disease will be minimal and the journey towards UHC will not yield value for money.

In line with this manual of standards, it is imperative for NPHCDA in collaboration with stakeholders to establish mechanisms, frameworks and protocols for standardizing, monitoring, and measuring all the domains of quality of care and clinical governance within the PHC system. This will reduce variations among providers and improve health outcomes. It will also complement the monitoring of structural components of quality which are already being implemented in various programs such as RI, NSHIP, BHCPF and MPDSR (Box 4.1) which have tools to assess structural and to some extent, processes of quality.

Box 4.1 Improving Quality through MPDSR

Maternal and Perinatal Death Surveillance and Response (MPDSR) is a continuous cycle of identification, notification, and review of maternal and perinatal deaths, followed by actions to improve quality of care and prevent future deaths. It is an established mechanism to examine the circumstances surrounding each death, including any breakdowns in care from the household to the health facility that may have been preventable. This process is an important part of the continuous action cycle for quality improvement that can link data from the local to national level. For PHC, MPDSR occurs at the facility and community level. Operational details for implementing MPDSR are contained within the National Guidelines for Maternal Perinatal Death Surveillance and Response in Nigeria.

In establishing this framework, the 5S-5M-5C,[27] model will be adopted. This holistic approach to addressing quality especially at PHC level will comprise of:

- structural measures of quality represented as **s**pace, **s**ystems, **s**taff, **s**tuff (consumables) and **s**urveillance **(5Ss).** The **5Ss** serve as the foundation of quality improvement efforts, however,
- it also entails the use of **m**ultidisciplinary teams, **m**anagement, **m**otivation, **m**onitoring, and **m**easurement **(5Ms).**
- The **5Ms** facilitate the desired outcomes that mark a functional PHC which are first **c**ontact access to care, **c**ontinuity of care,

[27] Bitton A, Veillard JH, Basu L, Ratcliffe HL, Schwarz D, Hirschhorn LR. The 5S-5M-5C schematic: Transforming primary care inputs to outcomes in low income and middle-income countries. BMJ Glob Heal. 2018;3(figure 1):3–6.

comprehensiveness of service and **c**oordination to facilitate person centred **c**are **(5Cs).**

Quality improvement cannot be imposed by decree but needs to be imbibed and driven intrinsically by trained health workers and maintained by adequately funded infrastructure.

4.2 POLICY

The National Health Act, 2014 makes room for a basic package of public health and clinical interventions that are cost-effective, socially, and economically accessible especially to the poor and deals with the priority disease burdens of the Nigerian population. Also, it clearly states health establishments including PHCs must possess a Certificate of Standards as proof that it has met all requirements – HRH, services, infrastructure/equipment – for delivering an effective, efficient, and high-quality care (Box 4.2)
services.

Box 4.2 Provisions of the NH Act on Certificate of Standards and quality requirements

Section 13.– (1) Without being in possession of a Certificate of Standards, a person, entity, or organisation shall not –

(a) Establish, construct, modify or acquire a health establishment, health agency or health technology.
(b) Increase the number of beds in, or acquire prescribed health technology at a health establishment or health agency.
(c) Provide prescribed health services; or
(d) Continue to operate a health establishment, health agency or health technology after the expiration of 24 months from the date this Act took effect.

(2) The Certificate of Standards referred to in sub-section (1) of this section may be obtained by application in prescribed manner from the appropriate body of government where the facility is located.

Section 19. – (1) All health establishments shall comply with the quality requirements and standards prescribed by the National Council on Health.

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

Within the National Health Policy, PHC is identified as the cornerstone of the health system for delivering effective, efficient, quality, accessible and

affordable health services to a wider proportion of the population and the cornerstone of the National Health System. Improved inter-sectoral collaboration in primary care delivery is one of the four approaches outlined in the policy for improving population health.

4.3 STRATEGIC APPROACHES

These comprise different strategies, interventions and programmes aimed at providing the ESP at the different service delivery points.

4.3.1 Essential Service Package (ESP)

Public health expenditures in developing countries are often not directed toward the most cost-effective programmes. Substantial amounts of public funds are often spent on services which result in little gain for the population in terms of life expectancy or quality of life.

The ESP is a guaranteed minimum priority set of health care interventions or services that are provided at primary and/or secondary facilities daily and always through government financing mechanisms, with the aim of concentrating scarce government resources on interventions which will provide the best 'value for money'. It is expected that the ESP will improve efficiency, equity, political empowerment, and accountability. It ensures that resources are allocated in a manner that guarantees the most cost-effective public health and clinical services are accessible to all.

Development of the ESP requires two critical components, defining the package of cost-effective PHC interventions and costing of the package. Other services, outside this Essential service package would be left to be financed through other funding mechanisms. Kindly refer to the Revised Ward Health Systems Strategy for guidance on costing the EPS.

4.3.2 Strategies for Immunization

A very critical intervention included in the MSP is immunization against vaccine preventable diseases in childhood. This section describes the strategies that Nigeria has adopted to improve the coverage of immunization services to drastically reduce the prevalence of vaccine preventable diseases and under-5 mortality in the country.

4.3.2.1 Routine Immunization Coordination Platforms

The National Emergency Routine Immunization Coordination Centre (NERICC) is a coordination platform established in response to the state of emergency of public health concern declared on Routine Immunization (RI).

Through the NERICC, SERICCs and LERICCs were also established to manage the full implementation of the RI programmes, strategies, and other recommendations of various expert committees towards boosting RI coverage for ALL antigens at national, state and LGA levels.

The objectives of the NERICC are to improve detection and responsiveness in the resolution of RI gaps, strengthen leadership and accountability, strengthen coordination, increase fixed and outreach services for immunization especially in the very low performing states as well as increase data visibility, quality and use for action at all levels.

4.3.2.2 Polio Emergency Operations Centre (EOC)

The National Emergency Operations Centre (EOC) was commissioned by the Presidential Task Force in October 2012 as a management tool for NPHCDA to coordinate overall emergency response. Its leadership comprises of the Incident Manager (NPHCDA) and Deputy Incident Manager (NPHCDA) with executive authority of Executive Director NPHCDA and the Honourable Minister for Health. All Global Polio Eradication Initiative (GPEI) partners assign senior staff to the EOC.

The EOC has 5 sub-divisions which aid it to deliver on its core mandate, the strategy group, data group, Supplemental Immunization Activity (SIA) operations, communication, and polio surveillance team. The strategy group provides strong technical knowledge and data-management skills, guides teams through complex fact-based analyses, critically examines the impact of strategic inputs to emergency plan on ongoing basis and are accountable for ongoing strategic review and course corrections.

The data group reviews and synthesizes operational, communication, and monitoring data. It also identifies and guides operational and social research and are accountable for maintaining programme 'Dashboard'; data visualization and Immunization Plus Days (IPDs) performance reports.

The SIA operations team is accountable for IPD state of preparedness analysis; national-level deployment of monitors; monitoring and assessing NPHCDA/partner reports as well as inputs (Technical assistants, nomad strategy, GIS/GPS, micro-planning, operational research, training, etc.). It tracks state operational issues and gaps, maps, IPD planning and logistics.

The communications team tracks development and implementation of communication strategies at national and state levels, co-ordinates

media/advocacy outreach. It is accountable for quality communication planning and implementation, national media outreach and advocacy coordination.

The polio surveillance team review and synthesize EPI and AFP surveillance data, tracks implementation of surveillance activities at national, state and LGA levels (**Box 4.3**). It is accountable for ensuring all APF surveillance indicators are met, and that the surveillance system is highly sensitive.

The EOC is replicated in 7 States: Borno, Bauchi, Kaduna, Kano, Katsina, Sokoto and Yobe with cross-agency membership (NPHCDA, WHO, UNICEF, CDC/NSTOP, Rotary & Core Group).

Box 4.3 Ending Polio in Nigeria

Over the last few years, the Polio Eradication Initiative (PEI) has implemented several innovative approaches towards eradicating polio in Nigeria. Some of these include:

Geospatial Research, Analysis and Services Program (GRASP) - Satellite Imagery Analysis: This innovation helps to determine the habitation of settlements that have been presumed to be abandoned due to insurgency by geospatial technology and satellite imagery analysis. The information gathered improves access to AFP surveillance, community informants and vaccination teams.

Use of GIS Technology: This technology has been used to map sites of interest where children can be found like schools, places of worship and playgrounds. It has helped the PEI programme determine the under 5 target population to expand access to children. It is also used in the Vaccination Tracking System (VTS) which has helped in tracking vaccination teams to ensure that planned settlements are visited by the teams, ensuring that no child is missed.

Health Camps: Camps are set up in underserved communities to increase the uptake of the Oral Polio Vaccine (OPV). Community members can also access a package of services including malaria chemoprophylaxis, deworming medications, LLINs, ANC and treatment of minor ailments.

Use of Open Data Kit (ODK): This android-based application is used by vaccination teams to upload real time data including geo-coordinates offline. This data is transmitted to a central server to inform immediate corrective actions during SIAs.

Household-Based Enumeration (walk-through): This has been used by health workers to enumerate immunisation target population that gives a more reliable data for planning.

4.3.2.3 Nigeria Strategy for Immunization and PHC Systems Strengthening (NSIPSS)

The Government of Nigeria in collaboration with partners and donors, developed the Nigeria Strategy for Immunization and PHC Systems Strengthening (NSIPSS) to guide and galvanize efforts aimed at achieving sustainable immunization outcomes and strengthening the PHC system.

The NSIPSS promotes a unified approach to improve all elements of immunization, while taking into cognizance the critical role of a strong PHC system as the gateway to sustainable growth in immunization coverage and service delivery in the country. The principles guiding the NSIPSS development are undergirded by the need to boost immunization, not as a stand-alone programme, but as a key component of PHC at all levels in Nigeria.

The NSIPSS strategic document describes the programmatic decisions made by Nigeria and outlines how the programme will be managed and financed. It presents the country's plan for transitioning to financial ownership of the immunization and PHC system over a ten-year period, from 2018-2028 – in line with Nigeria's proposed timeline for graduating from Gavi support. The goals, objectives, strategies, and operational guidelines are outlined in the ***NSIPSS*** document.

4.3.2.4 Non-Polio Supplementary Immunization Activities (SIAs)

The goal of accelerated disease control is to develop and implement strategies (campaigns/outbreak response and surveillance) geared towards control and elimination of measles (Box 4.4), cerebrospinal meningitis, yellow fever as well as maternal and neonatal tetanus. These diseases contribute significantly to the under-five morbidity and mortality rates. SIAs provide opportunities for additional doses of vaccines to be administered to susceptible populations within a period, to achieve herd immunity that was not achieved through routine immunisation and protect the population from outbreak of vaccine preventable diseases. The details of specific disease targets, barriers, and facilitators to successful implementation of SIAs can be obtained from the NSIPSS documents.

Box 4.4 Winning the Fight against Measles in Nigeria

Over the last decade, Nigeria has made giant strides to reduce child morbidity and mortality especially those caused by vaccine preventable diseases such as measles. Measles is a leading cause of death in children in Nigeria. To consolidate the gains of the fight against measles, the National EOC has employed several innovative approaches during implementation of non-Polio SIAs.

- Deployment of rapid convenience monitoring tool on the Open Data Kit (ODK): This helped with real time monitoring of immunisation during implementation and for tracking missed children and or communities.
- Use of readiness assessment dashboard / activity tracker: The use of this customised dashboard and tracker fitted with timelines and activities to monitor progress of the entire programme helps identify gaps in coverage to inform areas for mop-up activities.
- Establishment of data teams: Dedicated programme data teams help real-time analysis and interpretation of data for improved outcome of the programme.
- Use of national and state crisis communication plan: The crisis communication team, comprising the Executive Secretary of the SPHCB who the head is, health workers and media persons was established to address the spread of news, (true or fake), concerning PHC activities especially immunisation. The team developed a crisis communication plan that is updated periodically to address changes in how to combat information crisis.
- Use of House-2-House Mobilisers (H2H): In addition to community mobilisers and CHIPS agents, H2H mobilisers have been instrumental in mobilising caregivers and other eligible clients to the health facility and or vaccination post. They have been used to achieve quick mobilisation when needed for maximum output such as during vaccination campaigns and MNCH Week.
- Staggering: Staggering is a methodology that is used to address shortages in human resource, cold chain, and other commodities. There are 2 types of staggering:
    - Inter LGA: The state is divided into 2 parts based on paucity of resources (Human, equipment) during campaigns, either 50:50 or 70:30. The campaigns are commenced from LGAs where resources are more needed.
    - Intra LGA: For very resource limited states, this mode of staggering was used where the LGA was divided into 2 and the wards were split into these groups for implementation.

4.3.3Strategies for RMNCAEH+N

Reproductive, Maternal, New-born, Child, Adolescent and Elderly Health plus Nutrition (RMNCAEH+N) interventions are contained within the MSP, which are critical in determining a country's health indices. The poor maternal and child health indices in Nigeria have led the country to develop strategies to reverse the trend, towards achieving the SDGs

4.3.3.1 National Emergency Maternal and Child Health Intervention Centre (NEMCHIC)

The National Emergency on Maternal and Child Health Intervention Centre (NEMCHIC) established at NPHCDA, was borne out of concerns on the poor progress in reducing maternal and child deaths in Nigeria (**Box 4.5**). It coordinates the efforts of all RMNCAEH+N stakeholders within the PHC and community. The goal of the centre is to rapidly reduce maternal and child mortality by 50% by 2021. It also provides the trajectory for attaining the global SDG target of <70/100,000 live births for maternal mortality ratio and <25/1,000 live births for under-5 mortality rate.

The main objectives of NEMCHIC includes to improve awareness and promote community involvement in interventions to reduce maternal and child mortality; strengthen coordination, leadership, and accountability in RMNCAEH+N programmes; increase data visibility, quality and use for action at all levels; improve detection and responsiveness in the resolution of RMNCAEH+N service gap.

Similar coordination structures (SEMCHIC and LEMCHIC) are being established at state and local government levels respectively to drive this.

Box 4.5 Addressing the High Rates of Maternal and Child Deaths in Nigeria

In response to a declaration of the state of public health concern on maternal and child deaths, NEMCHIC has set up the following high impact quick win interventions to reduce the maternal and child mortality indices by 50% by the year 2021:

- Ending home deliveries: This coordination platform shall end home deliveries by sending out a CHEW or midwife called a Community Skilled Birth Attendant to the communities. They are to refer pregnant women and women in labour for ANC and health facility delivery, respectively. It also adopts the community skilled birth attendant (SBA) approach which offers emergency delivery in the community, where it is not possible to reach the health facility.
- Community-targeted approach: The platform aims to empower community members by using innovative communication tools like the Community Information Boards (CIB) displayed at a strategic point in the community. This serves to provide basic and readily available data that ensures that community members are empowered to increase their influence and control of maternal health.
- Maternal, Neonatal and Child Emergency Transport System (MaNCETS): Through the CHIPS agents/community volunteers, all pregnant women are line listed and provided with at least two pre-paid vouchers. The NEMCHIC team engages select drivers that would provide emergency transport scheme services in the community. These drivers have dedicated phone lines and shall present the vouchers given to them by patients that utilise their service, for payment at the health facility.
- Community Maternal, Perinatal Death Surveillance and Response (cMPDSR): NEMCHIC has devised a continuous surveillance system that reviews maternal and perinatal deaths occurring in health facilities by involving the people directly concerned with the management of the deceased. It utilizes verbal autopsies.
- Service, Quality Utilization, Accountability and Tracking (SQUATS): This is the use of a simple technologic innovation to create a feedback mechanism on user/client service quality rating of the service provided. This platform can also be used for dissemination of digital media and escalation of incidents etc.
- Program Assessment for Performance Management Action-Lots Quality Assurance Sampling (PAPA_LQAS): It is an integration of routine immunization indicators and RMNCH indicators to assess the quality of RI and RMNCH interventions from feedback from the community. It is a population-based survey that can distinguish lots meeting pre-set outcome targets from those that do not, using the LQAS methodology. Findings will not be representative of coverage, but of feedback from caregivers on the quality of the RI and MNCH programs.

4.3.3.2 Maternal New-Born and Child Health (MNCH) Week

The MNCH week is a 5-7-day campaign organized by states to promote the delivery of a set of priority MNCH services. It aims to contribute towards the reduction of maternal new-born and child mortality and improve health by improving health seeking behaviour, increasing awareness on key household practices, and generating demand for routine services. The objectives of the campaign are: to increase the coverage of RMNCAEH+N interventions in PHC facilities and through outreaches by 80%; improve the capacity of health workers through supportive supervision in at least 80% of target PHC facilities; and train community volunteers, mobilize commitment for MNCH programmes and health systems strengthening from government, and other stakeholders.

Current nutrition-specific intervention packages that focus on growth monitoring, food fortification, management of acute malnutrition, and strategies to combat micronutrient deficiencies are also administered during the MNCH Week campaign.

4.4 STANDARDS

Service delivery is in the purview of the health facilities at various levels (PHC centres and health outreach post). The NPHCDA sets standards, guidelines, and regulations while the SPHCB and LGHA monitor and supervise implementation. However, for some national level programmes like EPI, RMNCAEH+N and family planning activities, NPHCDA, SPHCB and the LGHA are involved in the planning, organization, and implementation. There are two categories of primary health care facilities providing services:

The **health outreach post:** This facility is manned by JCHEWs, opens over one shift, and provides treatment of minor ailments, antenatal and immunization services. It could serve as a site for outreaches, and it is hoped that as the WHS develops, these facilities would decrease in number and distribution across the ward. It is expected that there should be one health outreach post in every community that does not have a primary health centre. It is expected that 20% of JCHEW's time will be spent in the health post and 80% in the community.

The **Primary Health Care Centre:** The primary health care centres are divided into three levels:

- **Primary Health Care Centre** Level 1
- **Primary Health Care Centre** Level 2
- **Primary Health Care Centre** Level 3

While these facilities may have the same physical infrastructure, the main distinguishing features of the three levels are the human resources availability and the services they provide.

4.4.1 Use of Standing Orders /National Standard Treatment Guidelines

Every health worker at the PHC facility level shall be familiar with the value and use of Standing Orders. The Standing Orders are a set of specific guidelines arranged by age group, disease conditions, clinical findings, diagnosis, and actions, which define how clients shall be cared for at PHC facilities. The Standing Orders ensure uniformity in the quality of care and provide legal backing for the health workers. Details of treatment guidelines could be found in the *Standing Orders* for JCHEWs and CHOs/CHEWs.
Standing Orders for CHOs/CHEWs and JCHEWs must be always kept in the facility and adhered to.

Medical doctors, dentists/dental assistants and nurse/midwives working in PHC facilities should use the ***National Standard Treatment Guidelines***.

4.4.2 Referral Systems

Patients to be referred are those with conditions not covered by the Standing Orders, not responding to treatment within specified time in the Standing Orders, those who are rapidly getting worse and those with health conditions one is in doubt of. These conditions can include emergencies, maternal conditions, and common ailments. Every PHC worker should be familiar with the value and effective use of Standing Orders. The standard 2-way referral form that has been developed by FMoH/NPHCDA shall be made available and used in all health facilities.

4.4.3 Outreach Services

PHC services are delivered in health facilities on a fixed basis. The need to ensure that all members of the community are catered for is paramount and requires taking services to those far-to-reach, hard-to-reach, and special populations. The health services rendered outside the health facilities to bridge the access gap within communities are referred to as outreach services. Communities are mapped as catchment areas to which the health facilities can reach out to provide services. The services are usually based on needs which are derived from close collaboration between the health facility staff and the community represented by the WDC. Services for outreaches are:

- Immunization
- Nutrition and growth monitoring

- Antenatal Care (ANC)
- Treatment of minor ailments
- Health promotion, to mention a few

All communities 5 kilometres and above from the health facility should be covered by an outreach service. The different models of outreaches include: (1) Single intervention outreaches which are focused on a single health service such as RI, nutrition etc. and (2) Integrated intervention outreaches, which are a combination of more than one intervention for example, immunization with nutrition, vitamin A supplementation and de-worming of children.

4.4.4 Services and Fee Payment

Details of the types of services delivered by different cadre of health workers at each facility level are presented in appendix4.
Patients shall not be charged for services covered by insurance.

4.4.5 Quality of care

This will involve a joint annual quality improvement assessment by the NPHCDA, SPHCB and LGHA using a quality checklist with an observation component to assess staff certification, skill, competence, diagnostic accuracy, and patient interaction. It will also assess the facility, referral systems and service availability and readiness. The use of Standing Orders, national guidelines, protocols, best practices, job aids and job descriptions must be adhered to daily. This is necessary to sustain the delivery of high-quality care to clients routinely. Each facility shall have quality improvement team/officer that is responsible for ensuring that standards of care are monitored and measured through patient satisfaction surveys and clinical observations. There should also be empanelment of patients by CHIPS to ensure continuity of care.

4.4.6 Visibility/Signpost:

The health facility will put up and maintain at least one sign in a prominent place that describes the services that patients can obtain. The sign will be at least 50cm wide by 70cm tall and will be in English and another appropriate language. A font size of at least 24 will be used for the lettering.

4.4.7 Laying Complaint(s)

The procedure for laying complaint(s) shall:

a) Be displayed by all health establishments in a manner that is visible for any person entering the establishment and the procedure shall be communicated to users on a regular basis
b) In the case of a private health establishment, allow for the laying of complaints with the head of the relevant establishment
c) Include provisions for the acceptance and acknowledgment of every complaint directed to a health establishment, whether it falls within the jurisdiction or authority
d) Allow for the referral of any complaint that is not within the jurisdiction or authority of the health establishment to the appropriate body or authority

4.4.8 Certificate of Standards for PHCs

The Certificate of Standards should be obtained by application in a manner as prescribed by the NPHCDA. Without being in possession of a Certificate of Standards, a person, entity, government, or organization shall not provide prescribed PHC services or continue to operate a health establishment, health agency or health technology after the expiration of 12 months. NPHCDA, SPHCBs and LGHAs shall ensure that appropriate, adequate, and comprehensive information is disseminated and displayed at facility level on the health services for which they are responsible, which shall include:

a) The types of health services available.
b) Cost of services.
c) The organization of health services.
d) Operating schedules and timetables of visits.
e) Procedures for laying complaints.
f) The rights and duties of users and health care providers.

4.4.9 Integrated Supportive Supervision (ISS)

The NPHCDA introduced the Integrated Supportive Supervision (ISS) "to strengthen the PHC system towards achieving the goals and objectives of PHC programmes and activities. ISS is a strategy to ensure that PHC programmes/activities and implementers are regularly monitored and mentored, to improve the quality of routine PHC service provision at all levels.

The exercise includes routine PHC facility visit by superior officers from the national, state and LGHA observe and provide guidance and support to

staff at the lower level. An appropriate checklist is used to record key information regarding gaps and challenges in the quality of PHC services at all levels of PHC service delivery. It also provides an opportunity to teach and support the lower-level staff and is a learning opportunity for all.

Information collected using a checklist is then collated and analysed to identify common trends and to compare changes made. The review process provides useful information for management action at all levels. Observations/findings from the ISS serve to guide the smooth implementation of PHC programmes/activities, and this is also periodically shared with relevant stakeholders to jointly look at the progress, challenges, and way forward for a seamless PHC implementation in Nigeria.

CHAPTER 5
HUMAN RESOURCES FOR HEALTH

5.1 INTRODUCTION

Human Resources for Health (HRH) are vital for the successful implementation of the MSP. It is defined as "all people, engaged in actions whose primary intent is to enhance health." (WHO, 2006). Human resources constitute one of the most important resources in health and therefore demand effective planning and management for an efficient and effective PHC system to achieve better health outcomes.

To ensure that staffing requirements to deliver the MSP at PHC are met, the FGoN established Schools of Health Technology to produce Junior Community Health Extension Workers (JCHEWs), Community Health Extension Workers (CHEWs) and other support staff, namely the Medical Laboratory Assistants, Pharmacy Technicians, Medical Records Officers, and the Dental Technicians. The universities and teaching hospitals in various parts of the country train doctors, nurses and Community Health Officers (CHOs), while the schools of nursing and midwifery train nurses and midwives.

Several pro-active steps have been taken to address health workforce challenges in Nigeria. These include the development of a comprehensive National HRH Policy (2007); a National HRH Strategic Plan (2008-2012); a 2013 HRH situation analysis across Nigeria; a revised HRH Policy in 2015 and more recently the establishment of the Nigeria Health Workforce Country Profile and National Health Workforce registry (NHWR) platform (2018). In addition, the current NSHDP II (2018-2022) includes HRH as one of its strategic priority areas. However, challenges remain in addressing the needs of the country. Some States are yet to commence the full implementation of the HRH policies and plans, due to the lack of financing and the dearth of experience in strategic HRH management and development.

5.2 POLICY

Government efforts towards development of HRH in Nigeria include formulation of appropriate legislations and policies, most notably, the National Health Act, 2014, which provides strong legislative backing for HRH development. There are also the National Human Resources for Health Policy (NHRHP) and the National Human Resources for Health Strategic Plan (NHRHSP). Both the NHRHP and NHRHSP provide guidance for the development of policies and plans at the subnational levels and are

supposed to be adapted by states. In addition, a National Task Shifting and Task Sharing (TSTS) Policy with Standard Operational Procedures (SOPs) have been developed.

The National Health Act provides that the responsibility to develop and monitor guidelines on the provision, distribution, development, management, and utilization of HRH within the national health system lies with the National Council on Health (NCH). It also stipulates that the Minister, with the concurrence of the National Council, shall determine guidelines that will enable the State Ministries and Local Governments to implement programmes for the appropriate distribution of health care providers and health workers.

The NPHCDA Act mandates the Agency to provide strategic technical support to the implementation of PHC components as may be required to enhance orderly development and improve upon or introduce new skills required for health services or to integrate new components into them. The Act also mandates the Agency to promote health manpower development by:

i. providing technical support to the preparation of health manpower policy, including manpower projections to enhance development of PHC manpower plan.
ii. providing advocacy and support for the orientation of medical under-graduate education and the education of other health workers towards PHC.
iii. identifying the orientation and continuing education needs of PHC manpower, including medical manpower and by organizing programmes to meet those needs, using the Schools of Health Technology as a resource.
iv. Directly supporting the strengthening of the Schools of Health Technology.

The National TSTS Policy has been developed for adaptation and implementation at all levels of the national health system, as part of efforts to address the health workforce shortage in Nigeria and to complement some initiatives to increase access to health care service. The TSTS Policy aims to meet the health needs of the Nigerian population through mobilization of available human resources to ensure equity, accessibility, and effectiveness in the delivery of essential health care services towards UHC. The policy promotes rational redistribution of tasks among existing health workforce cadres. It allows moving specific tasks, where appropriate, from highly

qualified health workers to health workers with shorter training and fewer qualifications to make efficient use of the available health workers and to improve access to services for the Nigerian people.

5.3 STRATEGIC APPROACHES

The following are strategies to ensure basic training of the human resources for health, continuous medical education to meet additional training requirements, as well as their availability in PHCs across the country. This section discussed the strategies at policy, health facility and community levels. They include:

1. National Human Resources for Health Strategic Plan
2. Nigeria Health Workforce Country Profile
3. National Health Workforce registry (NHWR) platform
4. National Task Shifting and Task-Sharing Policy
5. Technical Support Programme /NPHCDA Leadership Development Academy (LDA)
6. Competency based training for health workers
7. Midwives Service Scheme /Expanded Midwives Services Scheme
8. Community Midwifery programme
9. Community Health Influencers, Promoters and Services (CHIPS)

5.4.1 Nigeria Human Resources for Health Strategic Plan

The **Nigeria Human Resources for Health Strategic Plan**[28] was developed as a follow up to the National Human Resources for Health Policy. The strategies and activities in the plan provide a framework to guide and direct interventions, investments and decision making in the planning, management, and development of human resources for health at the federal, state, LGA and institutional levels.

The focus of the HRH Strategic Plan is on developing the most appropriate, feasible and cost-effective mix of strategies for ensuring equity in staff distribution and access to quality care irrespective of geographic location, whilst making the health profession more attractive. The strategic plan should be used by health policy makers and managers at all levels as well as development partners to mobilize resources to strengthen HRH.

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[28] FMOH 2007. National Human Resources for Health Strategic Plan

5.4.2 Nigeria Health Workforce Country Profile and National Health Workforce registry

The National Health work force registry operational guidelines 2015, mandates the establishment of a web enabled register that serves as a source of up-to-date information on Health workers at National and subnational levels in both private and secondary health facilities. It currently captures data from the Nigeria Health Workforce Country Profile 2018 with submitting entities having access to their relevant information. In a bid to contribute to these efforts of the Federal Ministry of Health, National Primary Health Care Health workforce is profiled, and the data is managed in a web-based Information System that feeds into the National Health Workforce Registry. The system provides an avenue for use of data for planning, analytics, action, and decision making. It ensures regular updating of health worker information as required by the dynamics of human resource and to reflect changes from implementation of HRH plans.

5.4.3 National Task Shifting and Task Sharing Policy for Essential Health Services in Nigeria

WHO describes task-shifting to be the rational redistribution of tasks among health workforce teams with the goal of getting the right workers with the right skills in the right place doing the right things. The **Task-Shifting and Task Sharing Policy for Essential Health Care Services in Nigeria**[29] details the tasks to be shifted or shared in critical areas of MNCH, HIV/AIDS, malaria, and tuberculosis care in Nigeria (**Box 5.1**). This helps to solve the problem of shortage and inequitable distribution of health workers. There is, however, a need for health workers to know their limitations even while implementing this policy.

[29] FMOH 2014 Task-Shifting And Task-Sharing Policy For Essential Health Care Services In Nigeria

Box 5.1 Task-Shifting Programme (Capability Building for Routine Immunization)

NPHCDA, in a bid to bridge the gap of shortage in technical staff with surplus of support staff, employed the use of Task-Shifting Programme, renamed Capability Building for Routine Immunization. It developed an end-to-end standardized and systematic approach to task-shift interested and under-utilized support staff to address the technical personnel gaps.

The approach entails planned training consisting of a 1-year blend of classroom modules and field apprenticeship to be conducted at national and zonal levels. Rationale for the training, among others, included to ensure the reversal of the aforementioned disparity and utilization of those under-utilized staff, to re-position the Agency to achieve its core mandates for which it was set up and ultimately to strengthen Routine Immunization. With the programme being in phases, it is expected that at conclusion, trainees would be deployed to technical areas where their services will be required both at the headquarters and at the zones to boost the technical human resource for the agency and subsequent achievement of her mandates. The trainees will also add to the pool of technical staff required for the Technical Support Programme of the Agency.

5.4.3 Technical Support Programme (TSP)

The NPHCDA, with partners, developed a structured and coherent technical support programme that will enable the Agency to effectively deliver the required technical support to states in the delivery of PHC services. The programme presents a coordinated, effective, and sustainable system for determining SPHCBs' needs requiring technical support and delivering the needed support through resource persons available within and outside NPHCDA.

As part of the programme, the Leadership Development Academy (LDA) (**Box 5.2**) was set up by the NPHCDA to build the capacity of its workforce to lead the delivery of Technical Assistance (TA) to the SPHCBs and drive positive transformation of the corporate culture at the Agency. The academy focuses on core leadership and management skills (including problem solving, stakeholder management, team leadership, communication, conflict management, institutional and personal ethics) and basic functional skills such as MS Word, PowerPoint, and Excel. The aim is to ensure a pool of staff with the right competencies and work culture, positioned for effective TA delivery.

Box 5.2: Leadership Development Academy

In December 2018, the NPHCDA Leadership Development Academy enrolled 30 trainees as its first cohort, to build their capacities on basic functional and leadership skills necessary to deliver effective TA to states. Competent staff were drawn from various units and/or departments of the Agency and adult learning approaches including external rotations, learning tours, mentoring, capstone projects as well as in-person trainings were employed.

Focus of the training was on core leadership and problem-solving skills including problem identification, problem structuring, issue analysis (issue tree), prioritization, work planning, analysis, synthesis, and report writing as well as soft leadership skills to ensure effective communication, right work culture and to change staff orientation from focus on monetary gains, to selfless public service.

The Agency envisions the LDA evolving into a public health institute for postgraduate training programs. This shall include a transition phase from LDA to the PHC Leadership Development Centre with focus on capacity building on knowledge and skills required for PHC leadership targeted at staff of NPHCDA, SPHCDBs, other MDAs and relevant organizations. The final phase is that of transition to the National Public Health Institute with focus on training in public health leadership and management targeted at postgraduate fellows and candidates of public health.

5.4.4 Competency Based Training for Health Workers

NPHCDA conducts training programmes to build capacity of its staff and other PHC workers. These trainings cover various aspects of PHC practice including but not limited to the following:

- Basic Guide on Routine Immunization
- Integrated Management of Childhood Illness
- Basic/Comprehensive Emergency Obstetrics and Neonatal Care (BEmONC/CEmONC)
- Emergency New-born Care Courses (ENCC)
- Helping Babies Breathe (HBB)
- Life Saving Skills (LSS)
- Modified Life Saving Skills (MLSS)
- Expanded Life Saving Skills (ELSS)
- Long Acting Reversible Contraception (LARC)
- Family Planning (Technology)
- Drug Management/Drug Revolving Fund
- HIV Counselling and Testing
- Prevention of Mother-to-Child Transmission of HIV/AIDS
- Malaria

- Bookkeeping and Financial Management
- HMIS
- DHIS2

These are contained in the ***Integrated Training Manual for Health Workers*** and other training manuals of the Agency.

5.4.5 Midwives Service Scheme (MSS)/Expanded Midwives Service Scheme (EMSS)

The Midwives Service Scheme (MSS) has been implemented by the Agency since 2009 when it was funded by the MDGs Debt Relief Grant. It is an HRH intervention that focuses on providing skilled birth attendants in rural underserved PHC facilities across the thirty-six states and the FCT.

The scheme originally deployed four midwives per 1,000 designated PHC facilities in underserved areas to ensure 24-hour coverage for the provision of Basic Emergency Obstetric and Neonatal Care, towards the attainment of MDGs 4 and 5. Four of these PHC facilities were clustered around a General Hospital (250 in total) for referral and provision of Comprehensive Emergency Obstetric and Neonatal Care. The Scheme was implemented on a tripartite agreement based on an MoU between the federal, state and LGAs. These midwives included the unemployed, retired but able and the newly qualified from recognized Nigerian Schools of Midwifery. However, the original MSS initiative was belaboured by several challenges especially funding and inadequate ownership and political will by relevant stakeholders, especially at state and LGA levels. Consequently, it became difficult to pay salaries regularly leading to near collapse of the scheme.

To sustain the gains of the MSS, the Agency held several consultative meetings with the Nursing and Midwifery Council of Nigeria (NMCN) and other regulatory and implementing agencies, towards a review and improvement of the scheme for a more targeted and cost-effective approach using only newly graduated basic midwives on a one-year mandatory service. The basic midwives were deployed to facilities close to either their schools of training or residence to significantly reduce the challenge of attrition experienced with the original strategy.

The Agency in her bid to achieve health for all now and in the coming years and building on the lessons of MSS to ensure greater sustainability, proposed a more robust HRH approach in the implementation of the MSS scheme which is the Expanded Midwives Service Scheme (eMSS). This will involve the engagement of two midwives and 2 CHEWs to provide 24-hourRMNCAEH +N services per ward focal PHC facility. Additional 2-star midwives will be recruited per LGA to provide mentorship as well as monitoring, supervision and training for the midwives and CHEWs. The star midwives will be experienced retired senior nurse/midwives while the facility workers will be unemployed experienced midwives and nurses or newly graduated basic midwives with adequate interest in the scheme. There will be a wide stakeholder engagement, preference for local hire and adequate attention to both supply and demand side issues to reduce the challenges faced by the earlier schemes.

> "The eMSS programme should significantly improve on the gains of MSS through adequate engagement of state and local policy makers, prioritization of local recruitment and strengthening demand side issues too".

The programme will be funded by both federal and state government through the 10% of the BHCPF dedicated to improvement in HRH. This will be supplemented by other sources of funding as the traditional financing from government allocations, private sector financing, contributions from partners, community members including community development organisations, philanthropists, etc.

To keep the scheme on track, the Agency with other stakeholders will pursue vigorously its implementation through set strategic thrusts. Some major activities to be conducted within the programme include:

- Programme Coordination and Management
- National Secretariat at NPHCDA with linkage to Zones and States
- Building Partnership & Consensus among Key Stakeholders
- Community Involvement/Participation
- Enlistment of Midwives and CHEWs
- Orientation, documenting, and kitting
- Monitoring and supportive supervision
- Capacity building through training and retraining
- Programme evaluation
- Operational research

5.4.6 Community Midwifery Programme

The community midwifery programme is another initiative of the FGoN, implemented by accredited Schools of Nursing and Midwifery to bridge the human resource gap, especially in rural communities.

The community midwifery programme is a shorter course designed for areas with acute shortage of skilled birth attendants to cover the facilities. Students from local communities are incentivised to train as midwives and are later posted to serve in their local communities for agreed periods of time covered by bonds.

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

CHIPS programme is designed to improve on the village health worker concept established by the NPHCDA and endorsed by the FGoN. The programme provides the community-based human resource components of the PHC system whose mandate is to stimulate and support households in communities to seek and obtain PHC services through interventions at the community level.

5.5 PRACTICE

In view of the critical role HRH plays in health care some strategies have been put in place by the government at various levels to ensure good management of HRH. One of the strategies to improve coverage of PHC services at the rural and urban communities was the development of different cadres of health workers with training oriented towards provision of services in rural communities. At least one school of Health Technology was established in every state to scale up the quantity and quality of the health workforce at the PHC level. The cadres of health workers trained by the school are:

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

The Community Health Officers (CHOs) are trained at teaching hospitals under the Community Health Officers Training Programme (CHOTP). Other PHC workers include the nurse/midwife and medical doctors who receive their pre-service training in accredited Schools of Nursing/Midwifery and medical schools, respectively. The Medical Officer/doctor shall be the

head of the health team in the facility or LGA where available. In the absence of a medical doctor, a PHC facility should be headed by a CHO.

All PHC workers have a mixture of functions: administrative, community health, maternal and child health as well as clinical functions, including referral to higher facilities where necessary. **Environmental Health Officers are responsible for environmental sanitation and water issues only**. Each cadre of HRH has its peculiar roles and job descriptions as spelt out in the National Guideline for Development of Primary Health Care System in Nigeria.

The pre-service training of CHEWs and JCHEWs in Schools of Health Technology involves the use of Standing Orders for recognition and management of illnesses. The Standing Orders ensure uniformity in the quality of care and provide legal backing for the health workers. Medical doctors, dentists/dental assistants and nurse/midwives working in PHC facilities should use the **National Standard Treatment Guidelines**.[30] The most senior health worker in the ward should lead the ward PHC team as both the OIC of the PHC centre and the Ward Focal Person/Supervisor.

In-service training of PHC workers is very important not just to ensure they have adequate and current knowledge and skills to provide high quality PHC services, but also to motivate them for greater performance. This can be carried out through workshops, short-term courses, ISS, and mentoring. These trainings must be planned and budgeted for to ensure it achieves the desired health outcomes. On-site facility-based trainings are cheaper and less disruptive for service delivery and are therefore the preferable mode of training, where possible.

5.6 STANDARDS

The necessity of standard setting in health services has become widely recognized in recent times. According to the WHO, the purpose of setting health standards as a tool in health services management is to strive to achieve the highest quality of care possible within the resources available. Standards provide degrees of excellence to be pursued in each exercise. They provide the basis for monitoring, comparison, supervision, and regulation of the given services. Additionally, a key reason for standardizing

[30] FMOH 2008 Nigerian Standard Treatment Guidelines

PHC facilities is to make them instantly recognizable to all regarding the services provided at the different levels.

Adequate numbers and proportion of the various cadres of healthcare workers are necessary to provide services in the PHC facilities. The recommended mix of staff based on their competencies at various facility types are as shown in Table 5.1.

Table 5.1: Human Resource for Health Requirement per Level of Care

S/N	Type of HRH – Basic Training Requirement	Additional Training Requirement	Community	Health Outreach Post	PHC Level I	PHC level II	PHC Level III
1	Medical Officer if available	IMCI, CMAM			-	1	1
2	Community Health Officer*	IMCI, CMAM			-	-	1
3	Nurse/Midwife	IMCI, CMAM, Basic Essential Obstetric Care, FP, ≥2 on NCD management			-	1	Minimum of 2[31]
4	CHEW*	≥2 on NCD management			1	2	Minimum of 2
5	Pharmacy technician	-			-	1	2
6	JCHEW*	≥2 on NCD management		2	2	2	Minimum of 4
7	Environmental Health Officer	-			-	-	1
8	Health Record Technician	-			-	1	2
9	Medical Laboratory Technician	-			-	1	2
Support Staff							
10	Account Clerk	-			-	1	1
11	Driver	-			-	-	1
12	Health Attendant/Assistant	-			2	2	2
13	Security Personnel	-			2	2	3
14	Cleaner	-		1	1	2	3
15	CHIPS**	≥ 5 on NCD prevention, community awareness & support for self-management, ≥10 as health educators	10		-	-	-
16	CEFPs		2				

[31] This is a minimum recommendation based on the Revised Ward Health System Strategy (WHSS)

** Must Work with Standing Order*
CHIPS are trained community volunteers including, TBA, Village health Workers (VHW) and other community-based service providers that have been duly trained and are recognised by the LGA.* ***Note: TBAs are not expected to take deliveries.

In each LGA, there shall be a Medical Officer of Health, who is a Medical Doctor who directs and coordinates all the public health and primary health care activities in his/her area of jurisdiction and advice the relevant authorities on policy and matters relating to public health and primary health care.

Refer to the ***Implementation Guidelines for PHCUOR*** for the minimum staff requirement at LGHA and SPHCB, their job descriptions and terms of reference.

CHAPTER 6
HEALTH INFRASTRUCTURE AND EQUIPMENT

6.1 INTRODUCTION

The Ward Health System Strategy (WHSS) brings PHC services closest to the population and is critical towards UHC in Nigeria. Some objectives of the WHS are providing resources for maintenance and upgrading of the existing PHC facilities, construction of new ones where none already exists, procurement of essential medicines /consumables and equipment, deployment of appropriate manpower to provide services and other requirements to ensure full functionality.

The ***Minimum Standards for PHC in Nigeria*** defines and declares a set of standards in the areas of health infrastructure, human and financial resources and provision of essential drugs and commodities for primary health institutions in Nigeria in order to improve access and quality of services. The document defines health infrastructure for PHC as the types/levels of PHC facilities including recommended infrastructure dimensions, furniture, and equipment.

Health facilities are static or mobile structures where different types of health services are provided by various categories of health workers. These health facilities are in different groups and called different names depending on the structure (building), staffing, equipment, services rendered and ownership.

There are two categories of health facilities that provide services:

1. **Health outreach posts:** to serve a catchment area of a settlement or a village with an estimated coverage population of average of 2,000 persons.
2. **Primary Health Care Centres** There are three levels of Primary Health Care Centres:
    - **Primary Health Care Centre Level I:** to serve a catchment area comprising a group of settlements/neighbours, villages or village areas or a group of communities with an estimated coverage population of 5,000 to 10,000 persons.
    - **Primary Health Care Centre Level 2:** to serve a catchment area of one political ward in the LGA with an estimated coverage population of 10,000 to 20,000 persons.

- **Primary Health Care Centre Level 3:** to serve a catchment area of one political ward as the focal PHC with an estimated coverage population of 20,000 to 30,000 persons.

6.2 POLICY

Health infrastructure and equipment is a key focus area within the National Health Policy 2016, whose goal is to have an adequate and a well distributed network of health care infrastructure that meets quality and safety standards. The policy objectives mainly focus on ensuring the availability and distribution of health infrastructure, as well as ensuring that minimum quality standards are met and maintained for health infrastructure and equipment. The policy empowers the NPHCDA to ensure the efficient utilization of the 15% allocation from the BHCPF for the maintenance of health infrastructure, equipment, and transport for eligible PHC facilities, in line with the National Health Act 2014.

6.3 STRATEGIC APPROACHES

Within the scope of the WHS, the following approaches have been applied in PHC infrastructure and equipment: Definition of minimum standards for PHC infrastructure and equipment in Nigeria, PHC Revitalization Initiative of the FGoN, community efforts through the WDC and the Planned Preventive Maintenance (PPM) system.

6.3.1 Setting the Minimum Standards for PHC in Nigeria

The **Revised Ward Health System Strategy** is a document developed by the NPHCDA, which specifies the minimum requirements for PHC service provision at the various service delivery points.

6.3.2 PHC Revitalization

As part of efforts to enhance achievement of UHC, the FGoN initiated the PHC revitalization initiative, with the goal of making at least one PHC fully functional in each of the approximately 8094 political wards in Nigeria. This initiative considers the existing facilities that must be renovated, upgraded, or equipped and constructing new facilities to cater for identified gaps in all LGAs of the country from budgetary allocations to the federal, state, and local governments. It will concentrate on the PHC facilities, with emphasis on Level 3 facilities (PHC centres), which would serve as a means of improving access to the ward/communities with matching human resource availability.

6.3.3 Community Involvement and the Facility Maintenance Plan

Community efforts towards renovation and provision of additional PHC facilities will be supported through the WDC. This will be achieved through the development of a facility maintenance plan.

The facility together with the WDC, develops a facility maintenance plan on a quarterly basis, which addresses all issues identified and prioritized during PPM.

The PPM system incorporates a culture of maintenance of PHC facilities into the planning, budgeting, and implementation of PHC services. It refers to regular, routine maintenance to help keep equipment up and running, preventing any unplanned downtime and expensive costs from unanticipated equipment failure. Its purpose is to ensure that buildings, equipment, and utility services are always in a functional state so that the envisaged PHC service delivery is not interrupted at any time. This enables early detection of faults/damages and provides for procurement of spares as well as routine and emergency maintenance services by qualified artisans or physical asset maintenance specialists.

6.4 PRACTICE

On the premise of the RWHSS, the following approaches have been applied in PHC infrastructure and equipment maintenance and procurement. The responsibility for providing and maintaining PHC infrastructure and equipment lies with the SPHCB and health facility depending on the cost.

The SPHCB shall put in place mechanisms for major[32] repairs and preventive maintenance of technical equipment. A similar mechanism should be established for constructions, major repairs of buildings and utility services. The responsibility and budget shall be clearly laid out and disseminated to all OICs and staff to ensure that facility infrastructure, equipment and utility services are always in functional state.

The NPHCDA gateway of the BHCPF provides funding through the SPHCBs to eligible public PHC facilities as operational budgets for running of the PHC including provision and maintenance of infrastructure and equipment.

At the PHC facility, the OIC has overall responsibility for ensuring that all buildings and equipment are always in good condition. This responsibility is

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[32] Refers to activities that are beyond the capacity of the health facility in financial and technical terms.

delegated to unit heads who are in turn responsible for the day-to-day use of these buildings and equipment. They must, therefore, report malfunctioning or breakdown of such equipment to the OIC. For minor repairs, for example, of plumbing, electrical, masonry and vehicles, the FMC establishes a partnership arrangement with local artisans. Health workers must discuss PPM with the FMC and WDC members and other stakeholders. Details on PPM can be found in the ***RWHSS document***.

6.5 STANDARDS

The **Revised Ward Health System Strategy** document outlines infrastructure requirements for all three types of PHC facilities. These standards are summarized in the Table 6.1.

Table 6.1 Standards for PHC Infrastructure by facility type

Health Facility Type	Health Outreach Post	PHC Leve l	PHC Level II	PHC Level III
Catchment Area	4 Settlements or village level	Group of settlements/neighbourhoods, villages (village areas) or communities	Political ward	Focal PHC in a political ward
Estimated Coverage Population	Average of 2,000	5,000 to 10,000	10,000 to 20,000	20,000 to 30,000
Opening Hours	8am to 4pm (8 hours)	24 hours	24 hours	24 hours
Land Area	1200 sqm	2475 sqm	4200 sqm	4200 sqm
Colour	Cream	Blue	Green	
Rooms	2	At least 7	At least 11	At least 11
Toilet	2	3	6	6
Water	Clean source	Clean source	Clean source	Clean source
Electricity	National grid or any alternative	National grid or any alternative	National grid or any alternative	National grid or any alternative
General Waste	Burn in a protected pit / Dispose through LGA Municipal waste	Burn in a protected pit / Dispose through LGA Municipal waste	Burn in a protected pit / Dispose through LGA Municipal waste	Burn in a protected pit / Dispose through LGA Municipal waste
Infectious Waste	On site in an incinerator / burn in a protected pit	On site in an incinerator / burn in a protected pit	On site in an incinerator / burn in a protected pit	On site in an incinerator / burn in a protected pit
Highly Infectious Waste	On site in an incinerator / burn in a protected pit	On site in an incinerator / burn in a protected pit	On site in an incinerator / burn in a protected pit	On site in an incinerator / burn in a protected pit
Biodegradable Waste	Bury on site	Bury on site	Bury on site	Bury on site
Sharps	Remove offsite in a container	Remove offsite in a container/burn in an incinerator on site	Remove offsite in a container/burn in an incinerator on site	Remove offsite in a container/burn in an incinerator on site
Fence	With generator house, gate, gate house and security	With generator house, gate, gate house and security	With generator house, gate, gate house and security	With generator house, gate, gate house and security

Health Facility Type	Health Outreach Post	PHC Leve l	PHC Level II	PHC Level III
	man.	man.	man.	man.
Sign Post	Visible from both entry and exit points	Visible from both entry and exit points	Visible from both entry and exit points	Visible from both entry and exit points
Staff Housing	Within facility Premises 2 Units of 1-bedroom self-contained apartments	Within facility Premises 2-bedroom apartment	Within facility Premises 2 Units of 1-bedroom flats	Within facility Premises 2 Units of 1-bedroom flats
Equipment*	57 items	76 items	91 items	
HRH**	2	9	35	
Other Requirements	Bicycle (1) or motorcycle (1) Canoe (1) Mobile phone (1)	Bicycle (1) or motorcycle (1) Canoe (1) Mobile phone (1) Small motor boat (1)	Ambulance (1) Mobile phone (1) Computer (2) Internet service Motorcycle (1) Small motor boat (1)	Ambulance (1) Mobile phone (1) Computer (2) Internet service Motorcycle (1) Small motor boat (1)

*Refer to _Minimum Standards for PHC in Nigeria/National Essential Equipment list_ for full list of equipment required in the 3 PHC types. Also refer to appendix 3 of this document for full list.

**Refer to section 5.5 of this document for HRH requirements in the 3 PHC types

CHAPTER 7
HEALTH COMMODITIES AND SUPPLY CHAIN

7.1 INTRODUCTION

Health commodities comprise of essential medicines, vaccines and technologies which are essential to providing health services towards the goal of achieving UHC. The success of implementation of the MSP for PHC, is hinged on the availability of essential health commodities such as family planning commodities, vaccines, emergency drugs as well as drugs to address priority communicable and non-communicable diseases.

An effective supply chain system is necessary to ensure the availability of good quality health commodities at all operational levels, in a manner that prevents wastage. While the National Agency for Food and Drug Administration and Control (NAFDAC) ensures the quality of food, drugs and other regulated products which are manufactured, exported, imported, advertised and used in Nigeria, other institutions, such as the Nigeria Institute for Pharmaceutical Research and Development (NIPRD) and the National Vaccine Production Laboratory also facilitate sustainable supply of high quality, safe, affordable medicines and health commodities as stipulated in the National Health Policy.

7.2 POLICY

Various policies exist to standardize practice related to ensuring the availability of good quality medicines and other health commodities to the end user. These guide the choice of health commodities that should be available at the point of care, quality control practices, as well as effective supply chain systems.

The **National Drug Policy**[33] provides guidance on ensuring availability and adequate supplies of drugs that are effective, affordable, safe and of good quality; the rational use of such drugs; as well as increased local production of essential drugs. It provides guidance on effective drug management processes and stipulates that there shall be a compendium of drugs approved for use in health facilities throughout the federation, referred to as the **Nigeria Essential Medicines List**[34] which shall be reviewed every four years by the Essential Drugs List Review Committee. The National Vaccine

[33] FMOH 2005. National Drug Policy
[34] FMOH 2020. Nigeria Essential Medicines List

Policy Vaccine and cold chain equipment procurement are well organized through an MoU with UNICEF.

The **National Quality Assurance Policy for Medicines and Other Health Products**[35] guides quality assurance processes in ensuring that the consumers of medicines and other health products have access to safe, efficacious, and good quality products irrespective of their route of entry into the market.

The **Nigeria Supply Chain Policy for Pharmaceuticals and other Healthcare Products**[36] provides a framework for streamlining supply chain management within the public health system. It guides governance and ensures coordination of supply chain systems across all levels to ensure the effective management, coordination, and supervision of health commodities.

7.3 STRATEGIC APPROACHES

Different strategies are required to ensure coordination, availability of health commodities, effective drug management processes (such as rational drug selection, proper quantification of drug needs, and effective procurement practices), quality assurance, appropriate storage, proper costing, effective distribution of drugs, proper accountability, and rational use of drugs by health workers and consumers in PHC.

7.3.1National Logistics Working Group (NLWG) and State Logistics Working Group (SLWG)

The NLWG and its state counterpart were set up by NPHCDA and SPHCB, respectively to improve vaccine and health commodities supply chain in Nigeria. The NLWG coordinates the national supply chain activities and investments made by NPHCDA and development partners. It provides guidance, expertise and technical assistance on all matters concerning supply chain operations and improvement initiatives. It also engages with key stakeholders in the process of sharing information, evidence, and lessons learned. It identifies and overcomes programme bottlenecks, explores opportunities for innovation and makes optimal use of resources.

7.3.2 Drug Revolving Funds (DRF)

DRF is a mechanism for financing drug supply to ensure sustainability and continuous availability of drugs at all levels of health care. It is a system whereby after an initial capital investment on drugs is made, subsequent

[35] FMOH 2015. National Quality Assurance Policy for Medicines and Other Health Products
[36] FMOH 2016. Nigeria Supply Chain Policy for Pharmaceuticals and other Healthcare Products

drug supplies are replaced with monies collected from the sales of drugs to the community. Establishment of a DRF system follows identification of priority health problems in the community, quantification, rational procurement, storage, and rational dispensing. (Refer to the ***National Guidelines for Development of PHC in Nigeria*** for details on DRF).

7.3.3 Basic Health Care Provision Fund (BHCPF)

Of the 45% of the BHCPF allocated to the NPHCDA gateway, 20% is earmarked for the provision of essential drugs, vaccines, and consumables for PHC.

7.3.4 Nigeria Supply Chain Integration Project (NSCIP)

The Nigeria Supply Chain Integration Project (NSCIP) emerged from the National Product Supply Chain Management Programme (NPSCMP) of the Department of Food & Drugs Services in the Federal Ministry of Health. It was set up to integrate health disease programmes supply chain management activities effectively and efficiently for optimal Pharmaceutical Supply Management (PSM) services that would prevent stock outs, minimize wastages, and efficiently run the entire health system which includes the infrastructure, human resources, and tools.

7.4 STANDARDS

Standards, within this document are defined for essential medicines and commodities, vaccines, and vaccine devices, specifically in line with the following practices:

1. Forecasting/planning
2. Procurement
3. Supply chain
4. Storage
5. Inventory control and prescriptions
6. Financial management, drugs, and vaccine accountability
7. Waste management/modalities for handling expired drugs

7.4.1 Forecasting / Planning

7.4.1.1 Essential Medicines and Commodities

For essential medicines and commodities, PHC facilities, in their quarterly business plans, make plans to procure essential medicines from accredited distributors within the state. This plan is based on identified health needs in the community, prevailing health conditions, consumption patterns, size of store, patient load, and magnitude of health problems. The above information will guide quantification of the medicines to be procured. The

business plan is reviewed by the LGHA and approved by the SPHCB if satisfactory.

7.4.1.1 Vaccine and Vaccine Devices

The forecasting for vaccine procurement is carried out at national level, together with stakeholders from the states. However, the forecast begins at the lower level where vaccine demand is established and channelled to the higher level. Vaccine forecasting for the new year is done not later than the second quarter of the previous year. The quarterly vaccine needs are shipped to Nigeria four times each year.

7.4.2 Procurement

7.4.2.1 Essential Medicines and Commodities

The state office of the Pharmacists Council of Nigeria (PCN), in collaboration with the SMoH will conduct an inspection of all wholesale pharmacies, certify those who meet the accreditation standards and develop a list of certified pharmacies in the state.
The PHC facility shall, always, be expected to conform to the list of certified distributors as updated annually by the state PCN. In choosing the distributors, availability of drugs, best price and quality should be the guiding principle.

All drugs procured must be on the essential drugs list according to the PHC type, must be generic and NAFDAC certified. Health facilities should record the expenses and keep receipts.

Procurement of non-essential (not listed in the essential drugs list and/or non-generic drugs (expensive brands whilst cheaper generic drugs are available) is not allowed. Non-compliance with this obligation will lead to sanctions. Procurement of drugs and/or medical consumables from non-PCN accredited distributors will be considered a violation of the standard and will lead to sanctions.

7.4.2.2 Vaccines and Vaccine Devices

Procurement of vaccines and vaccine devices are carried out at national level.

7.4.3 Supply Chain

7.4.3.2 Essential Medicines and Commodities

Essential medicines and commodities are directly procured at health facility level. The DRF system ensures sustainable availability of essential medicines.

7.4.3.2 Vaccines and Vaccine Devices

The federal government is responsible for distribution of vaccines to the states, from where LGAs collect their vaccines. In most states, the health facilities collect their vaccines from the LGAs depending on their RI session plans and storage capacity. This is the "push and pull" system of vaccine distribution practised in the country.

However, in some states, distribution is through the PUSH-Plus system, where vaccines are distributed directly from the state to health facilities that have functional Cold Chain Equipment. Buffer stocks for the health facilities and stock for unequipped facilities near the LGA cold store are kept at the LGA store. Other facilities without CCE have their supplies delivered to the nearest equipped health facility. Vaccine distribution from the national level to the state is fully outsourced. There are standing contractual arrangements with the private sector (a vendor for each zone) to distribute vaccines from the national to the state stores on a quarterly basis with top-ups when the need arises. Four-wheel drive vehicles are employed for distribution of vaccines and supplies at state, LGA and health facility levels.

7.4.4 Standards of Storage

7.4.4.1 Essential Medicines and Commodities

The following standards for storage of essential medicines and commodities must be maintained at the health facility level. They include:

1. Provide adequate storage space for supplies and materials in a clean and well-ventilated space
2. Provide adequate security for doors and windows using iron burglary proof
3. Allow 4 – 6 feet between each shelf and 4 – 6 feet for alleys
4. Allow space (section) for mixing and preparing drugs
5. Arrange drugs on shelves in alphabetical or therapeutic order
6. Received drugs, supplies and materials should be entered into a stock book or ledger, using a page for each item
7. Attach tally sheet/bin cards relating to each drug/material on the shelf next to the item
8. Dispense, using first-in first-out for drugs with the same expiry date and first-expired first-out methods for those with different expiry
9. Keep controlled drugs in locked-up cupboards with special issuing register
10. Use red sticker labels to flag drugs approaching expiration dates
11. Separate expired drugs from the main stock and destroy appropriately

7.4.4.2 Vaccine and Vaccine Devices

The PHC revitalization initiative specifies that at least 1 health facility in each of the 8094 political wards nationwide must be fully equipped to provide regular RI services. All PHC facilities must have Solar Direct Drive (SDD) refrigerators. Maintenance of cold chain is paramount to the storage of vaccines. At all levels of the supply chain, temperatures between +2 and +8°C must be maintained. The standard storage protocol for vaccines is nested in the cold chain system consisting of the National Strategic Cold Store (NSCS) in Abuja, six zonal cold stores located in each of the six geo-political zones, 36 state vaccine cold stores plus the Federal Capital Territory (FCT) and 774 LGA vaccine stores.

7.4.5 Rational Prescribing, Dispensing and Use of Essential Medicines

The health facility shall ensure that all drugs and medical consumables are prescribed using a prescription form, which shall be always maintained and be accessible for control at the pharmacy. Prescriptions should indicate - (a) the name and age of the patient; (b) the date; (c) clearly legible listed generic drugs with quantities; (d) name and signature of the prescriber.

Prescription of drugs should strictly follow protocols (types of generics and recommended quantities) as mentioned in the treatment guidelines. Standing Orders are to be strictly adhered to. Systematic non-adherence to these treatment guidelines would therefore lead to sanctions. In addition, tracking consumption, preventing stock-out, overstock, practicing First-Expired First-Out (FEFO) and preventing expiry should be ensured.

7.4.6 Financial Management and Drugs Accountability

Drugs and medical consumables available at the health facility should be clearly listed and accessible at the public notice board and at the pharmacy and should list the unit price and the number of items for a typical course. The unit price (the 'retail price') should not exceed the whole sale price plus a reasonable mark-up as negotiated with the FMC and ratified by the WDC.

7.4.7 Standards for Waste Management and Modalities of Handling Expired Drugs

For the management of unusable and expired pharmaceuticals, at the facility level, it is expected that these items are segregated, and the designated staff should generate a list of the items indicating description, quantity, batch number, date markings and cost (where applicable). A

written application for disposal should be sent to the relevant government authority for approval.

Following this, logistics should be made available by the Agency for conveyance to a disposal site. NAFDAC shall be informed, particularly during the transfer process of bulk pharmaceutical waste. The facility would need a letter from NAFDAC authorizing the movement and destruction of waste.

Use safety boxes for the disposal of sharps. These shall be transported to the LGA, for destruction by incineration. Expired vaccines, empty vaccine vials and VVM stages 3 and 4, shall be documented by the health facility and returned to the distribution points at the LGHA and SPHCB for accountability purposes.

CHAPTER 8
COMMUNITY PARTICIPATION

8.1 INTRODUCTION

The Alma Ata declaration identified community participation as a key principle of PHC, central to the attainment of Health for All. It seeks to establish a partnership between government and local communities who can benefit from increased self-reliance as well as social control over the PHC system. 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.

Community participation starts from needs identification and analysis, leading up to mobilization for effective participation in developing programme responses to addressing those needs or gaps identified and eventually being part of monitoring the outcomes of the various programmes and interventions that have been implemented. It necessarily addresses the social, cultural, political, and economic determinants that underpin health, and seeks to build partnerships with other sectors in finding solutions. It culminates in community ownership and sustainable action that explicitly aims at societal transformation.

Different stakeholders such as organized groups, agencies, institutions, or individual collaborators may be involved at varying stages of a programme. Resources at the community level, local institutions/organizations, local associations, opinion leaders etc, are leveraged upon at the inception of programmes. This ensures that underserved populations are reached, community capacity to manage their health challenges is built and health promotion reaches the grassroots.

Communities will participate in PHC in several different ways: facility performance assessment, quality assessment and recognition; facility governance; strategic planning, policy development processes, legislation, management of priority health conditions at community level through behaviour change communication activities and community radio initiative. Hence participation ranges from community to facility to LGA to state and national levels.

Several health interventions and programmes have accorded great emphasis on community participation such as the use of community

volunteers in the Community Health Influencers, Promoters and Services (CHIPS) program (**Box 8.1**), Onchocerciasis control (CDTI), Malaria Control (CDD), Community IMCI (CORPs), Community Management of Acute-severe Malnutrition (CMAM) (Community Volunteers), Polio Supplemental Immunization Activities (SIA) (Volunteer Community Mobilisers) among others.

The PHC system of development of, and engagement with community structures is the WDCs, the VDCs/CDCs, and the FMCs. These committees are empowered for demand-creation, monitoring of health services, community mobilization, and participation in programme implementation. Communities, based on these structures, will be involved in the design, and planning of health interventions and should be able to hold government and service providers accountable.

8.2 POLICY

The National Health Policy identified PHC as the cornerstone for delivering an effective, efficient, quality, accessible and affordable health services, to a wider proportion of the population through the promotion of community participation in planning, management, monitoring, and evaluation of the local government health system through the committee system.

The NPHCDA Strategic Plan II provides for strengthening institutional and coordinating mechanisms for promotion of community participation, strengthening capacities of communities to participate in the planning and facilitation of health interventions at the community and facility level. This is to empower citizens, make them understand their roles and responsibilities and make their voices heard. The National Health Promotion Policy, 2006 sought to improve understanding of the concepts of health promotion, consumer rights, the need for multi-sectoral action and the promotion of a supportive environment for behavioural changes in health care.

8.3 STRATEGIC APPROACHES

8.3.1 Community Engagement in Governance (WDC and the Ward Health System Strategy

The management infrastructure of the Ward Health System Strategy (WHSS) is based mainly in the community. It consists of two committees: the WDC at the ward level and the VDC/WDC at both urban and rural settings. The WDC consists of chairmen of each VDC in the ward and serves as the apex body for the functions of the PHC centre and other development activities carried

out in the ward. It has a direct link with the LGHA through a representative of the WDC serving on the LG Advisory Committee.

PHC facilities have Facility Management Committees (FMCs) directly managing the health facilities and report to the WDC or VDC as applicable for coordination and support. These committees serve as the entry points for community participation in PHC by identifying health and health-related needs in the community and planning for the health and welfare of the community. The MSP outlines health education and community mobilization as part of its priority interventions.

8.3.2 Community Engagement in Service Delivery (CHIPS)

The CHIPS programme was initiated to address the barriers between the community and the PHC system and improve maternal and child health indices especially in the rural areas. The programme is structured to stimulate and support households in communities to seek and obtain PHC services through various delivery platforms, such as the facility, outreaches, and home services.

CHIPS agents are community-selected and community-based human resource components of the PHC system. CHIPS agents are carefully selected through community-level structures such as the WDC and traditional leaders based on a set of criteria aimed at ensuring they live in and are active members of the socio-economic lives of their communities. They are trained and engaged by the government through the NPHCDA to provide health education and basic health services in households within communities, link the community to PHC services in the facilities and improve integration of services across the facility, outreach as well as household service delivery mechanisms.

Community Engagement Focal Persons (CEFPs) are preferably male CHIPS personnel in the community that function primarily in engaging with men to create demand for service uptake, promotion of positive behavioural change using inter-personal communication, male engagement in reproductive health as well as fostering community participation in health actions. The CEFPs are also responsible for summarizing and uploading data being collected by the CHIPS agents into the community health information system and DHIS2 platforms.

CHAPTER 9
HEALTH MANAGEMENT INFORMATION SYSTEMS

9.1 INTRODUCTION

An inevitable requirement for countries to achieve the UHC goal is an integrated health information system; that could interact with multiple information systems, generate good quality information to inform decisions, evaluate performance and monitor progress towards these goals.

The Health Management Information System (HMIS) is a system whereby health data are recorded, stored, retrieved, and processed to improve decision-making[37] at all levels of the health system. The HMIS consists of inputs (regulatory, legislative, and planning frameworks, personnel, financing, logistics support, information and communication technology and coordinating mechanisms); processes (indicators, data sources and data management methods for collecting, storing, analysing, and disseminating data); and outputs (information products, dissemination, and use). HMIS combines various data to create information about health status, health care provision, use of services and health impact.

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

Evaluation is a periodic assessment of overall programme status - performance, effectiveness, and efficiency. It is linked to policies, programme processes, systems under which the programme operates strategic choices, outcomes, and impact. It assesses the relevance, performance, and success of ongoing and completed programmes.

The need to review the existing health system and the need for a co-ordinated health information system for the effective management of the health system led to the establishment of the National Health Management Information System (NHMIS) in 1993.

9.1.1 Structure of NHMIS

The structure of NHMIS is an institutional framework of hierarchical levels from which health data and information are to be obtained. The Federal NHMIS

[37] World Health Organization. Developing health management information systems: a practical guide for developing countries: World Health Organization; 2004.

Unit is in the Department of Health Planning and Research of the Federal Ministry of Health. The Unit coordinates health information activities of FMoH departments, parastatals, agencies and professional bodies and interfaces through established protocols with health information related activities at SMoH.

The State NHMI Unit is in the State Department of Planning, Research & Statistics. The information pathway is vertical with the federal level and horizontal with data producers and users in the state.

The LGA HMIS Unit is in the PHC M&E office at the LGA. The Unit collates data from all health-related programmes and transmits electronically via the DHIS2 platform. The establishment of an effective NHMIS involves substantial investment in HRH, infrastructural development as well as technical assistance by all levels.

9.1.2 Data use

Objectives of the HMIS consist of:

- provision of appropriate infrastructure
- establishment of mechanisms and procedures for collecting and analysing health data to provide needed information
- assessing the state of health of the population
- identifying major health problems
- monitoring the progress towards PHC goals and targets of health services
- providing indicators for evaluating the performance of health services and their impact on the health status of the population
- providing information to those who need to act, those who supplied the data and the general public.

9.2 POLICY

The 56th session of the NCH approved the use of a single, integrated but decentralized national routine health database hosted at Federal Ministry of Health/DPRS on DHIS2 platform and harmonised NHMIS (version 2013) tools for data collection and reporting for routine data management by all programmes and implementing partners.

The NSHDP II articulated interventions that will improve the integration of existing surveillance systems and disease registries into the overall national health information platform, the DHIS2, as well as to create an integrated

data repository for data sharing among stakeholders while continually tracking the performance of the sub-sector at all levels.

The **National Health Information Systems Strategic Policy**[38] prescribed strategies and activities to institutionalize the Health Data Governance Council chaired at the national level by the Honourable Minister of Health and replicated at the state level.

The National Health Act 2014 stipulates that the National Bureau of Statistics (NBS), an agency of the National Planning Commission is responsible for coordinating the Nigerian statistical system. NBS ensures ownership of statistics by government at all levels.

9.3 STRATEGIC APPROACHES

There is a great need for generating, analysing, and storing comprehensive data for planning and implementing PHC service. The following approaches contribute to achieving a holistic HMIS.

9.3.1 Routine Data System

- Routine health services data include the HMIS and IDSR. These are uploaded onto the DHIS2.

9.3.2. Surveys

- Household surveys such as the National Demographic Health Survey (NDHS), Multiple Indicator Cluster Survey (MICS), National Immunisation Coverage Survey (NICS), SMART survey.
- Health-facility surveys such as the FGoN funded annual health facility survey, Service Provision Assessment (SPA) and Service Availability and Readiness Assessment (SARA).
- Programme Assessment for Performance Management and Action (PAPA) (see **Box 9.1**)
- Routine Immunization (RI) Lot Quality Assurance Sampling Surveys (LQAS), etc.

Box 9.1 Programme Assessment for Performance Management and Action (PAPA)

The PAPA is an innovation in health management information / M&E systems. It uses the Routine Immunization Lots Quality Assurance Sampling (RI LQAS) methodology to collect population-based data on RMNCAH services. The survey is carried out quarterly in high priority states and bi-annually in other states by the NPHCDA and partners using Open Data Kit tool.

[38] FMOH 2014. The National Health Information Systems Strategic Policy

9.3.3 Periodic Data System

- Civil registration and vital statistics
- Financial and management information
- Censuses
- Operations research
- Facility business plans
- Walk-through micro plan household enumeration
- Budgetary allocation data

9.3.4 Quality Improvement System

- ISS
- Data Quality Assessment
- Data Quality Survey

9.4 PRACTICE

9.4.1 HMIS Input

Regulatory, legislative and planning framework: This has been established by the Federal Government through the NHMIS and Logistics Management Information System (LMIS). The Department of Health Planning, Research and Statistics of the FMoH is the final repository for these data (DHIS2 portal) and is responsible for the overall HMIS framework. The Department of Health Planning, Research and Statistics at the NPHCDA hosts all PHC related data.

Resources: The CHIPS, JCHEW at health posts, Monitoring and Evaluation (M&E) officers at health facilities, the LGHA, the SPHCB as well as NPHCDA data/HMIS officers all make up the personnel required in HMIS.
All health facilities and community-based health workers shall use the set of nationally recognized platforms to collect and collate data on health services utilization. Available tools are paper based at the community and health facility levels, electronic at the LGHA, SPHCB and NPHCDA. Open Database Kits (ODK) with Geographic Information System (GIS) enabled devices and paper-based questionnaires are used for surveys.

The tools to be used for routine health data collection include tally sheets, patient records or registers, forms, worksheets, survey instruments, commodity management forms, summary forms, etc. The PHC information consists of health maps, house numbering, home-based records (child health card, personal card) facility-based Family Master Card, the wall chart, health facility/district referral forms, M&E forms and health facility registers etc.

9.4.2 HMIS Processes

HMIS data obtained from routine and periodic sources as well as surveys are analysed to generate relevant PHC indices. Health facilities shall transmit their data to the LGHA M&E team every month, which is uploaded into the DHIS2 portal.

NPHCDA and SPHCBs monitor data completeness, correctness, consistency, validity, timeliness, and accuracy. Each level (health facility, LGHA, state and the national) will use the collected/aggregated data to review performance, monitor progress, provide feedback, and take informed decisions. A multi-stakeholder data quality assessment shall be conducted on a quarterly basis by the SMoH and FMoH according to the national protocol.

9.4.3 HMIS Output

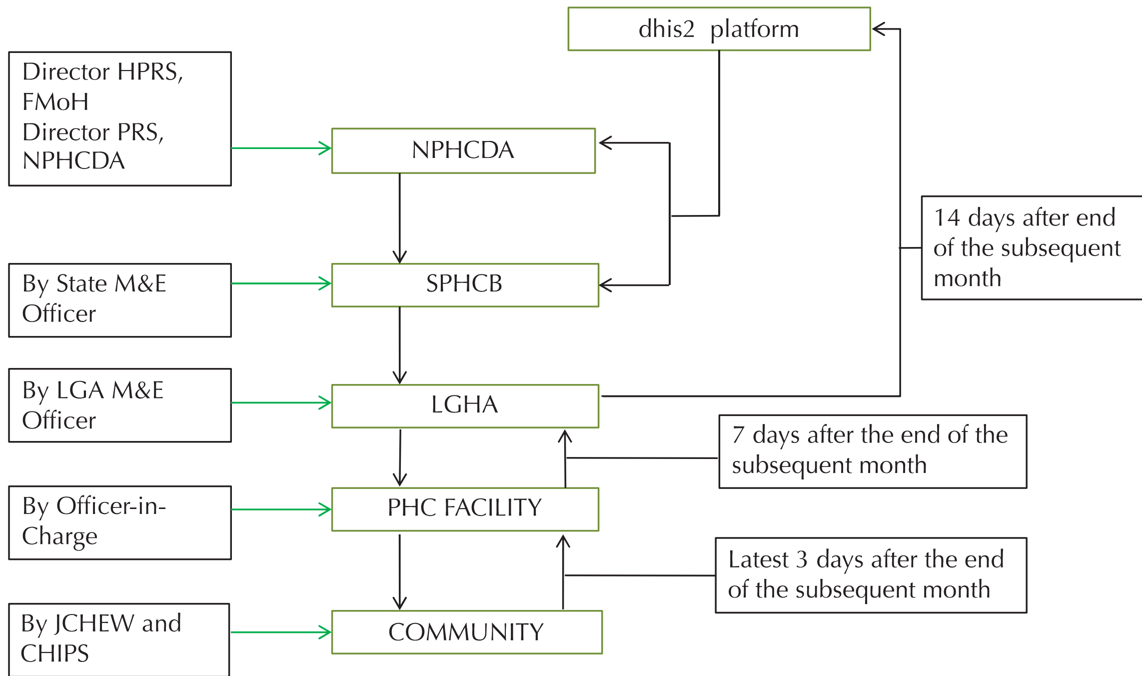
Information products: The value of collected data is showcased in dashboards of the DHIS2 platform, printed reports, alerts on low performing facilities, graphs, and statistical data.

9.5 STANDARDS

The availability of comprehensive well-reported data for PHC requires that data is collected from the facilities, outreaches, and households in communities on a regular basis. The best practice for data management is real time input of data at the facility level with the use of GIS compatible electronic devices in to the NPHCDA database for access and review by the LGHA, SPHCB and NPHCDA. Quarterly data quality assessment visits to the PHCs will serve for supervision using similar devices.

Information flows in both directions from the community to the national level (**Figure 9.1**). The Ward Focal Person/Supervisor must take responsibility for data emanating from his or her ward to ensure accurate data reporting.

Figure 9.1: Information flow in PHC Health Management Information System



There shall be appropriate data collection tools on health and health-related activities at the community, health facility, ward and LGA levels (**Table 9.1**). All health data shall be captured on the DHIS2 platform.

Table 9.1. Standard PHC Data Requirements

Domain	Data requirements	Purpose
Services	Tally sheets, daily registers, community health profile sheets, mother and child health cards, referral slips and discharge forms, and summary forms, etc.	To monitor delivery of quality PHC services
Finances	Business plan, bank statements, transaction records, assets register, financial reports etc	To ensure transparency and accountability
LMIS	Inventory control card, ledgers and bin cards, transaction, and consumption records such as daily consumption records, Combined Report and Requisition Form (CRRF) etc	For accountability in the utilization of health commodities
HRH	Appraisals, staff deployment, duty roster, capacity building plans etc.	To keep track of availability of skilled health workers
Infrastructure and equipment	Quarterly assessment report of facilities for availability and functionality of infrastructural amenities and equipment by the LGHA	To guide facility infrastructure improvement effort
Governance	Minutes of meetings of the WDC, VDC and FMC Receipts for expenditure Reports on community outreaches and CHIPS activities etc.	To keep track of governance at all levels of the PHC system
Partnerships	Stakeholder mapping at all levels	For continued collaboration and co-ordination of activities

CHAPTER 10
PARTNERSHIPS AND COLLABORATION FOR HEALTH

10.1 INTRODUCTION

Partnership in health is a collaborative relationship between two or more parties based on mutual understanding for the achievement of common goals. It involves risks as well as benefits, making shared accountability critical. All players or stakeholders at each level, through their actions, will influence health service delivery. (World Health Organisation, 2021).
Successful delivery of the MSP relies on the collaboration with and coordination of government and partners at all levels as well as a system of continuous and effective monitoring.

Given the heavy burden of disease and myriad of socio-economic and resource constraints in Nigeria, external support is continually needed from bilateral and multilateral organisations and the private sector, to support health service delivery. Internally, it is also important to optimise partnerships with communities and foster inter-sectoral collaboration among MDAs since health is multi-dimensional in nature. Effective partnerships would yield increased resources which, if utilised efficiently with a high sense of accountability, would impact the health services performance as envisaged.

NPHCDA continually seeks to promote effective partnerships among the public, private sectors and other stakeholders for optimum resource mobilisation and utilisation towards Universal Health Coverage (UHC). The Agency has also developed engagement guidelines and platforms with Civil Society Organizations, noting the important role they play in Primary Health Care

10.2 POLICY

The National Health Act 2014, SDG3 and PHCUOR policy encourage effective intra and inter-sectoral partnership and collaboration at all levels of implementation to strengthen the platforms for effective and efficient coordination and integration of PHC services. The main policy backing for partnerships and collaboration in health is the National Health Policy of 2016, which has a goal of promoting effective partnerships among the public, private and other stakeholders for optimum resource mobilisation and utilisation towards the attainment of UHC.

The **National Policy on Public Private Partnership for Health in Nigeria**[39] was developed in 2005 to promote and sustain equity, efficiency, accessibility and quality in health care provision, through a collaborative relationship between the public and private sectors. In 2008, Nigeria signed up to the Global Compact of the International Health Partnerships and Related Initiatives. A complementary country compact, with development partners, was also signed in 2010.

10.3 STRATEGIC APPROACHES

There are several platforms for collaboration and coordination of partners implementing PHC. As part of efforts to establish an apex platform for the coordination of all programmes in PHC at national level, the Inter-Agency Coordination Committee (ICC) approach is being expanded to cover other PHC programmes.

10.3.1 Coordination Platforms

Co-ordination among PHC actors takes the form of an integrated approach to training, service delivery, supervision, and monitoring. The establishment of a single Development Partners Forum at Federal, State and LGA levels brings partners working in the health sector together to strengthen coordination, minimise duplication and improve accountability as it relates to the technical and financial resources. This aligns with the concept of PHCUOR that fosters the integration of PHC service delivery, inclusive of ISS and the principles of "three ones": one management, one plan and one M&E system.

The Advocacy Communication and Social Mobilisation (ACSM) Working Group established at National, State and Local Government levels is a platform for collaboration between stakeholders working in PHC. The Terms of Reference (TORs) of the ACSM Working Group includes: to develop, implement, secure resources, monitor and evaluate the annual ACSM work plan which is to be reviewed and updated quarterly. Other roles include coordination of all National ACSM activities, identify, pursue, and support strategic partnership opportunities, ensure regular reporting, facilitate information sharing and feedback among partners. The ACSM Working Group is also responsible for adapting best practices, identifying, and supporting research opportunities which will enhance the quality of ACSM strategies and activities towards improving health outcomes.

[39] FMOH 2005. National Policy on Public Private Partnership for Health in Nigeria

The quarterly review meeting of the Executive Director NPHCDA, Executive Secretaries of SPHCBs and development partners is another platform aimed at improving accountability at the managerial level of PHC. Similar mechanism shall be replicated at State and LGA levels.

10.3.2 Community-Based Health Research, Innovative Training and Services Programme (CRISP)

The Decree No. 29 of 1992 that established the NPHCDA gave the Agency a responsibility to engage the academia in research and provision of technical support for the development of PHC in Nigeria. In fulfilment of these mandates, the Agency has previously collaborated with Colleges of Medicine/Health Sciences to develop models for PHC service delivery and centres of excellence for PHC human resource development. In 2018, CRISP was conceived as a collaborative approach between the NPHCDA, SPHCBs and the academia. The programme aims to strengthen the development and implementation of PHC at health facilities used for Community-Based Medical Education (CBME) through programme oriented-research, innovations in training and service delivery, as well as direct technical support to policy makers and programme managers. The components include; a programme component driven by the Colleges of Medicine which, through its staff, implement community-based education trainings for various cadres of health workers undergoing undergraduate and postgraduate training; an integrated and linked service delivery component through the existing community, primary, secondary and tertiary health facilities linked to the CBME programmes; finally, a policy engagement component through platforms provided by the SPHCB, and the LG Advisory Committee.

10.5 STANDARDS

NPHCDA shall establish frameworks for the regulation and guidance on PPPs. The Agency shall establish and maintain the partnership desk and register at the national level to revive and facilitate the mobilisation and coordination of partnerships for PHC. The SPHCB shall establish and maintain the partners register at the State level and will advocate for a virtual funding basket which it will manage. Similarly, the partnership desk and register will be established and maintained at the LGA level. The register shall contain details of partners' – full name, country of origin, funding source, area of focus, geographical coverage, scope of work and duration of project.

Partners shall adopt an integrated approach to training, service delivery, supervision, and monitoring. They are also expected to attend the WDC meetings and provide briefings on the progress of implementation in the ward.

States and LGAs can also sign an MoU with relevant Partners with guidance from the NPHCDA. All stakeholders implementing or supporting PHC mandates in the State, LGA, PHC facilities or through communities shall be required to sign an MoU/Service-Level Agreements (SLAs). The agreement shall spell out details of involvement, expected benefits, obligations/roles of each party, and accountability framework.

Individuals and organisations will be rewarded or sanctioned based on performance. Pursuit of the public-health goal shall take precedence over the special interests of parties. Social safeguards that incorporate considerations of conflicts of interest shall be implemented to mitigate risks.

CHAPTER 11
HEALTH RESEARCH

11.1 INTRODUCTION

Research is the backbone of innovative and sustainable development of the health sector. Research findings enhance evidence-based policy and decision making at all levels of government and ensure more targeted health interventions that have a higher impact on reduction of the country's disease burden. It is also required for improving health status. Health research is crucial for generating knowledge that will shape the delivery of programmes. There are several institutions involved in health research at the academic level and at government agencies.

11.2 POLICY

The National Health Act 2014 stipulates the establishment of a National Health Research Ethics Committee (NHREC) at the FMoH. The NHREC, along with identical committees at State and institutional levels, provide ethical oversight for all health research studies. The National Health Research Policy and Priorities, 2014, developed by the FMoH provides overall governance for the conduct of systematic and nationally relevant health research and development in Nigeria.

To increase domestic funding for research, the NCH ratified the 2008 commitment of African Health Ministers (during Ministerial Conference on Research for Health in the African Region) at Algiers, Algeria, to allocate 2% of health budget and at least 5% of health external project and programmed aid to research and research capacity building.

11.3 STRATEGIC APPROACHES

NPHCDA promotes and supports problem-oriented health systems research as a tool for generating evidence for decision making for PHC.

11.3.1 Collaboration with Academic Institutions and Partners

The Agency designed a strategy called Community-based health Research, Innovative training, and Services Programme (CRISP) which fosters collaboration with Colleges of Medicine/Health Sciences to develop models for PHC service delivery and centres of excellence for PHC human resource development. This is central to its mandate in promoting quality of PHC interventions in the community through research, innovative training, and services.

The goal of CRISP is to refocus community-based medical education programs in colleges of medicine/health Sciences and Colleges/Schools of health technology, for the improvement of health indicators in host communities through PHC research, innovative training, and provision of quality health services. The goal will be achieved, through the following objectives:

1. To strengthen community-based practice areas of medical and health institutions to serve as model sites to demonstrate best practices in the provision of integrated, comprehensive, and coordinated primary health care services, and the systems required to support them
2. To strengthen community-based practice areas of medical and health institutions to serve as functional PHC research hubs that can undertake research into various aspects of health and disease
3. To strengthen community-based practice areas of medical and health institutions to serve as training platforms for context-relevant academic training on the principles of, and tools required for primary health care practice in the Nigeria
4. To establish community hubs for testing and demonstrating the efficacy and effectiveness of emerging PHC strategies and national health priorities.

The CRISP programme will require the multidisciplinary engagement of all the knowledge domains and expertise required to cause a transformation of the healthcare indices of the focal areas of coverage. Hence, at the operational level, the CRISP programme implementation will be organised into three components through which training, research and service will be delivered. These are the Programme, Service Delivery and Policy Engagement Components.

1. Programme component driven by the college of medicine, which, through its staff, implements Community Based education trainings for various cadres of health workers undergoing undergraduate and postgraduate training
2. Integrated and linked service delivery component through the existing community, primary, secondary, and tertiary health facilities
3. Policy engagement component through platforms provided by the State Primary Health Care Board, and the Local Government Health Management Authority

Programme Component: Programme coordination component will be driven by the colleges of medicine and colleges of health technology, which, through its staff, implements community-based activities for various cadres of health workers and public health specialists undergoing undergraduate and postgraduate training. The appropriate departments in these institutions will serve as anchor points for the implementation of CRISP. The staff will provide academic training, serve as health providers, and conduct PHC related research in the various LGAs where the PHC facilities are located. Through the several academic staff and students, they will serve as the core manpower needed for driving the CRISP in the states where they are located. These staffers will invest time in developing and implementing research and

training, and also complement healthcare service provision at primary health care level. Through routine work and projects, staff and students, with also play a role in supporting the health programme planning for LGAs and facilities, as well implementation and evaluation.

Service Delivery Component: The integrated and linked service delivery component covers the existing community, primary, secondary, and tertiary health facilities, with a focus on at least one LGA in a state. The primary and secondary healthcare services are under the control of the State Primary Health Care Board, and the State Health Management Board, respectively. These agencies of government organize the health services at these levels and provide the infrastructure, commodities, and human resources. Their effort will be complemented by colleges of medicine and health technology, through its community-based programme at the primary health care level in the form of support for service planning and provision.

Policy Engagement Component: Policy engagement component through platforms provided by the NPHCDA, the State Primary Health Care Board, and the Local Government Health Authority will serve as platforms for generation of research needs, decisions on approaches, support for operational plan development, grant mobilization, and use of evidence to improve policy and practice. These platforms will enable the bridging of the evidence and policy gap for PHC and will help strengthen the capacity of SPHCBs to deliver PHC mandates. The platform will also be used to translate lessons learned from focal LGAs to other LGAs not supported by the CRISP programme.

The NPHCDA also collaborates with other organisations in conducting surveys such as the 2016/2017 Multiple Indicator Cluster Survey (MICS), 2016/2017 National Immunisation Coverage Survey, 2018 National HIV/AIDS Indicator and Impact Survey (NAIIS) as well as post campaign coverage surveys.

11.3.2 Conduct Operational Research

The Planning Research and Statistics Department in the NPHCDA and SPHCBs coordinate the conduct of operational research. This is in line with its mandate in promoting quality of PHC practice.

11.3.3 Supporting Research through Grants

The Agency awards financial grants to individuals and/or institutions that have presented research proposals in line with its priorities.

11.4 STANDARDS

Every institution, health agency and health establishment at which health research is conducted, shall establish, or have access to a health research ethics committee, which is registered with the NHREC. The Agency selects health research areas from its current priorities. It develops a proposal and submits this to the NHREC or any appropriate ethics committee for ethical approval. All research activities must be in line with ethical stipulations of the NHREC.

Part 2 – Roles and Responsibilities, Accountability Framework, Rewards and Sanctions Matrix

CHAPTER 12
NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY (NPHCDA)

12.1 ROLES AND RESPONSIBILITIES

The following section outlines the roles and responsibilities of the National Primary Health Care Development Agency as described in Act establishing the Agency based on the following different thematic areas:

Leadership and Governance

i. Perform oversight function for PHC
ii. Develop, review, and promote polices and propose legislation relating to PHC
iii. Develop and regulate standards for PHC in collaboration with SPHCB/LGHA
iv. Develop guidelines and design frameworks for periodic evaluation of primary health care at the various levels
v. Provide support for the monitoring and evaluation process nationally, with respect to the use of data for management decision-making at all levels of the PHC system
vi. Promote technical collaboration by stimulating the academia, NGOs, and international agencies to work with Primary Health Care systems in building capacity for problem solving
vii. Provide technical support for the planning, management, and implementation of PHC by the SPHCB and LGHA
viii. Establish a performance-based reward and sanction system for PHC at all levels

Health Financing

i. Mobilise resources from government and donors/partners nationally and internationally
ii. Implement the NPHCDA gateway of the BHCPF
    a. Conduct implementation research to generate evidence for improvement in implementation of the NPHCDA Gateway and PHC
    b. Work with the SPHCB to determine the baseline at 'on-boarding' of State on to the BHCPF in collaboration with other stakeholders.
    c. Publish a 'Handbook' for the NPHCDA Gateway to further guide OIC of Health Facilities and LGHA Staff on Gateway operational

actions.

d. Ensure timely and quarterly disbursement to the States, audit and verification based on an accountability framework

iii. Support SPHCBs in costing exercises particularly of the Revised Ward Health System Strategy (RWHSS)
iv. Build capacity of SPHCBs/LGHAs on financial management tools and protocols

Health Service Delivery

i. Develop and periodically review the MSP
ii. Develop and update the National Standing Orders for PHC workers
iii. Establish an NPHCDA clinical governance/Quality Improvement Team
iv. Develop and maintain a standardised framework and protocol for clinical quality of care for PHC
v. Publish and periodically review standards for PHC services
vi. Conduct quarterly supportive supervision of health facilities
vii. Periodically review the PHC component of Integrated Supportive Supervision (ISS).
viii. Develop and periodically review the criteria for issuance of annual certificate of standards
ix. Perform oversight function for PHC service delivery
x. Provide technical support for PHC service delivery

Human Resources for Health (HRH)

i. Develop and update the standards for HRH requirements in PHC
ii. Develop and review job descriptions for all cadres of PHC workforce
iii. Strengthen institutional capacities for management of HRH at all levels
iv. Strengthen the quality assurance for HRH training institutions especially for producing frontline health workers
v. Strengthen the linkage between HRH training institutions, regulatory bodies, and other stakeholders to ensure alignment between health workforce production and needs
vi. Establish mechanisms for annual HRH reviews and reporting for evidence and decision making at the Federal and State levels
vii. Improve the production and use of HRH research evidence for improving HRH management

Health Infrastructure and Equipment

i. Set and periodically review the standards for health infrastructure and equipment requirements for the Ward Health System.

ii. Develop modalities for Private Public Partnership (PPP) in providing health infrastructures
iii. Conduct periodic health facility assessment to update the master health facility register of PHC
iv. Maintain an electronic database for information regarding infrastructure and equipment availability and functionality
v. Mobilise funding for PHC infrastructure and equipment

Health Commodities, Logistics and Supply Chain

i. Set guidelines for rational prescribing, dispensing and use
ii. Determine logistics and health commodities requirements for health facilities
iii. Provide oversight functions for logistics and health commodities
iv. Provide vaccines and devices
v. Support supply of equipment and essential medicines to health facilities
vi. Develop mechanism to ensure accountability for logistics and health commodities
vii. Establish guidelines for effective Drug Revolving Fund (DRF) system with cost sharing mechanism at all levels

Community Participation

i. Strengthen institutional and coordinating mechanisms for promoting community participation
ii. Strengthen Community Engagement by promoting community participation, ownership, and responsibility for health through Ward Development Committees and communication programmes.
iii. Set guidelines and support the establishment of managerial infrastructure for PHC at all levels (formation of the Development Committees)
iv. Build capacity of States and LGAs to set-up the governing structures at the LGA and community levels
v. Support State to build capacity of community structures on participatory appraisal of needs, planning and implementation as well as monitoring and evaluation of health interventions
vi. Produce concept designs and provide technical guidance on the production of IEC Materials for PHC.
vii. Develop, produce, and disseminate IEC materials (electronic & print) for advocacy, social mobilisation and Social and Behaviour Change (SBC)

viii. Support State to adopt, produce and disseminate IEC materials (electronic & print) for community awareness on PHC programmes
ix. Scale up utilisation of traditional communication mechanisms for mobilising communities and disseminating health information
x. Advocate for Health Promotion and Consumer Rights at all levels
xi. Design a Grievance Resolution Mechanism strategy that will be implemented at all levels
xii. Support SPHCBs to implement strategies to increase community participation in creating demand for PHC services
xiii. Promote community/public awareness and sensitisation of citizens on the BHCPF & potential benefits
xiv. Facilitate resource mobilisation for BHCPF from private donors and public sector
xv. Support SPHCBs to engage and train CHIPS Agents and other community links (traditional, religious, CBOs, WDCs, etc.)
xvi. Support the implementation of community-based monitoring systems that will make community participation and empowerment more meaningful and sustainable
xvii. Promote the inclusion of Community Participation and Empowerment principles into the curricula of training programmes for public health practitioners and managers.
xviii. Promote participation of women especially in areas where they are at relative disadvantage in terms of accessing care.

Health Management Information Systems

i. Participate and support the generation, transmission, and maintenance of accurate and timely PHC system data.
ii. Promote the use of data for decision making at all levels
iii. Establish feedback mechanism between the various levels.
iv. Conduct quarterly ISS and follow up visit to sub-national levels to improve data quality.
v. Monitor and evaluate performance of PHC service delivery.
vi. Conduct quarterly review meeting with the leadership of SPHCBs to monitor progress

Partnerships and Collaboration

i. Mobilise stakeholders such as MDAs and Development Partners to support funding and the implementation of PHC.
ii. Promote support for all PHC efforts by networking and creating formal and informal collaboration with relevant Nigerian and international institutions

iii. Support the establishment of coordination platforms for engaging stakeholders in PHC
iv. Support the production and maintenance of registers of partners in the PHC landscape at all levels
v. Conduct periodic consultative meeting with some key stakeholders in PHC programme
vi. Design strategies for implementing PPP initiatives for PHC in line with the national policy.
vii. Promote joint monitoring visits to health facilities delivering PHC services
viii. Promote effective partnership with professional groups for development, monitoring, and review of PHC strategies and programmes
ix. Promote joint advocacy visits with stakeholders in PHC

Health Research

i. Plan and conduct operations research for PHC
ii. Collaborate with relevant stakeholders to conduct research for PHC
iii. Promote the analysis, validation and dissemination of policy and practice evidence through publications, reports, conferences, advocacy briefs and other channels
iv. Create and operationalise a database on PHC research and researchers in the country.
v. Provide research grants to encourage research into priority PHC programs and commission research into priority PHC issues such as health seeking behaviour/utilisation of PHC services; motivation and sustainability of PHC coordinating structures (VDCs, WDCs, CHIPS, etc.)
vi. Establish terms of agreement and MoU with partner agencies, NGOs for collaborative research activities
vii. Promote health systems research by endorsing and supporting problem-oriented health systems research as a tool for finding better ways for the provision of essential care as a component of health for all and, in particular, by introducing health systems research in the Local Government Area and supporting either level in this effort
viii. Support the documentation of primary health care research through commissioning of case studies, reviews, books, articles, newsletters, and other media productions as appropriate
ix. Establishing resource centres to serve as national and zonal depositories of information on PHC research implementation
x. Maintain a library and website of relevant publications on PHC.

Public Health Emergency and Health Security

i. Liaise and coordinate with other relevant MDAs and stakeholders to institute emergency and outbreak response
ii. Provide guidance, technical coordination, and support at national and state levels for epidemic/outbreak response
iii. Develop guidelines and train primary health care workers on emergency preparedness and response strategies
iv. Ensure adequate risk communication strategies are implemented
v. Ensure non-interruption of the health commodities/vaccine logistics supply chain during public health emergencies
vi. Develop, plan and implement Mitigation/ Resilience measures to ensure continuity of health service delivery during outbreaks
vii. Resource mobilization for outbreak response
viii. Ensure availability of national level data for planning during public health emergencies

CHAPTER 13
STATE PRIMARY HEALTH CARE BOARDS (SPHCB)

13.1 ROLES AND RESPONSIBILITIES

The following section outlines the roles and responsibilities of the State Primary Health Care Board in PHC practice, based on the following different thematic areas:

Leadership and Governance

i. Set State targets for the entire primary health care spectrum on prevention, treatment, and care services in line with national priorities such as the health sector strategic plan
ii. Develop the PHC annual operational plan for improved PHC outcomes in the State
iii. Manage coordination platforms set up at the State level for PHC programme implementation
iv. Undertake technical and administrative supervision of PHC health professionals/workers
v. Ensure that health system performance gaps (clinical and management/administrative) identified during supervision are addressed through appropriate capacity building and quality improvement interventions
vi. Ensure that all relevant PHC committees are in place and functioning.
vii. Monitor the activities of the LGHA Management committee.
viii. Ensure implementation of accountability framework for PHC and other relevant frameworks and guidelines.

Health financing

i. Create budget line for PHC operations
ii. Prepare annual estimates based on the SPHCB work plan and ensure its incorporation into the SMoH Budget
iii. Mobilize resources within the State, nationally and internationally for the implementation of PHC.
iv. Disburse funds to the PHC facilities based on approved guidelines
v. Conduct periodic auditing of all PHC resources
vi. Identify and adopt health financing mechanisms that will ensure efficient financing of PHC programmes taking into cognizance issues of equity and social justice
vii. Create a basket fund for PHC, where public funds comingle with donor funds

PHC Managerial and Support Systems

i. Conduct quarterly Integrated Supportive Supervisory functions
ii. Approve quarterly health facility business plans
iii. Maintain an updated list of vendors for consumables and essential medicines
iv. Provide oversight on plans and activities of the FMC and VDC/WDC

Health Service Delivery

i. Provide technical support to LGA and health facilities on PHC service delivery
ii. Ensure delivery of community-based health services, facility-based health services, outreach services and referral linkages.
iii. Carryout assessment of PHC services, providers and facility performance using appropriate and defined quality assurance mechanisms.
iv. Support and ensure an efficient 2-way referral system
v. Establish SPHCB clinical governance/quality improvement team
vi. Ensure dissemination, adoption and implementation/use of national guidelines and standing orders
vii. Adopt national standards for PHC services and establish systems for compliance
viii. Adopt protocols for clinical quality of care
ix. Conduct continuing professional development for HRH (targeted education, case-based learning, and interactive and multi-model teaching techniques and professional retraining) to increase clinical quality of care.
x. Provide regular communication to the public on health-related issues (Social and Behavioural Change Communication)

Human resources for Health

i. Adopt National guidelines on HRH for planning, production, recruitment, distribution, management, and practice
ii. Provide support to Schools of Health Technology, Schools of Nursing and Midwifery and other PHC training institutions for manpower development
iii. Develop a State-wide primary health care human resource management plan to ensure the availability and appropriate mix of PHC workers at all levels
iv. Conduct human resource recruitment, selection, placement, and transfers.

v. Design appropriate job descriptions for PHC workers and contracts for ad-hoc staff.
vi. Conduct training and orientation/reorientation for staff on their jobs
vii. Establish and maintain a regularly updated HRH database to ensure that the right number of staff with the right skills are in the right place, carrying out the right services
viii. Promote staff motivation through effective leadership and provision of appropriate incentives
ix. Carry out effective supervision, performance appraisal, rewards, and sanctions for HRH
x. Promote continuing education in the delivery of health services; coordinate various activities in the State/LGA for effective integration.

Health Infrastructure and Equipment

i. Update and maintain the State health facility list/database including functionality
ii. Coordinate the LGAs to conduct mapping of all PHC facilities according to their types
iii. Ensure the distribution of PHCs as recommended by the Ward Health System.
iv. Conduct facility assessments and document appropriately
v. Disseminate the recommended standards for infrastructure and equipment as updated/reviewed by NPHCDA
vi. Conduct and coordinate new construction and rehabilitation of PHC facilities and carry out the maintenance of major facility infrastructure
vii. Provide and distribute equipment, where centrally supplied.
viii. Mobilize resources for PHC infrastructure and equipment from all sources

Health Commodities, Logistics and Supply Chain

i. Facilitate the publication of a list of accredited drug suppliers in the State for use by the LGHA and PHCs
ii. Adopt appropriate procurement method based on extant procurement laws
iii. Conduct facility assessments for the requirement of essential commodities
iv. Support and develop commodities and pharmaceutical supply chain management system at all levels.

Community Participation

i. Empower communities through participatory planning and implementation of communication activities to improve knowledge and attitudes to healthcare
ii. Strengthen institutional capacity for demand creation by training service providers on communication and mobilization skills to effectively mobilize parents, caregivers, and communities for improved and sustained participation in PHC services
iii. Strengthen partnerships through mobilizing key partners and stakeholders within and outside the healthcare sector to harness existing structures to achieve coordinated and wider stakeholder participation in PHC activities
iv. Leverage social media and other channels as plat forms to mobilize communities and create demand for PHC services.
v. Enable and encourage communities to participate in initiating, devising, implementing, and monitoring decisions and plans based on their local needs, priorities, capacities, and resources.
vi. Mobilize resources for Health Promotion from the community and LGA.
vii. Monitor the performance of the Ward Development Committees (WDCs) and facility health Committees as well as other health-related community support groups.
viii. Ensure adequate representation of women in the Ward Development Committee (WDCs)

National Health Management Information System

i. Ensure timely production and transmission of quality NHMIS data on PHC services, and relevant reports to facilitate decision making at the State and LGA.
ii. Ensure use of evidence from the NHMIS and other sources to evaluate the impact of various programmes and services.
iii. Monitor data completeness, correctness, timeliness, and accuracy from the LGHA on the DHIS2 platform.
iv. Conduct quarterly DQA visits to LGHA and PHC facilities
v. Provide regular feedback to LGHAs, health facilities and communities on observations identified from service data and recommend actions
vi. Organize State level data review meetings with LIO and LGA M&E Officers
vii. Ensuring the preparation of State health bulletins for decision-making, dissemination, and feedback.

Partnerships and Collaboration

i. Leverage the established coordination platform to ensure integration of all partner activities and programmes
ii. Collaborate with partners in other sectors (e.g., education, agriculture, and public works) on initiatives targeted at improving PHC services.
iii. Ensure LGHAs and PHC facilities maintain a partner register and that programmes are integrated in operational plans
iv. Monitor activities of partners and compliance to MOUs

Health Research

i. Develop protocols for conducting research
ii. Plan and conduct operations research for PHC in collaboration with relevant stakeholders
iii. Promote the analysis, validation and dissemination of policy and practice evidence through publications, reports, conferences, advocacy briefs and other relevant channels
iv. Create and operationalize a database of PHC research and researchers in the State.
v. Establish terms of agreement and MoU with partner agencies, NGOs for collaborative research activities
vi. Promote health systems research by endorsing and supporting problem-oriented health systems research as a tool for finding better ways for the provision of essential care as a component of health for all and by introducing health systems research in the Local Government Area health system and supporting either level in this effort
vii. Support the documentation of PHC research through commissioning of case studies, reviews, books, articles, newsletters, and other media productions as appropriate.

Public Health Emergency and Health Security

i. Liaise and coordinate with other relevant State MDAs and stakeholders to institute emergency and outbreak response
ii. Provide guidance, technical coordination, and support to LGHA for epidemic/outbreak response
iii. Ensure alignment with National to implement guidelines on emergency preparedness and response strategies
iv. Ensure adequate risk communication strategies are implemented
v. Resource mobilization for outbreak response
vi. Ensure availability of state level data for planning during public health emergencies

13.2 ACCOUNTABILITY FRAMEWORK OF SPHCB

To be assessed by NPHCDA on a Quarterly basis, during the Integrated Supportive Supervisory visit.

Table 13.1: Accountability Framework for SPHCB

No	Activity	Data Sources	Validation Criteria	Responsible Individual	Weight	SCORE
LEADERSHIP AND GOVERNANCE						
1	Organization management by the SPHCB	Annual operational Plan for PHC	1. Strategic plan developed by the State (SMOH), to last 4 years 2. Up to date operational plan for SPHCB available 3. Operational plan is prepared at least one month before the expiration of existing plan for the current year.		10	
2	SPHCB serves as Secretariat for meetings and relationship management	Monthly Technical Meeting conducted and minutes available	1. 3 monthly meetings conducted during the quarter under review and minutes available 2. The minutes contain (a) date, agenda (b) signed attendance (c) follow up decisions from previous meeting (d) detailed coaching and mentoring plan for LGHAs based on data analysed (e) data discussed in meeting and follow up with responsible persons and deadline. 3. Next date of meeting agreed during the past meeting		7	
			4. Minutes distributed within 7 working days after the meeting - For hard copy, signed acknowledgement of receipt - For Soft copy, email proof		3	
HEALTH FINANCING						
3	Financial Management By SPHCB	Quarterly financial reports	1. Approved budget line for routine activities 2. No delay in the release of funds for routine activities 3. No delays in release of overhead budgets to health facilities 4. Financial Reports available and accessible to the officer		5	

			on duty.			
4	Timely disbursement of BHCPF to PHCs	• Quarterly financial reports	1. No delays in payments/disbursements of the BHCPF funds to benefiting Health Facilities - *Deadline for payments to HEALTH FACILITIES = 14 days after receipt of funds*		10	
HEALTH SERVICE DELIVERY						
5	Quarterly Integrated Supportive Supervisions to the LGHAs and health facilities	Supervision (ISS) Reports Travel forms	1. Plans for supervision for the current quarters with responsible persons, timeframe, areas of interest based on key observations, findings, challenges and recommendations from the previous quarter's supervision report 2. Proof of dissemination of the supervision plans to the LGAs - For hard copy, signed acknowledgement of receipt - For Soft copy, email proof.		10	
			3. Review of supervision reports for the quarters under review 4. Proof of dissemination of reports to the LGAs - For hard copy, signed acknowledgement of receipt - For Soft copy, email proof.		15	
HUMAN RESOURCE FOR HEALTH						
6	HRH Database exists and is up-to-date	Electronic Database of HRH for the State	1. Nominal roll for the State available. 2. Individual Staff files present in the SPHCB for sighting 3. Electronic database for HRH available and content verifiable		5	
7	Continuous Capacity Building programme for health workers	Calendar for the training programme. Training protocols, e.g., Quality of care protocol for State. Training reports.	1. Training plan available, topics indicated, and dates indicated, trainer indicated, target audience specified		1	
			2. At least 25% of the training plan has been implemented quarterly 3. At least one quality of care officer trained per PHC centre (the Ward Health Centre) 4. Reports of training sessions organized in the previous		4	

			quarter with list of staff who attended			
HEALTH INFRASTRUCTURE AND EQUIPMENT						
8	Updated master list of functional PHCs in the State	Electronic database of status of PHC in the State. ISS reports.	1. Electronic database of status of PHC in the State available and content verifiable 2. Sample health facilities from the database for spot checks to verify functionality		5	
VACCINE AND LOGISTICS MANAGEMENT						
9	Ensure the availability of vaccine in the health facilities Assess this in the State Cold store	Vaccine managemen t stock cards. Vaccine movement register to health facility. Vaccine ledger SDD refrigerators	1. The State is not out of stock of any vaccine within the quarter 2. All LGAs in the State have a functional cold chain with full complement of vaccines. 3. Vaccines register well-kept and all vaccine stocks and vaccine supply stocks are within recommended stock limits 4. Fixed supply facility temperature records are available, temperatures are measured according to the protocol, and temperature is always within the recommended range 5. Backup measures for the EPI supply facility are available at the State cold chain and consist of (a) a functioning second SDD refrigerator; (b) frozen ice packs		10	
HEALTH MANAGEMENT INFORMATION SYSTEMS						
10	Monthly Validated health facility HMIS report for the State,	HMIS Database Monthly validated HMIS Report for State (Electronic/Pa per)	1. Monthly validated HMIS Report for State Available 2. Evidence of dissemination to LGA and partners - For hard copy, signed acknowledgement of receipt - For Soft copy, email proof.		5	
11	Utilization of operational data	Summary report of State service delivery data for the past quarter	1. Routine trend analysis of data conducted quarterly and presented in a report detailing poor performing (a) LGA (b) facilities and (c)indicators 2. Availability of coaching plan to address issues identified		5	
PARTNERSHIPS AND COLLABORATION						
12	Establish and Update	Updated	1. 3 monthly coordination meetings conducted during		3	

	Partners Register at State level for harmonisation and alignment of health development activities Monitor activities of partners and ensure compliance to MoUs	partner register Minutes of coordination meetings Signed list of participants Evidence of expenditure	the quarter under review and minutes available 2. Each minute contains (a) date, agenda (b) signed attendance (c) follow up decisions from previous meeting (e) data discussed in meeting and follow up with responsible persons and deadline. 3. Next date of meeting agreed during the past meeting			
			4. Minutes of meetings should be distributed within 7 working days after the meeting - For hard copy, signed acknowledgement of receipt - For Soft copy, email proof		2	
Grand Total Score for SPHCB					**100%**	

CHAPTER 14
LOCAL GOVERNMENT HEALTH AUTHORITIES (LGHA)

14.1 ROLES AND RESPONSIBILITIES

The following section outlines the roles and responsibilities of the Local Government Health Authority in PHC practice, based on the different thematic areas:

Leadership and Governance

Leadership and governance roles of the LG Advisory Committee include the following:

i. Set the overall vision and mission of the LGHA
ii. Provide oversight functions for PHC implementation in the LGA
iii. Mobilise and allocate resources for PHC programmes and activities
iv. Ensure the implementation of accountability framework for all stakeholders in PHC
v. Conduct quarterly review meetings to monitor progress of PHC implementation
vi. Receive and deliberate on health reports of LGA and advise Local Government Health Authority Management Team (LGHAMT) on decisions to improve health outcomes
vii. Ensure the development of Annual Operational Plan (AOP)

The Leadership and governance roles of the LGHA Management Team include the following:

i. Day-to-day management of LGHA resources through effective planning, implementation, and coordination of PHC activities in the LGA
ii. Develop operational plan for achieving the strategic goals of PHC in the LGA
iii. Ensure that health system performance gaps (clinical and management/administrative) identified during supervision are addressed through appropriate capacity building and quality improvement interventions.
iv. Build capacity of community members to participate in initiating, planning, implementing, and monitoring programmes based on their local health needs, priorities and resources
v. Provide LGA-wide partner coordination and alignment with priorities and planning to avoid duplication and waste of resources.
vi. Work with partners in other sectors (e.g., education, agriculture, infrastructure) to promote stakeholder participation on PHC matters

vii. Provide technical and management support to WDCs and FMC
viii. Support and supervise the activities of the LGHA and PHC facility staff
ix. Collate and review business plans from health facilities and submit to the State for approval

Health financing

i. Create budget line for PHC programmes and activities
ii. Mobilise resources from partners, philanthropists, private sector, and other sources for PHC
iii. Maintain all financial transactions of the LGHA
iv. Commission Bi-annual auditing of LGHA and PHC facility accounts

Health Service Delivery

i. Ensure MSP or RWHSS is available
ii. Establish Quality Improvement Team/officer per PHC
iii. Ensure implementation of good quality PHC services in all health facilities
iv. Monitor and supervise Quality of Care Officers
v. Conduct quarterly assessments of PHCs in the LGA
vi. Empanelment of patients by CHIPs to ensure continuity

Human Resources for Health (HRH)

i. Deploy appropriate number and mix of HRH to all PHC facilities
ii. Provide job descriptions for all PHC personnel
iii. Provide regular training and re-training of HRH
iv. Conduct annual HRH gap analysis and ensure appropriate distribution
v. Establish and maintain an HRH database for the LGA
vi. Monitor performance of all PHC personnel

Health Infrastructure and Equipment

i. Supervise and monitor new constructions and rehabilitation of health facilities as well as distribution of equipment, where centrally procured.
ii. Support health facilities in the development and implementation of a facility maintenance plan, as part of the business plan
iii. Conduct quarterly supportive supervisory visits to all PHCs in the LGA
iv. Submit quarterly reports to the SPHCB

Health Commodities, Logistics and Supply Chain

i. Distribute a published list of accredited drug suppliers in the State to all health facilities within the LGA

ii. Ensure effective implementation of Drug Revolving Fund (DRF) for all commodities and supplies.
iii. Conduct verification of health commodities
iv. Ensure the implementation of a commodity logistic system in all facilities under its jurisdiction
v. Ensure proper documentation of all health commodities and supplies
vi. Ensure proper storage, handling, and utilisation of all health commodities in the LGA
vii. Ensure timely distribution of essential drugs and commodities to health facilities if centrally procured

Community Participation

i. Ensure the formation/reactivation of WDCs using the Participatory Learning and Action (PLA) tools
ii. Provide orientation on roles and responsibilities to the WDCs
iii. Monitor the performance of the VDCs, WDCs and Facility Management Committee (FMCs)
iv. Reproduce and distribute IEC materials to health facilities and communities as may be required
v. Train health workers on Client Oriented Provider Efficient (COPE) strategy

Health Management Information Systems

i. Ensure the availability of NHMIS data tools in the LGA
ii. Collate, analyse, utilise, and disseminate PHC data in the LGA
iii. Ensure timely upload/sharing of data on the DHIS2 platform within 7 days of receipt from the PHCs
iv. Train and supervise health workers on data management
v. Provide regular feedback to PHCs and communities
vi. Use PHC data for planning, monitoring and decision making

Partnerships and Collaboration

i. Open and maintain a register of all PHC partners operating within the LGA
ii. Ensure the inclusion and harmonisation of the activities of all partners in the LGAs in alignment with the SPHCB operational plan
iii. Collaborate with partners in the implementation of the LGA operational plan
iv. Monitor and supervise the activities of all partners in the LGA

Health Research

i. Identify topics for operations research within the LGA
ii. Participate in operations research conducted in the LGA
iii. Disseminate research findings to communities and PHCs
iv. Implement recommendations from research

Public Health Emergency and Health Security

i. Provide guidance, support at ward level for epidemic/outbreak response
ii. Ensure guidelines on emergency preparedness and response strategies are implemented at the PHC facility and ward level
iii. Ensure adequate risk communication strategies are implemented at the PHC facility and ward level
iv. Resource mobilization for outbreak response
v. Ensure availability of LGA level data for planning during public health emergencies

14.2 ACCOUNTABILITY FRAMEWORK OF LGHA

To be assessed by the SPHCB quarterly during the Integrated Supportive Supervisory Visit. Table 14.1 presents a summary of accountability framework for LGHA.

Table 14.1: Accountability framework for LGHA

No	Activity	Data Sources	Validation Criteria	Responsible Individual	Weight	SCORE
HEALTH SERVICE DELIVERY AND INFRASTRUCTURE MAINTENANCE						
1	**All PHC Facilities** have received Integrated Supportive Supervision (ISS) at least once per month by the LGHA team	Monthly ISS Plan Monthly ISS Reports	1. **All** Health Facilities were supervised within the past month, 2. The ISS checklist was used for each facility visit		10	
			3. Monthly Supervision Reports (three reports per quarter) exists and are readily available at the LGHA 4. The reports are in accordance with the Standard reporting template found in the ISS manual 5. Follow-up plan developed, based on outcome of previous visits		15	
2	Monthly Assessment framework of **all health facilities** done	Health facility Monthly Assessment framework Report of health facility assessment	1. All HEALTH FACILITY performances for the past month evaluated 2. Assessments completed prior to the LGHA management meeting, using the designated assessment framework 3. All HEALTH FACILITY assessment framework well		10	

No	Activity	Data Sources	Validation Criteria	Responsible Individual	Weight	SCORE
			completed (all items filled) including the recommendation sections 4. Individual health facility folders with assessment frameworks correctly filed			
3	Support health facilities to develop their Business Plans (not from the LGHA office)	Availability of the approved health facilities business plans Copy of health facility business plans meeting minutes conducted at the health facility Copy of signed list of attendance of the health facility business plan meeting	1. Approved copies of the health facility Business Plans received at the LGHA (Approved before the 15th of the first month of the next quarter) 2. Business plans have a signature of the LGHA director		5	
			3. Copy of health facility business plan, minutes of meetings for all health facilities in the LGA 4. Copy of signed list of attendance of the health facility business plan development meetings showing LGHA participation		5	
HUMAN RESOURCE FOR HEALTH						
4	HRH Database exists and is up-to-date	Electronic Database of HRH for the LGA	1. Electronic database for HRH available and content verifiable 2. Nominal roll for the LGA available.		10	

No	Activity	Data Sources	Validation Criteria	Responsible Individual	Weight	SCORE
			VACCINE, DEVICES AND HEALTH COMMODITIES			
5	Ensure the availability of vaccine in the health facilities Assess this in the LGHA Cold stores	Vaccine management stock cards Vaccine movement register to HEALTH FACILITY Vaccine ledger SDD refrigerator	1. The LGHA is not out of stock of any vaccine within the quarter 2. All health facilities in the LGA have a functional cold chain with full complement of vaccines. 3. Vaccines register well-kept and all vaccine stocks and vaccine device stocks are within recommended stock limits 4. Fixed supply facility temperature records are available, temperatures are measured according to the protocol, and temperature is always within the recommended range		10	
			5. Backup measures for the EPI supply facility are available at the LGHA cold chain and consist of (a) a functioning second SDD refrigerator; (b) frozen ice packs		10	
6	Ensure the availability of health commodities in the health facilities Assess this in	Bin cards Store Issue Vouchers and Store Receipt Vouchers Tally cards Store ledgers	1. There were no stock-outs of commodities during the quarter being assessed 2. No expired		5	

No	Activity	Data Sources	Validation Criteria	Responsible Individual	Weight	SCORE
	the LGHA dry stores	distribution plan if centrally procured	commodities in stock, pilferages, wastages and damages 3. Distribution pattern; actual distribution versus the plan			
HEALTH MANAGEMENT INFORMATION SYSTEMS						
7	Monthly health facility HMIS report entered in the HMIS database	Health facility-HMIS Monthly Cumulative Report HMIS Database (DHIS2) Monthly health facility HMIS reports (original)	1. Original Monthly health facility HMIS summary Reports of **all** health facilities in the LGA available and filed in the Specific health facility Files at LGHA 2. Summary of LGHA HMIS analysed reports		20	
Grand Total Score for LGA					**100%**	

CHAPTER 15
PRIMARY HEALTH CARE (PHC) CENTRE

15.1 ROLES AND RESPONSIBILITIES

The following section outlines the roles and responsibilities of the Primary Health Care Centre under the leadership of the ward health supervisor / Ward Focal Person (Ward Focal Person is the most senior health personnel in the ward) in PHC practice, based on the different thematic areas:

PHC Management / Governance

i. Mobilise and ensure effective utilisation of resources from government and other stakeholders to improve services within the facility
ii. Monitor facility performance and progress in making service improvements
iii. Implement the Drug Revolving Fund (DRF) in accordance with the guideline
iv. Identify and address problems that discourage community members, particularly women and the poor, from using the health services provided in the facility
v. Work with the WDCs to identify persons to be selected and trained as CHIPS agents
vi. Provide regular reports of PHC activities to the WDC or Village Development Committee (VDC) as applicable
vii. Develop business plan, including facility maintenance and quality improvement plans, along with the WDC
viii. Ensure monthly meetings of the FMC, VDC and WDC to assess progress on business plan implementation
ix. Ensure development of, and adherence to job descriptions by all staff for improved PHC practice

Health financing

i. Open and operate a facility bank account in a reputable commercial bank in accordance with the BHCPF guidelines/PHCUOR
ii. Utilise funds received in accordance with set guidelines
iii. Prepare Monthly /quarterly financial reports

Health Service Delivery

i. He should lead as the Quality-of-Care focal person in the PHC
ii. Deliver appropriate health care services (Revised Ward Health System Strategy (RWHSS), WMHP)
iii. Conduct outreach or mobile activities in the community

iv. Ensure availability and adherence to standards of care
v. Facilitate two-way referral system
vi. Receive and resolve complaints
vii. Monitor and supervise the activities of CHIPS agents

Human resources for Health

i. Ensure availability and visibility of a functional staff duty roster.
ii. Maintain and adhere to a staff duty roster
iii. Maintain a register of trainings received by PHC staff
iv. Maintain a record of the staff nominal roll
v. Support the Facility Management Committee (FMC) to conduct a monthly appraisal of all the staff in the health centre

Health Infrastructure and Equipment

i. Develop a ward planned preventive maintenance plan for infrastructure and equipment
ii. Implement the ward/facility planned preventive maintenance plan
iii. Submit quarterly reports to the LGHA.

Health Commodities, Logistics and Supply Chain

i. Collect vaccines and devices from the LGA cold stores
ii. Maintain stock of drugs and commodities for all PHC services
iii. Ensure proper disposal of medical waste
iv. Establish and sustain an operational DRF system,
v. Use standing orders and other treatment protocols in patient care
vi. Maintain an inventory system for essential drugs, vaccines, and other commodities.

Community Engagement

i. Develop and implement a community mobilisation plan
ii. Maintain a detailed geographic and social map of the ward
iii. Involve community social groups in community mobilisation and outreach activities
iv. Display and regularly update the community profile on the Community Information Board as well as the available services and charges at the facility
v. Display Patients' Charter (Admin, 2020) and periodic reports on the information boards at each facility
vi. Disseminate information on available services offered by the PHC and prices through community "Town Announcers", local electronic media, religious, traditional, and social groups

Health Management Information System

i. Generate data on PHC service delivery
ii. Ensure completeness, accuracy, and timeliness in filling HMIS data
iii. Collate community data from JCHEW and CHIPS
iv. Submit paper based NHMIS summary data to LGHA within the first 7 days of the subsequent month
v. Ensure Community Engagement Focal Persons submit monthly collated community data from CHIPS Agents to the PHC Centre

Partnerships and Collaboration

i. Ensure agreements with partners are operationalised at the facility level
ii. Establish partnerships with local artisans and CBOs to enhance PHC activities.
iii. Ensure a robust relationship with the NURTW/local transporters for seamless transportation service.

Public Health Emergency and Health Security

i. Implement guidelines on emergency preparedness and response strategies
ii. Ensure adequate risk communication strategies are implemented
iii. Collate data from disease surveillance activities within assigned communities
iv. Ensure epidemic/outbreak response related IEC materials are posted at strategic points within the PHC facility

15.1 ACCOUNTABILTY FRAMEWORK OF PHC CENTRES

Table 15.1: Accountability Framework of PHC Centres

PHC Management and Governance			
1	**Management of the PHC Facility [Max 49 points]**	**Weight**	**Score**
1.1	**Proper filing system**	**3**	
1.1.1	In a filing cabinet/shelf/cupboard and accessible by the officer on duty (except individual staff files)		
1.1.2	Minimum documents to be filed include: (i) Monthly HMIS reports; (ii) Weekly surveillance reports; (iii) approved business plans; (iv) minutes of meetings; (v) patient cards / folders (OPD; ANC; Partograph; Family Planning and 'bed head tickets'); (vi) individual staff files (where manager is available).		
1.1.3	The health facility operates a system whereby each patient has a file folder that contains all individual patient records for all utilised services with a unique patient number		
1.1.4	Each patient has a single identification number on their hand card which is used for every service and can be matched with the number in the register. The hand cards should show complete identification (including age, sex) complete location/address and different dates they visited the different services for easy tracing of patients.		
1.2	**Staff duty roster (with phone number of each staff on duty) available and well displayed up to date for current month and visible for staff and patients to see**	**1**	
1.3	**Technical meetings (Facility Management Committee (FMC) meetings) are conducted monthly and minutes available**	**8**	
1.3.1	Each monthly minutes contains at least: (i) date of the meeting; (ii) signed list of participants; (iii) follow-up of decisions taken during the previous meeting; (iv) there is a list of developed recommendations or decisions taken; (v) each month the monthly financial balance is discussed (opening balance, revenues, expenditure and closing balance); (vi) strategies to assure financial accessibility for the vulnerable discussed; (vii) minutes of the meeting are signed by the Chairman and Secretary		
1.4	**Availability of dedicated mobile phone for communication between health facility and general hospital**	**1**	
1.4.1	Mobile phone functional with batteries and/or call credit of a minimum of N500 and contact details on the phone (e. g: Medical Director GH/Cottage Hospital, health facility Staff, other health facility's OICs in the LGA, LGHA Team and SPHCB Team)		
1.5	**HMIS reports are filled, updated and transmitted to the LGA on schedule**	**2**	
1.5.1	Transmission of HMIS report **before the 7th of the next month** and a signed receipt of acknowledgement is available		
1.6	**HMIS data analysis report for the quarter being assessed concerning priority problems**	**1**	
1.6.1	Five priority health problems are followed each quarter and data have been updated up to the month prior to the supervisor's visit (all or nothing) (Monthly summary of the health problem classified at the closing of each month in the General register)		
2	**The Health Facility Business Plan**		
2.1	**Quarterly business plan for the quarter under review made and accessible**	**2**	
2.1.1	Valid and renegotiated for the quarter under evaluation (signed by all authorised signatories)		
2.2	**Business plan prepared with key stakeholders**	**2**	

PHC Management and Governance			
2.2.1	FMC Members involved (Chairman signed off on the plan): minutes of special meeting to prepare the business plan available with signed attendance list.		
2.3	**Presence of map of health facility catchment area**	**1**	
2.3.1	Health map of the health area available and on the notice board of the health facility showing population adjusted yearly, other health facilities, villages, main roads, natural barriers, special points and distance in Km, a legend/key showing specific age group population adjusted yearly (<1, <5, WCBA)		
2.4	**Quality of the Business Plan**		
2.4.1	**Business plan contains convincing geographic coverage plan**	**2**	
2.4.1.1	Outreach strategies are used and planned for villages and settlements within the catchment area of the facility		
2.4.1.2	Business plan contains social marketing strategies		
2.4.1.3	Business plan contains strategies for collaboration with the public and private sector		
2.4.1.4	Health facility has a list of informal practitioners transmitted quarterly to the LGHA for action, treats this subject in the business plan, and suggests strategies for dealing with informal practitioners		
2.4.2	**Business plan shows a plan to assure financial accessibility for the population**	**2**	
2.4.2.1	Business plan shows negotiated rates between health facility, committee and community		
2.4.3	**Business plan shows strategies to strengthen referrals**	**3**	
2.4.3.1	Strategies available for transfer of persons to hospital (for emergency care, FP, Complicated Deliveries, HIV etc.)		
2.4.4	**Business plan analyses Hygiene and waste management**	**2**	
2.4.4.1	Health facility treats this subject in the business plan (toilets; showers; medical and non-medical waste disposal; safe sharps disposal practices; general cleanliness; infection prevention), and suggests a strategy for improvement		
2.4.5	**Business plan shows convincing strategies for health facility infrastructure maintenance – the health facility maintenance plan**	**5**	
2.5	**Business Plan Implementation**	**5**	
2.5.1	Analysis of implementation of the business plans is done monthly and evidence available		
2.5.2	Business plan analysis should be one of the agenda items in the monthly FMC meeting.		
2.5.3	Quality Improvement Plan present and updated on a monthly basis		
3	**Financial Management**		
3.1	**Financial and accounting documents available and well kept**	**5**	
3.1.1	Monthly financial report (income and expenditure books) available and correctly filled and signed by the Health Facility Officer in Charge. Send to the LGA PHC department/LGHA once completed and acknowledged		
3.1.2	1. Theoretical balance of cashbook corresponds to liquidity in cash 2. Total income for the period under review = total expenditure during the period + total cash in hand + bank balance. 3. The monthly bank statements, income/ expenditure book, cash invoices and cash in hand are accessible by the assessor and complete.		
3.2	**Document available (Income and expenditure statement, bonus calculation sheet) to show that quarterly calculation of incomes, running costs, and investments are done**	**4**	
3.2.1	This document guarantees that income equals/balances the expenditures. The document guarantees that Running costs equal: = salaries, purchase of drugs and equipment, subcontracts, petty cash for		

PHC Management and Governance			
	small expenditures, social marketing, maintenance and rehabilitation;		
Total Score [Max 49 poi		…/49	

PHC INFRASTRUCTURE			
4	**Availability and Maintenance of Infrastructure [max 50 points]**	**Weight**	**Score**
4.1	**Fence for the health facility available and well-maintained**	**1**	
4.1.1	Fence exists, can be closed at night and there are no holes. A gatekeeper/security is available.		
4.2	**Health Facility has electricity 24/7**	**1**	
4.2.1	Good light source (e.g., Electricity, solar light, rechargeable lamp, or functioning kerosene lamp etc.) present		
4.3	**Health facility has a functional water source**	**2**	
4.3.1	A borehole, well, water reservoir etc.		
4.4	**Good conditions in waiting area for OPD, Immunisation, etc.**	**1**	
4.4.1	Sufficient benches and or chairs protected against sun and rain and waiting area is not inside the consultation room		
4.5	**Health facility infrastructure is well maintained**	**5**	
4.5.1	Walls with durable materials well painted, floor paved with cement without fissures, undamaged ceiling		
4.5.2	Windows with curtains		
4.5.3	Functional doors with functional locks		
4.6	**Presence of sufficient latrines/toilets which are well-maintained (except riverine areas)**	**3**	
4.6.1	At least four water closet functional latrines/toilets (either the flushable squatting closet or the sitting closet) two for staff: Male and female, two for patients: Male and female		
4.6.2	Floor without fissures		
4.6.3	Recently cleaned without visible faecal matter		
4.6.4	Door lockable from the inside, ceiling and super structure with roofing, without flies and no smell		
4.6.5	Proof of use of bleach used as a disinfectant (e.g., jik, hypo, etc)		
4.7	**Presence of sufficient showers which are well-maintained**	**2**	
4.7.1	At least two bathing facilities (with floor without fissures, Door lockable from the inside, super structure with roofing)		
4.7.2	Bathing facility with running water, or container with at least 20L of water		
4.7.3	Evacuation of the wastewater in a sanitation pit		
4.8	**Availability of a room for a mortuary: corpse should not be stored for more than 12 hours (check-ins/outs mortuary registers), one stretcher and one table**	**1**	
4.9	**Availability of an enclosed kitchen space, separate from the main building, for inpatients**	**1**	
4.10	**Organic Waste pit for Health Care Waste is available**	**5**	
4.10.1	Waste disposal pit minimum 2 meters deep, lined with clay, concrete or brick or plastic, it is fenced and has a bright flag		
4.10.2	The waste pit is a minimum of 15 meters from the health facility, minimum of 50 meters from a household, and 100 meters from a water source except in cases where the available surface area does not allow for these distances (written support of the LGA health administration is required)		
4.10.3	Health Care Waste is not visible (covered by at the least 10 cm of soil or lime between burial intervals)		
4.10.4	The health facility maintains a register indicating the date of the creation of the Waste pit, the location and last date of use and closure		
4.11	**On site Waste Disposal for Health Care Waste is available**	**8**	
	If Health Facility is practicing On-site waste disposal only score for this section, if not score for the Off -site section. DO NOT SCORE BOTH ONSITE & OFFSITE FIELDS FOR A HEALTH FACILITY		

PHC INFRASTRUCTURE			
4	**Availability and Maintenance of Infrastructure [max 50 points]**	**Weight**	**Score**
4.11.1	Waste Disposal Unit (WDU) built according to norm; on a solid concrete foundation with refractory bricks and chimney (at least of 4 metres high). Shelter over incinerator		
4.11.2	The Incinerator is a minimum of 15 meters from the health facility, minimum of 50 meters from a household, and 100 meters from a water source except in cases where the available surface area does not allow for these distances (written support of the LGA health administration is required)		
4.11.3	The health facility maintains a register indicating the date of creation of the incinerator, the location and last date of use, weight of waste burnt, and weight of ash evacuated		
4.12	**Incinerator Construction Manual and Operators manual available**	**2**	
4.13	**Ash pit for final disposal of incineration ash available**	**5**	
4.13.1	Ash disposal pit minimum of (3.25 cubic metres) 2 meters deep, lined with clay, concrete or brick or plastic, it is fenced and has a bright flag warning of the pit location		
4.13.2	The Ash pit is a minimum of 15 meters from the health facility, minimum of 50 meters from a household, and 100 meters from a water source except in cases where the available surface area does not allow for these distances (written support of the LGA health administration is required)		
4.13.3	Health Care Waste is not visible (covered by at the least 10 cm of soil or lime)		
4.14	**Offsite Waste Disposal for Health Care Waste is available and according to the norms**	**15**	
	If Health Facility is practicing On-site waste disposal only score for this section, if not score for the Off -site section. DO NOT SCORE BOTH ONSITE & OFFSITE FIELDS FOR A HEALTH FACILITY		
4.14.1	Agreement with the SMoEor other appropriate institution to evacuate health facility waste		
4.14.2	Detailed plan by health facility on offsite transportation Register for transmission of HCW from health facility to State approved waste disposal sites by the SMoE (dated and signed by health facility and SMoE)		
4.15	**HCWM Monitoring & Evaluation**		
4.15.1	Availability and proper use of HCWM data tools	**4**	
4.15.2	Availability of well-maintained and filled internal HCW record sheet. Check three random entries in the monthly register and compare with record sheet to verify if the waste handler correctly measures weight of waste before disposal		
4.15.3	Health facility HCWM schedule available and up to date. The schedule includes daily routines for collection, handling, segregation, and packaging of the different categories of waste. Name of waste handler and incineration date	**2**	
4.16	**Availability of storage area for health care waste.**		
4.16.1	Storage should also be provided for tools, records, personal protective equipment and fuel (both kerosene and firewood).	**2**	
4.16.2	Personal Protective Equipment (PPE) for personnel managing HCW available; boots, overalls, thick rubber gloves, disposable hand gloves, mouth respirators/facemask, helmet, goggles/protective eye glass	**3**	
4.16.3	Availability of waste operation tools such as (a) shovels (b) steel rods for poking the fire (c) brooms (d) waste ash buckets (e) coloured bin liners (f) Stickers for labelling waste (g) scale to measure waste (h) cleaning equipment and disinfectant (i) wheeled bins/trolleys for collecting waste	**2**	
Total Points Infrastructure (50)		**…/50**	

SERVICE DELIVERY AND QUALITY OF CARE IN PHC

SERVICE DELIVERY AND QUALITY OF CARE IN PHC			
5	**Curative Consultations [max 105 points]**	**Weight**	**Score**
5.1	**Standard forms for referral available**	**1**	
5.1.1	At least 10 standard forms are present during the evaluation evidence of previous received counter referral slips		
5.2	**Unit fees of drugs displayed to the public**	**1**	
5.2.1	Easily visible in the consultation room waiting area, updated, with (i) unit price per item; (ii) price for a standard treatment of the drug		
5.2.2	Drugs are all generics		
5.3	**Existence and use of waiting card system with numbers, specifically for OPD**	**1**	
5.4	**Consultation room in good condition**	**5**	
5.4.1	Consultation room and waiting space separated assuring confidentiality		
5.4.2	Windows with curtains		
5.4.3	Functional door with functional lock		
5.4.4	Running water (tap or water dispenser) with hand washing soap/liquid available		
5.5	**Consultations are done by skilled staff**	**2**	
5.5.1	Identification of consulting staff in card or folder (names, rank and signature)		
5.6	**Consulting staff is well-dressed**	**1**	
5.6.1	Clean blouse/uniform, footwear and name tags		
5.7	**Service availability 24/7**	**2**	
5.7.1	Supervisor verifies entries in register for the last three Sundays		
5.8	**Treatment guidelines available in consultation room (Standing Orders)**	**1**	
5.9	**Treatment of Malaria according to protocol**	**6**	
5.9.1	National protocol for diagnosis and treatment of simple and severe malaria put on wall and accessible for staff		
5.9.2	**Simple malaria treated according to protocol -** see last five cases of simple malaria and review treatment according to protocol		
5.10	**Treatment of ARI according to protocol**	**6**	
5.10.1	flow diagram for ARI put on wall and accessible for staff		
5.10.2	ARI protocol applied		
5.10.3	See last five cases of ARI and review treatment according to protocol		
5.11	**Treatment of Diarrhoea according to protocol**	**6**	
5.11.1	protocol for diarrhoea put on wall and accessible for staff		
5.11.2	diarrhoea protocol applied		
5.11.3	See last five cases of diarrhoea and review treatment according to protocol		
5.12	**Proportion of consultations treated with antibiotics <30%**	**4**	
5.12.1	See last 100 cases in register, check diagnosis and treatment given. Where antibiotics are an appropriate treatment, remove from sample. and calculate the rate (< 30 cases) (In case less than 100 cases during the quarter calculate 30% of the cases in the register)		
5.13	**Non-Communicable Disease**	**7**	
5.13.1	Measure blood pressure, height, weight, waist circumference and calculate BMI (kg/m^2)		
5.13.2	Follow protocol and referral for Hypertension, Diabetes, Chronic respiratory disease, cancer and Sickle cell anaemia		
5.14	**Knowledge of tuberculosis danger signs**	**5**	
5.14.1	Select any available qualified medical staff, and ask the question on TB dangers signs		

SERVICE DELIVERY AND QUALITY OF CARE IN PHC			
5.15	**Stethoscope and BP machine available and functional**	**1**	
5.15.1	Let consulting staff check BP and review measure		
5.16	**Thermometer available and functional**	**1**	
5.17	**Otoscope available and functional**	**1**	
5.18	**Examination bed available with mattress**	**1**	
5.18.1	Non-torn, plastic cover, specific for the OPD consultations only		
5.19	**Weighing scale available and functional**	**1**	
5.19.1	Inspect in comparison with known weight of supervisor: after weighing, the balance should calibrate to zero		
5.20	**Determination of nutritional status (weight, Mid Upper Arm Circumference, height)**		
5.20.1	Determination of nutritional status of all children under 5 who come to the health facility (check five children under five through a random sampling method: take a random number between 1 and 3 and using this sampling interval check five consultations)	**4**	
5.20.2	Determination of nutritional status of all women with a sick child under 6 months of age (as above)	**4**	
5.21	**Integrated Management of Childhood Illnesses (IMCI)**	**2**	
5.21.1	IMCI Protocol is available in the consultation room and a trained staff		
5.22	**Direct observation (or review of patient records in case of no patients) of three consecutive children under five according to the IMCI protocol (Each child maximum 14 points; max 42 points)**	**(0;14; 28;42)**	
5.22.1	Ask about fever and IF FEVER ask about (i) since when; (ii) persistent or intermittent		
5.22.2	Ask about cough and IF COUGH ask about since when		
5.22.3	Ask for diarrhoea IF DIARRHOEA then ask (i) since when; (ii) how often per day; (iii) consistency - water or mucus or bloody; (iv) vomiting		
5.22.4	GENERAL IMPRESSION: awake or tired?		
5.22.5	FIRST - COUNT RESPIRATION RATE (observe before touching child!!!)		
5.22.6	Temperature (measure)		
5.22.7	Signs of dehydration (in case of diarrhoea) OR chest auscultation (in case of cough)		
Total Points (105)		**…/105**	
Recommendations			

6	Family Planning [max 17 points]	Weight	Score
6.1	**At least one qualified staff trained in Family Planning (check certificate: original or photocopy certified by the SPHCB)**	**2**	
6.2	**Confidentiality in consultancy room assured**	**2**	
6.2.1	Room with closed doors, curtains at windows or non-transparent glass		
6.3	**Family planning methods available and visible in demonstration box for potential users**	**2**	
6.3.1	Condoms; OCP; Injectable; Implant; IUD; are available in the demonstration box (**all five items**)		
6.3.2	Penis model available on the desk; box with condoms available with at least 50 condoms		
6.4	**Staff correctly calculates number of clients expected monthly for oral and injectable contraceptives**	**1**	
6.4.1	For example, for 10,000 population (target is entire ward catchment pop) = 10,000 * 22.5% * 25%/12 * 4 * 90% (assuming 25% unmet need; 22.5% target population; 90% of oral/inject AC at HC level. Ask any medical personnel involved in care for clients to explain this target calculation.		

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	Total number of women of childbearing age (15 - 49) divided by four. Note that each dose is for 3 months (one blister per month for three months or one injection of Depo-Provera covers three months)		
6.5	**Security Stock of oral and injectable contraceptives is adequate**	**2**	
6.5.1	For example, for 10,000 pop 84 doses of oral (3-month cycles) and injectable methods combined. Total number of women of childbearing age (15 - 49) - 22.5% times unmet need 25% divided by 12 (months) times 2 months (min supply) times 90% delivered at health centre level => result 84 doses). Note that each dose is for 3 months		
6.6	**IUCD available and staff trained to use it**	**3**	
6.6.1	At least five IUCDs and at the least one staff trained to use it (check certificate original or photocopy certified by the SPHCB)		
6.7	**Implant method available and staff trained to use it**	**3**	
6.7.1	At least five implants available and staff trained to use it (Sight certificate original or photocopy certified by the SPHCB)		
6.8	**FP individual cards available and filled according to the format**	**2**	
6.8.1	Check at least five cards for breast examination, BP, hepatomegaly, varicose veins, weight (all cards; all elements checked)		
	Total Points (17)	**…/17**	
Recommendations			
7	**Laboratory [max 16 points]**	**Weight**	**Score**
7.1	**Medical Laboratory Scientist or Technician available with current license or permit**	**1**	
7.2	**Laboratory is open every day of the week**	**1**	
7.2.1	Supervisor verifies the last 4 Sundays in laboratory register		
7.3	**List of laboratory examinations visible for the public with fees**	**1**	
7.4	**Results recorded correctly in laboratory register and match with results in inpatient sheets, OPD examination cards or laboratory request form**	**3**	
7.4.1	Supervisor verifies last five results		
7.5	**Availability of parasites demonstrations**	**1**	
7.5.1	On plastic paper, in a colour book, or put on wall		
7.5.2	Blood smear: Vivax, Ovale, Falciparum and Malariae (Not applicable where not a microscopy centre) but other blood and skin parasites		
7.5.3	Stools: Ascaris, entamoeba, ankylostoma and schistosome		
7.6	**Microscope available and functional**	**2**	
7.6.1	functional objectives; immersion oil available, mirror or electricity		
7.6.2	Scalpel Blades, one packet of glass slides cover slips and GIEMSA stain available		
7.7	**Malaria rapid tests available**	**2**	
7.7.1	At the least 20 tests available in the laboratory; non-expired		
7.8	**Bench and haematocrit centrifuge available and functional**	**1**	
7.9	**Personnel adequately washes dirty pipettes in containers with disinfectant**	**2**	
7.9.1	A functioning water source or at the least 20L		
7.10	**Laboratory equipment for testing for PTB**	**2**	
7.10.1	Reagents for AAFB testing available; stock control cards for reagents are available and lists stock; at the least 30 non-recycled slides available for testing (N/A IF NOT A DOTS		

SERVICE DELIVERY AND QUALITY OF CARE IN PHC			
	Centre)		
7.10.2	External Quality assurance protocol for PTB testing available and implemented: slides sampled and sent for quality control according to protocol, and latest report, as per protocol, is available and shows results as per cut-off point of the protocol		
	Total Points (16)	**../16**	
Recommendations			
8	**In-patient Wards [max 7 points]**	**Weight**	**Score**
8.1	**Guard duty roster clearly visible for staff and followed up**	**0.5**	
8.1.1	Supervisor verifies guard duty's report - names and signatures match		
8.2	**Furniture in in-patient wards available and in good state**	**1**	
8.2.1	Each bed has a (i) non-torn plastic covered mattress, (ii) mosquito net, (iii) clean sheets, (iv) night table		
8.3	**Patient comfort and hygiene**	**2**	
8.3.1	The wards are clean: no debris on the floor; and wards smell of disinfectant AND OR proof of use of bleach for cleaning the wards (around 12% hypochlorite)		
8.3.2	Space between the beds is at the least one meter		
8.3.3	Each ward has access to drinking water		
8.3.4	Each ward has running water or water dispenser with water and soap		
8.4	**Confidentiality**	**2**	
8.4.1	Women in separate ward from men; the inside of the wards are not visible from the outside		
8.5	**In patient register available and is well maintained**	**0.5**	
8.5.1	check identity and hospital bed days		
8.6	**Recording forms for hospitalisations available and well filled and well stored**	**1**	
8.6.1	At least 10 blanks; supervisor verifies 5 filled forms		
8.6.2	Weight, temperature, and eventual laboratory exams recorded		
8.6.3	Treatment monitoring checked		
Total Points (7)		**…/7**	
Recommendations			
9	**Maternity [max 24 points]**	**Weight**	**Score**
9.1	**Sufficient water with antiseptic soap *or* liquid antiseptic in delivery room**	**2**	
9.1.1	A functioning water source or at the least 20L		
9.2	**Delivery room is well-maintained**	**5**	
9.2.1	Walls with durable materials and painted		
9.2.2	Curtain/screen between delivery bed and door		
9.2.3	Delivery room smells of disinfectant AND OR should have proof of use of bleach as a disinfectant for cleaning (e.g., jik, hypo, etc)		
9.2.4	Floor should be levelled with cement, without fissures and ceiling not damaged		
9.2.5	Windows with curtains and functional door		
9.3	**Availability and use of the partograph**	**2**	
9.3.1	At the least 10 blank forms available for use		
9.3.2	Verify three randomly selected partograph whether filled according to the norms		
9.4	**Deliveries performed by skilled personnel**	**2**	
9.4.1	Identification of the skilled provider from names in the partograph/folder/card /register		
9.5	**Availability of scales for weight/length, an obstetrical stethoscope and an aspirator**	**3**	

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9.5.1	Tape to measure length		
9.5.2	Scale to measure weight (check functionality)		
9.5.3	Aspirator plunged into a non-irritating disinfectant or functional manual/electric aspirator		
9.6	**Availability of at the least 10 pairs of (sterile) surgical gloves**	**1**	
9.7	**Availability of at the least 2 sterilized obstetrical pack (delivery kit)**	**2**	
9.7.1	Contains at the least 1 pair of scissors, 2pairs of forceps		
9.8	**Availability of at the least one episiotomy pack**	**1**	
9.8.1	One sterilized box with 1 pair of scissors, needle holder, needles, 2 dissecting forceps		
9.8.2	Catgut and absorbable sutures; antiseptic, local anaesthetics, sterile swaps		
9.9	**Delivery table in good state**	**1**	
9.9.1	Table in two parts with removable non-torn plasticized mattress and two functional leg supports		
9.10	**Available equipment for care of the new-born**	**2**	
9.10.1	Sterile tying string or clip for umbilical cord and chlorhexidine		
9.10.2	1% tetracycline eye ointment/ Gentamycin or Chloramphenicol ointment non-expired		
9.11	**Availability of post-natal ward**	**3**	
9.11.1	All mattresses covered in impermeable plastic		
9.11.2	Sheets, blankets and mosquito nets on each occupied bed		
Total Points (24)		**…/24**	
Recommendations			

10	**Antenatal Care [max 11 points]**	**Weight**	**Score**
10.1	**Weighing scale present, functional and calibrated to zero**	**1**	
10.2	**ANC form for health facility available and well filled in: last five forms verified**	**3**	
10.2.1	All: Examinations: weight - BP, uterus height, parity, date of last menstruation		
10.2.2	All: Laboratory: albuminuria, glucose, HIV screening		
10.2.3	All: Obstetrical examination conducted foetal heart rate, uterine height, presentation, foetal movement recorded		
10.3	**ANC form shows the administration of Ferrous Sulphate/Folic Acid, SP and Td (for the last five forms above)**	**2**	
10.4	**ANC cards for mother available: at least 10 blanks in stock**	**1**	
10.5	**ANC register available and well filled in**	**2**	
10.5.1	Complete identity, state of vaccinations, date visit, whether high risk pregnancy or not/danger signs		
10.5.2	All columns well filled including the identification of problems if any, and actions taken		
10.6	**ANC conducted by qualified personnel**	**1**	
10.6.1	Nurse, midwife, CHO or CHEW, verified on ANC cards		
10.7	**Group IEC/SBC**	**1**	
10.7.1	Group meeting held before ANC consultation (check the schedule of health education sessions)		
10.7.2	Existence of updated IEC report with (a) topic, (b) number of participants, © name of health educator, (d) key messages delivered, (e) date and (f) signature		
Total Points (11)		**../11**	
Recommendations			

11	**HIV/TB [max 8 points]**	**Weight**	**Score**
11.1	**Well-equipped HIV counselling room ensuring privacy:**	**1**	
11.1.1	Plastered and painted wall of solid material		
11.1.2	Smooth cement floor		

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11.1.3	Ceiling in good condition		
11.1.4	Windows with glass and curtains		
11.1.5	Doors that close		
11.2	**Availability of IEC/SBC material related to HIV**	**1**	
11.2.1	Penis model on the table or in demonstration box		
11.2.2	A box of condoms on the table which has at the least 50 condoms		
11.3	**Existence of a VCT/PMTCT counselling register and lab register according to the norms**	**1**	
11.4	**Staff trained in counselling (certificate original or photocopy certified by LGA)**	**1**	
11.4.1	At the least one staff trained as a counsellor		
11.4.2	All counselling done by a trained counsellor (check certificate and register)		
11.5	**Functional referral system and follow up for HIV clients**	**1**	
11.5.1	Individual client cards and referral forms available		
11.6	**Referral system and follow up for TB patients**	**2**	
11.6.1	Each AAFB+ PTB patient has a person attached to him/her who supervises DOTS: proof of in register; mobile phone number of such a supervisor is registered		
11.6.2	Each PTB patient has a contact address and/or phone number in both the register and the individual card		
11.7	**Availability of anti-tuberculosis drugs (for at least three new clients)**	**1**	
Total Points (8)		**../8**	
Recommendations			
12	**Hygiene and Sterilisation [max 16 points]**	**Weight**	**Score**
12.1	**Availability of a Health Care Waste Management focal person**	**2**	
12.2	**Courtyard clean**	**1**	
12.2.1	No waste or medical waste in the courtyard (sharps, ampoules, plastics, gloves, syringes, needles, used gauze, etc.)		
12.3	**Disposal of Health Care Waste according to national norms**	**6**	
12.3.1	Availability of waste segregation poster on the wall		
12.3.2	Waste disposal of non-contaminated waste in **Black Bin** with lid and foot pedal, lined and not full		
12.3.3	Waste disposal of contaminated HCW in **Yellow Bins** with lid and foot pedal, lined with cellophane bag and not full		
12.3.4	Waste disposal of organically HCW in **Red Bins** with lid and foot pedal, lined with cellophane bag and not full		
12.4	**Sterilisation**	**4**	
12.4.1	Sterilisation according to norms using a sterilizer		
12.4.2	Steriliser functional (e.g. Steam sterilizer or autoclave)		
12.4.3	Sterilisation protocol available and followed (medical personnel present can explain the protocol or demonstrate the process)		
12.5	**Hygienic conditions assured during wound dressing and injections**	**3**	
12.5.1	Yellow and Red Bins for medical waste with lid and foot pedal, lined with bag and not full		
12.5.2	Security box for needles well positioned, and used (and not full)		
12.5.3	Needle cutter (when available)		
12.5.4	Container/bowl with lid containing disinfectant used for putting used instruments		

SERVICE DELIVERY AND QUALITY OF CARE IN PHC		
Total Points (16)	../16	
Recommendations		

13	RI - Vaccine availability and Management [max 19 points]	Weight	Score
13.1	**Personnel calculates correctly target for fully vaccinated children**	1	
13.1.1	Target = population * 4% / 12: asked from any medical personnel dealing with care for clients		
13.1.2	The target population concerns the ward population (or the defined catchment pop in case ward has more PBF primary contract holders)		
13.2	**SDD Refrigerator**	4	
13.2.1	Presence of an SDD - temp form available, filled twice a day including the day of the visit		
13.2.2	No food or drink stored in the fridge		
13.2.3	Temperature remains between +2°C and +8°C in register sheet		
13.2.4	Supervisor verifies functionality of thermometer		
13.2.5	Temperature between +2°C and +8°C also according to the thermometer		
13.3	**Appropriate storage of vaccines**	1	
13.3.1	Freezing compartment: Measles, OPV, Yellow Fever and BCG		
13.3.2	Non-freezing compartment: Penta, HepB, TT, Diluents, IPV, PCV,		
13.3.3	Absence of expired vaccines		
13.3.4	All vaccines with readable VVM label		
13.4	**Appropriate stock of vaccines**	1	
13.4.1	BCG, Penta, OPV, Yellow Fever, HepB, Measles, TT, IPV, PCV, Diluents		
13.4.2	Availability of vaccine stock ledgers for all vaccines; concordance paper and physical stock verified		
13.5	**Cold Chain maintenance**	1	
13.5.1	If kerosene fridge: stock of at the least 14L Kerosene; if solar fridge: battery not damaged		
13.6	**Cold packs are well frozen**	1	
13.6.1	At the least 5		
13.7	**Syringes available**	1	
13.7.1	Auto-disable at least 30; for dilution - at least 3 5mls syringe		
13.8	**Waste collection**	1	
13.8.1	Availability of safe disposal box		
13.9	**Stock of under-five 5 growth monitoring cards available**	1	
13.9.1	At the least 10 blank cards should be available		
13.10	**Child immunisation register well maintained & Monthly monitoring chart well filled and updated**	3	
13.10.1	Personnel calculates correctly the monthly coverage rate (children under 1 immunized/ target population) *100		
13.10.2	Personnel calculates correctly the monthly dropout rate ((no. of children immunized for penta 1 – no. of children immunized for penta 3)/ no. of children immunized for penta 1) *100		
13.10.3	System is capable of identifying dropouts and Fully Vaccinated Children		
13.10.4	Schedule, record of appointments, well arranged individual cards		
13.11	**Conditions in waiting area for immunisation services**	1	
13.11.1	Sufficient benches and or chairs, protected against sun and rain		
13.12	**Patients receive numbered waiting buttons according to their arrival**	1	
13.13	**Baby weighing scale available and in working condition**	1	
13.13.1	Balance calibrated to zero + pants available (if spring balance), clean and in good condition		
13.14	**Group Information Education Communication (IEC) /Social and Behaviour Change (SBC)**	1	
13.14.1	Group meeting held before vaccinations (check the schedule of		

SERVICE DELIVERY AND QUALITY OF CARE IN PHC			
	health education sessions)		
13.14.2	Existence of updated IEC report with (a) topic, (b) number of participants, (c) name of health educator, (d) key messages delivered, (e) date and (f) signature		
Total Points (19)		**../19**	
14	**Essential Drugs Management [max 20 points]**	**Weight**	**Score**
14.1	**The Pharmacist/Pharmacy Technician is available (sight current licence/permit)**	**1**	
14.1.1	Staff maintains stock cards for ED showing security stock levels = monthly average consumption (MAC= six months Consumption divided by six) * 2 (two months monthly average consumption)	**3**	
14.1.2	Supply in register corresponds with physical supply: random sample of three essential drugs		
14.2	**Health facility purchases drugs, equipment and consumables from the Pharmacist Council of Nigeria certified wholesale pharmacies, approved by SMOH/SPHCDB**	**3**	
14.2.1	Latest Pharmacist Council of Nigeria certified wholesale pharmacies list for the State available		
14.2.2	Last procurement list is shown which shows the certified distributor which sold the drugs		
14.2.3	All drugs and medical consumables are (i) NAFDAC certified and (ii) Generic		
14.3	**Main pharmacy store delivers drugs to health facility dispensary according to requisition**	**10**	
14.3.1	Supervisor verifies whether quantity requisitioned equals quantity served		
14.3.2	Drugs to clients are uniquely dispensed through prescriptions. Prescriptions are stored and accessible		
14.3.3	Drugs and medical consumables prescribed, are all in generic form		
14.4	**Drugs stored correctly**	**2**	
14.4.1	Clean place, well ventilated with all drugs on cupboards, labelled shelves		
14.4.2	Drugs and medical consumables stored in alphabetical order according to therapeutic usage, first expired - first out basis		
14.5	**Absence of expired drugs or drugs with unreadable labels**	**1**	
14.5.1	Supervisor verifies randomly three drugs and 2 consumables		
14.5.2	Expired drugs well separated from stock		
14.5.3	Destruction protocol for expired drugs available and applied		
Total Points (20)		**../20**	

CHAPTER 16
WDC/VDC

16.1 ROLES AND RESPONSIBILITIES

The following section outlines the roles and responsibilities of the WDC/VDC in PHC implementation, based on the different thematic areas.

Leadership and Governance

i. Identify health and social needs of the ward and plan for them
ii. Supervise the implementation of ward health plans
iii. Forward all health/community development plans (facility, village, and wards levels) to LG Health Authority and follow up for action.
iv. Mobilize and stimulate active involvement of prominent and local people in the planning, implementation, and monitoring of PHC activities
v. Take active role in management of the Drug Revolving Fund (DRF) in the ward
vi. Liaise with government and partners in finding solutions to health, social and other related problems in the wards
vii. Monitor and support the activities of the VDCs/FMCs/CHEWs/Support the health facility in developing a business plan and its implementation
viii. Provide support to the needs of the PHC facility.

Health financing

i. Open and operate bank account for all WDC fund, in accordance with BHCPF/PHCUOR guidelines.
ii. Raise funds for health and other development programmes in the ward
iii. Mobilize resources (manpower, finances, material) to improve service delivery
iv. Ensure accountability by providing regular feedback to the community on how funds raised are utilized
v. Participate in determining price list for drugs and services
vi. Establish mechanism for fee exemption

Health Service Delivery

i. Monitor staff attitudes to clients and community members
ii. Assist in ensuring all complaints are resolved
iii. Support logistics for two-way referral system

Human resources for Health

i. Identify human and material resources to meet these needs
ii. Monitor and support the activities of the JCHEWs and CHIPS agents
iii. Identification and selection of CHIPS agents
iv. Report erring staff to LGHA

Health Infrastructure and Equipment

i. Provide sites for construction of PHC facilities
ii. Monitor and supervise the construction and rehabilitation of PHCs
iii. Monitor the implementation of facility PPM
iv. Provide security to the PHC facility
v. Monitor equipment inventory and infrastructure at quarterly intervals (WHS)

Health Commodities, Logistics and Supply Chain

i. Monitor inventory for essential drugs, vaccines, and other health commodities at the PHC facility. Monitor drug use by CHIPS agents at community level

Community participation

The following roles of the WDC in community participation are outlined

i. Serve as a pressure group for LGA support in providing health and other developmental services for the people in the ward
ii. Promote demand for quality PHC services
iii. Advocate with local stakeholders to increase their involvement in Health.
iv. Provide feedback to the rest of the community on all health and other developmental activities.
v. Monitor and support planned activities at both the health facilities and village levels

The roles of the VDC/CDC in community participation are outlined below:

i. Identify health and health related needs in the village/community
ii. Plan for the health and welfare of the community
iii. Identify available resources (human and material) within the community and allocate as appropriate to PHC programmes
iv. Monitor the implementation of PHC work plan
v. Establish a village health post, where there is none already
vi. Monitor the progress of the implementation of health activities,
vii. Mobilize and stimulate active community involvement in the implementation of health plans

viii. Determine exemptions for drug payment and deferment; but provide funds for the exemptions/deferments.
ix. Determine the pricing of drugs to allow for financing of other PHC activities.
x. Monitor all facility account books and the quantity of drug supply
xi. Recommend appropriate persons within the community to be trained as CHIPS agents.
xii. Monitor the activities of the CHIPS agents
xiii. Remunerate in cash or kind, the CHIPS for his/her work in the community
xiv. Agree with the CHIPs the number of hours he/she should work per day
xv. Monitor that CHIPs agent kits are stocked to top-up level for drugs.
xvi. Provide necessary support to CHIPs for the provision of health care services
xvii. Forward local health community plan to wards level.

Health Information Systems

i. Establish and regularly update community information board
ii. Support the line listing of households, pregnant women children for immunisation and other vulnerable groups
iii. Participate in community-based surveillance, contact tracing and defaulter tracking

Partnerships and Collaboration

i. Ensure agreements with partners are operationalized at the village and community level
i. Mobilize artisans and community-based organisations to support PHC activities
ii. Advance health as a political agenda in the ward

Public Health Emergency and Health Security

i. Create enabling environment and platforms for Community (based) health workers to create awareness of disease of public health importance
ii. Provide community support to epidemic/outbreak response efforts
vii. Ensure emergency preparedness and response strategies are implemented within the communities
viii. Ensure adequate risk communication strategies are implemented at community level
ix. Appropriate resource mobilization for outbreak response at community level

x. Ensure epidemic/outbreak response related IEC materials are posted on community boards and strategic locations

Part 3
Rewards and Sanction Matrix

CHAPTER 17
REWARDS AND SANCTION MATRIX

Table 17. 1 presents a summary of rewards and sanctions associated with PHC implementation in Nigeria.

Table 17.1: Summary of rewards and sanctions: PHC Implementation in Nigeria

Action	**Target Entity**	**Reward**
Performance above 80% in the accountability framework	SPHCB LGHA PHC Facility	Awards, Recognition, Certification, Recommendations for Honours
Performance above 80% in PHCUOR implementation	SPHCB	Awards, Recognition, Certification, Recommendations for Honours

<table>
<tr><th>Action</th><th>Target Entity</th><th>Penalty</th><th>Comments</th></tr>
<tr><td>Performance below 50% cut-off in the accountability framework</td><td>SPHCB
LGHA
PHC Facility</td><td></td><td></td></tr>
<tr><td rowspan="4">Falsification of Information
(Data, records or reports falsification)</td><td>Ad-hoc staff</td><td>First Offence:
Investigate. If found guilty, issue warning in writing to offending officer
Repeat Offence:
Investigate. If found guilty, blacklist from carrying out surveys</td><td rowspan="4">Blacklist by:
Displaying names of offending officers on NPHCDA website / Database Publish names in the media (print and electronic)</td></tr>
<tr><td>Public officers</td><td>Investigate.
If found guilty, Serious Misconduct
Apply sanctions based on Public Service Rule (PSR)</td></tr>
<tr><td>Consultants / Contract staff</td><td>First Offence:
Investigate. If found guilty, issue warning in writing to offending officer or institution
Repeat Offence:
Investigate. If found guilty, terminate contract, blacklist, and report to ICPC for prosecution</td></tr>
<tr><td>Contractors/Third Party Agents</td><td>First Offence:
Investigate. If found guilty, Terminate contract, blacklist, and report to ICPC for prosecution</td></tr>
</table>

Action	Target Entity	Penalty	Comments
Diversion and/or theft of medical equipment, CCEs and commodities meant for health facilities / beneficiaries	Public officers	Investigate. If found guilty, Serious Misconduct Apply sanctions based on Public Service Rule (PSR)	**Blacklist by:** Displaying names of offending officers on NPHCDA website / Database Publish names on the media (print and electronic)
	Consultants / Contract staff	**First Offence:** Investigate. If found guilty, terminate contract, blacklist, and report to ICPC/EFCC for prosecution	
	Institutions	**First Offence:** Investigate. If found guilty, terminate contract, blacklist, and report to ICPC/EFCC for prosecution	
Misuse of Medical equipment including CCE	Public officers	Investigate. If found guilty, Serious Misconduct Apply sanctions based on Public Service Rule (PSR)	
Vaccine theft, Wastages, and diversion	Ad-hoc staff	**First Offence:** Investigate. If found guilty, issue warning in writing to offending officer **Repeat Offence:** Investigate. If found guilty, blacklist from participating in any immunization activities	**Blacklist by:** Displaying names of offending officers on NPHCDA website / Database Publish names on the media (print and electronic)
	Public officers	Investigate. If found guilty, Serious Misconduct Apply sanctions based on Public Service Rule (PSR)	
	Consultants/Contract staff	**First Offence:** Investigate. If found guilty, terminate contract, blacklist, and report to ICPC/EFCC for prosecution	
	Contractors/Third Party Agents	**First Offence:** Investigate. If found guilty, terminate contract, blacklist, and report to ICPC/EFCC for prosecution	
Violation of contract terms for constructions e.g. 1. Giving and Taking bribes 2. Using substandard material 3. Non-completion/exec	Private Contractors	**First Offence:** Investigate. If found guilty, terminate contract, blacklist, and report to ICPC/EFCC for prosecution	**Blacklist by:** Displaying names of offending officers on NPHCDA website / Database Publish

Action	Target Entity	Penalty	Comments
ution of project as at when due 4. Non-execution of contracts or transfer to third party 5. Alteration of project design 6. Deliberate wrong siting of projects 7. Data falsification e.g. Fake pictures in project report, overvaluing job done	Public Officers	Investigate. If found guilty, Serious Misconduct Apply sanctions based on Public Service Rule (PSR)	names on the media (print and electronic)
Misappropriation of funds	Ad-hoc staff	**First Offence:** Investigate. If found guilty, discontinue engagement, blacklist and report to ICPC/EFCC for prosecution	**Blacklist by:** Displaying names of offending officers on NPHCDA website / Database Publish names on the media (print and electronic)
	Public officers	Investigate. If found guilty, Serious Misconduct Apply sanctions based on Public Service Rule (PSR)	
	Consultant/Contract staff	**First Offence:** Investigate. If found guilty, discontinue engagement, blacklist, and report to ICPC/EFCC for prosecution	
	Government or Private Institutions	Withholding of transfers, e.g., BHCPF, report to EFCC/ICPC	

APPENDICES

APPENDIX 1

LIST OF NATIONAL POLICY AND OPERATIONAL DOCUMENTS REFERENCED IN THIS DOCUMENT

SN	Focus / Thematic Areas	Policy Documents	Operational / Programmatic / Strategic document
0	All	National Health Policy NPHCDA Act CAP. N69 L.F.N. 2004 National health Act, 2014	National Strategic Health Development Plan NPHCDA Strategic Development Plan II NSHIP User Manual
1	Governance and Administration	-	Integrating PHC Governance in Nigeria (PHC Under one roof operational manual) Ward Health System (WHS)
2	Health Financing	-National Health Financing Policy	Operational Guidelines for the Basic Health Care Provision Fund (BHCPF) NSHIP Project Implementation Manual
3	Health Service Delivery and Quality of Care	Health Sector Component of National Food and Nutrition Policy	National Guidelines for development of PHC systems in Nigeria Minimum Standards for PHC in Nigeria Operational Guidelines for the Basic Health Care Provision Fund (BHCPF) National Standing Orders Ward Minimum Health Care Package (WMHCP) National Strategic Plan of Action for Nutrition
4	Human Resource for Health	National Human Resource for Health Policy National Task Shifting and Task Sharing (TSTS) Policy	National HRH Strategic Plan 2016 – 2020 National Health Workforce registry documents – operational guidelines Minimum Standards for PHC in Nigeria Ward Health System (WHS) BHCPF Operations Manual Ward Minimum Health Care Package (WMHCP) National Guidelines for Development of Primary Health Care System in Nigeria, June 2012
5	Infrastructure	-	Minimum Standards for PHC in Nigeria National Guidelines for Development of PHC systems in Nigeria Ward Health System (WHS)

SN	Focus / Thematic Areas	Policy Documents	Operational / Programmatic / Strategic document
			Ward Minimum Health Care Package (WMHCP) BHCPF operational guidelines
6	Health Commodities and Equipment	National Drugs Policy National Quality Assurance Policy for Medicines and other Equipment Nigeria Supply Chain Policy for Pharmaceuticals and Other Healthcare Products	Management and disposal of unusable and expired pharmaceuticals and other healthcare products in Nigeria – Guidelines and SOPs – Sept 2017 NSHIP Project Implementation Manual National essential equipment list National Essential medicines list
7	Managerial Support systems	-	NSHIP Project Implementation Manual
8	Community Participation	-	Primary Health Care under One Roof policy Technical Report on the Revitalization of PHC in Nigeria. Integrating PHC Governance in Nigeria (PHC Under one roof operational manual) National Guidelines for Development of PHC Systems in Nigeria
9	Health Information Systems		National health information strategic plan National SOP for the collection and management of routine health data in Nigeria Accountability Framework for RI in Nigeria, 2012 National Health ICT Strategic Framework
10	Partnerships and Collaboration	National Policy on Public Private Partnership for Health in Nigeria, 2005	Technical Report on Revitalizing PHC in Nigeria – NPHCDA, March 2013 Integrating PHC Governance in Nigeria (PHC Under one roof operational manual) National Guidelines for Development of PHC Systems in Nigeria
11	Health Research	National Health Research Policy and Priorities	

APPENDIX 2

PHASES OF PHC IMPLEMENTATION IN NIGERIA

Phase 1: Basic Health Services Scheme 1975 – 1980

1975: Establishment of the National Basic Health Services Scheme (BHSS) as part of the third National Development Plan

1977: WHA resolution specified that "main target of government and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that would make them live a socially and economically productive life."

1978: Alma Ata Declaration at the International Conference on Primary Health Care

Phase II: BHSS Evolving to PHC 1980 - 1985

1981: Development of the fourth development plan

1983: From 1979 to 1983, The Federal Ministry of Health with the assistance of British Ministry of Health supplied equipment to the health facilities

1985: African Health Ministers' re-affirmation to the Alma Ata Declaration through the adoption of the Three-Phased Health Development Scenario (TPHDS)

1987: The Bamako Initiative

Phase III: PHC Development Period (1986-1992)

1986: Adoption of PHC in Nigeria when 52 pilot LGAs were selected as models for PHC implementation funded and managed by FGN.

1987: Adoption of the Bamako Initiative by African Health Ministers

1988: Launch of Nigeria's first comprehensive National Health Policy based on Primary Health Care.

1986-90: Establishment of Schools of Health Technology, Expansion of PHC to all LGAs, Achievement of Universal Child Immunization Target of over 80%, Devolution of responsibility for PHC to LGAs

1991: Review of Nigeria's efforts toward the implementation of PHC by a WHO High Level Review Team

Phase IV: Period of PHC Collapse (1992-1998)

1992: Establishment of the National Primary Healthcare Development Agency (NPHCDA) on the recommendation of the WHO High Level Review Team

1993: Beginning of the collapse of PHC in Nigeria

1997: Establishment of the National Programme on Immunization (NPI)

Phase V: Initial PHC Revival Period (1999-2008)

2001: Report on **Needs Assessment Survey to Determine the Status of PHC in Nigeria**

2001: Development of the National Reproductive Health Policy and Strategy Establishment of the Ward Health System, Launch of the Ward Minimum Health Package and Launch of the National Policy on Food & Nutrition

2004: Development of the **National Economic Empowerment & Development Strategy** (NEEDS), Approval of the Revised National Health Policy, Development, and Implementation of the Health Sector Reform Programme (2003-2007) and Launch of the National Plan for Action on Food & Nutrition

2005: Launch of the National Policy on Infants & Young Child Feeding and Launch of the Formal Sector Programme of the National Health Insurance Scheme

2006: Launch of the National Child Health Policy, Launch of the Accelerated Child Survival and Development: Strategic Framework & Plan of Action and Launch of the Roadmap for Accelerating the Achievement of MDGs Related to Maternal & New-born Health

2007: Approval of the Integrated Maternal New-born & Child Health (IMNCH) Strategy, Merger of the NPI with NPHCDA

Phase VI: Further Revitalisation of PHC Period (2009 to date)

2009: National Health Conference with the theme **'Primary Health Care in Nigeria: 30 years after Alma Ata'** and Launch of the **Midwives Service Scheme** (MSS)- Skilled Birth Attendant focused

2010: Launch of the National Strategic Health Development Plan (NSHDP) 2010-2015 and Launch of the Nigeria's State Health Investment Project (NSHIP) – includes Skilled Birth Attendant Component

2011: Launch of the President Jonathan's Transformation Agenda

2012: Launch of the SURE-P MCH (includes Skilled Birth Attendant component) and Launch of the Save One Million Lives (SOML) Initiative (which is now an umbrella for MSS, and SURE-P MCH)

2014: National Health Bill signed into law (National Health Act)

2017: Launch of National Emergency Routine Immunisation Coordination Centre

2018: Launch of Community Health Influencers, Promoters and Services (CHIPS) Program

2019: Launch of National Emergency Maternal and Child Health Intervention Centre

APPENDIX 3
ESSENTIAL EQUIPMENT LIST FOR PHC FACILITIES

ITEM DESCRIPTION	Household	Community	Outreach post	PHC Centre (Level 1)	PHC Centre (Level 2)	PHC Centre (Level 3)
Medical Equipment	Quantity					
AMBU Bag with Face mask	0	0	0	1	1	2
Artery forceps (medium)	0	0	0	3	6	8
Bowls (stainless steel) with stand	0	0	1	2	4	6
Centrifuge manual vacuum	0	0	0	0	2	4
Cup with cover for ORS	0	0	4	6	10	12
Diagnostic Set	0	0	1	1	1	2
Dissecting forceps	0	0	2	4	6	8
Dressing Forceps	0	0	2	2	2	4
Dressing scissors	0	0	2	3	4	6
Dressing trolley	0	0	1	2	3	5
Drinking Mug	0	0	2	6	10	12
Drinking mug stainless steel	0	0	4	4	4	6
Fetoscope stainless steel	0	0	2	2	4	6
Forceps jar	0	0	1	2	3	5
Gallipots (medium)	0	0	2	6	6	8
Graduated medicine cup (stainless steel)	0	0	2	10	10	12
Incision and Drainage kit	0	0	2	2	6	8
Kidney dish (large stainless steel	0	0	2	4	6	8
Length measures for babies	0	0	2	2	4	6
Manual Aspiration Set	0	0	0	0	2	4
MUAC Tapes (Nutrition)	0	0	2	4	4	6
Mucus Extractor	0	0	0	2	4	6
Pen torch	0	0	1	2	2	4
Respiratory timer	0	10	1	2	5	6
Speculum Vagina (Sim) set of 3	0	0	0	1	1	2
Sphygmomanometer (mercurial, tabletop)	0	0	1	2	3	6
Sponge holding forceps	0	0	1	2	2	4

ITEM DESCRIPTION	Household	Community	Outreach post	PHC Centre (Level 1)	PHC Centre (Level 2)	PHC Centre (Level 3)
Stainless covered bowl for cotton wool	0	0	1	4	6	8
Stainless instrument tray	0	0	1	2	3	5
Stethoscope	0	0	1	2	3	5
Stitch removal / suture scissors	0	0	2	2	3	5
Suction Pump	0	0	0	1	2	4
Suture kit	0	0	1	2	2	4
Tape measure	0	0	4	2	4	6
Thermometer (oral)	0	10	5	5	10	12
Thermometer (rectal)	0	10	5	5	10	12
Ultrasound scanning machine	0	0	0	0	1	1
Consumables						
Blood Lancet (Pack of 100)	0	1	1	1	1	1
Cotton wool (100g)	0	1	1	1	1	1
Disodium hydrogen phosphate (NAHPO) (for buffered water)	0	0	0	1	1	1
Distilled water						
Dyes (stain powder) :	0	0	0	0	1	1
Elastic Band	0	1	1	1	1	1
Ethanol (ethyl alcohol), 70%, 95%,100% (absolute)	0	0	0	0	1	1
Ether, anaesthesia or technical grade, or ethyl acetate	0	0	0	0	1	1
Eye goggles	0	0	1	1	1	1
Face masks (pack of 100)	0	0	1	1	1	1
Formalin (formaldehyde)	0	0	0	0	1	1
Gauze bandage (4.5cm x4.5cm)	0	0	3	5	10	15
Glacial acetic acid	0	0	0	0	1	1
Gloves disposal (packs of 50	0		2	4	4	8
Glycerol	0	0	0	0	1	1
Hep B testing kits (packs of 50	0	0	0	4	4	10
HIV test kits (packs of 50	0	1	0	4	4	10
Hydrochloric acid, concentrated (HCL)	0	0	0	0	1	1
Iodine Crystals (1)	0	0	0	0	1	1

ITEM DESCRIPTION	Household	Community	Outreach post	PHC Centre (Level 1)	PHC Centre (Level 2)	PHC Centre (Level 3)
Isopropanol (isopropyl alcohol)	0	0	0	0	1	1
LLINs	20	30	30	50	50	100
Malaria RDT kits (pack of 25)	0	2	2	4	4	8
Mercuric chloride crystals (HgCl)	0	0	0	0	1	1
Methanol (methyl alcohol)	0	0	0	0	1	1
Microcuvette for Hb 3x1/Box - 2XX	0	0	0	1	1	2
Phenol crystals (carbolic acid)	0	0	0	0	1	1
Phosphotungstic acid crystals (II,IPO(IV,O)I.511,0)	0	0	0	0	1	1
Plasters (2.5cm x5yards)	0		3	5	10	1
Plastic Apron	0			2	4	1
Polyvinyl alcohol (PVA)	0	0	0	0	1	1
Potassium dihydrogen phosphate (KH,PO) (for buffered water)	0	0	0	0	1	1
Potassium iodide crystals (KJ)	0	0	0	0	1	1
Soap/ hand sanitizers	0	0	1	2	4	1
Sodium acetate powder (CH, COONs) or sodium acetate crystals	0	0	0	0	1	1
Sodium chlorine (NaCl)	0	0	0	0	1	1
Sodium citrate crystal (C611507Na321120)	0	0	0	0	1	1
Specimen bottles for stool and urine	0	0	0	0	100	150
Stains (solutions)	0	0	0	0	1	1
Sterile gloves (box of 100)	0	0		1	2	3
Syringes and needles, pack of 100 (2cc & 5cc)	0	0	1	4	4	6
Urine Dip stick for sugar and Albumin (Pack of 110)	0		2	10	10	15
Xylene	0	0	0	0	1	1
Lab Equipment						
Binocular Microscope	0	0	0	0	1	1
Haemoglobinometer	0	0	1	2	2	2
Test tube rack	0	0	0	0	1	1
Clinic Equipment						
Angle poised lamp	0	0	1	1	2	2

ITEM DESCRIPTION	Household	Community	Outreach post	PHC Centre (Level 1)	PHC Centre (Level 2)	PHC Centre (Level 3)
Aspirator	0	0	1	2	4	6
Autoclave	0	0	0	0	1	2
Baby dressing table for maternity	0	0	0	0	1	2
Bed pan (stainless steel)	0	0	0	3	4	6
Bed Screen	0	0	0	2	5	6
Delivery couch with stirrups	0	0	0	1	2	4
Drip stand	0	0	0	2	4	6
Examination couch	0	0	1	2	3	4
Hospital bed with mattress	0	0	0	6	10	10
Ice packs	0	0	8	8	8	10
Instrument Cabinet	0	0	0	1	1	2
Mackintosh sheet	0	0	1	2	2	4
Medicine cupboard	0	0	0	1	1	2
Nursery Cots with Mattress	0	0	0	2	2	2
Sharps bin	0	0	1	3	5	6
Stadiometer	0	0	1	1	2	3
Sterilizer (medium) 15 Litre	0	0	0	1	2	2
Sterilizing Drums (set of 3)	0	0	0	1	1	1
Trolley patient stretcher	0	0	0	0	1	2
Urinal (Female) stainless steel	0	0	0	2	4	4
Vaccine carriers	0	0	1	1	1	2
Weighing scale (Adult)	0	0	1	1	2	2
Weighing scale (Child)	0	0	1	1	3	4
Wheelchairs	0	0	0	2	4	4
Foetal stethoscope (Aluminium)	0	0	0	1	2	2
Personnel Commodities						
Personal protective equipment	0	0	2	3	5	6
Boots	0	0	2	3	5	6
Aprons and bags for CHIPS agents	0	10	0	0	0	0
Khaki jacket for CEFPs	0	2	0	0	0	0
Life jackets	0	Required in riverine areas. Quantities dependant on number of people going out				

ITEM DESCRIPTION	Household	Community	Outreach post	PHC Centre (Level 1)	PHC Centre (Level 2)	PHC Centre (Level 3)
Mobile phones	0	2	0	0	0	0
Tablet devices	0	1	1	1	1	1
General Items						
Bed sheets & pillowcase	0	0	0	12	24	24
Brooms	0	0	2	5	10	10
Bucket with Tap	0	0	1	2	3	4
Buckets (plastic)	0	0	0	4	6	6
Chairs	0	0	5	10	12	12
Dust bin (pedal) metal	0	0	3	6	6	6
Filing cabinet	0	0	0	1	3	4
Fire Extinguisher (9kg)	0	0	1	2	2	2
Generator set	0	0	0	1	1	1
Kerosene lamp	0	0	1	2	4	4
Long benches	0	0	0	8	12	12
Mop buckets	0	0	1	2	4	4
Mops	0	0	3	6	12	12
Motorcycle	0	1	0	1	1	1
Rechargeable lamp with Fluorescent	0	0	1	2	4	4
Refrigerator medium	0	0	0	1	2	2
Set of Aluminium Pot & Utensil	0	0	0	0	1	1
Small size cooking gas cylinder	0	0	0	0	1	1
Solar-powered refrigerators	0	0	0	1	1	1
Standing fan	0	0	1	4	6	6
Swivel stool	0	0	1	1	2	2
Table-top Cooker	0	0	0	0	1	1
Wall clock	0	0	1	4	6	6
Writing table and Chairs	0	0	1	2	6	6

APPENDIX 4

PHC SERVICE DELIVERY

A. Maternal Health

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Pregnancy							
Antenatal Care							
Identification, documentation and referral of pregnant women	X	X					
Counselling and health education (including nutrition in pregnancy)	X	X	X	X	X	X	
Detection and management of complications in pregnancy							
• Screening and treatment for syphilis				X	X	X	
• Screening and treatment of anaemia	X		X	X	X	X	
• Screening for diabetes	X		X	X	X	X	
• Screening for pre-eclampsia	X		X	X	X	X	
• Screening for HIV	X		X	X	X	X	
• Treatment HIV-positive pregnant women (PMTCT)					X	X	
• Detection of other health problems and treatment/referral (e.g. diabetes, TB, hypertensive diseases)			X	X	X	X	
Iron and folic acid supplementation	X		X	X	X	X	
Malaria prevention (administration of SP and provision of LLIN	X		X	X	X	X	
Diagnosis and treatment of uncomplicated malaria in pregnancy	X		X	X	X	X	
Tetanus toxoid for NTT Prevention		X	X	X	X	X	
Detection and treatment/referral of pregnancy – related complications (e.g. Pre-eclampsia/eclampsia, Antepartum			X	X	X	X	

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
haemorrhage, Pre-mature rupture of membrane, etc)							
Distribution of misoprostol to pregnant women	X		X				
Support development of birth preparedness and complication readiness plan	X	X	X	X	X	X	
Link pregnant women with Emergency Transport Service	X	X	X	X	X	X	
Distribution of Mama Kits (delivery kits)	X				X	X	
Conduct of Two abdominal ultrasound scans during pregnancy (first one before 24 weeks of gestation)					X	X	X
Promotion of male involvement	X	X	X	X	X	X	
Labour and Delivery							
Normal Labour and Delivery Services							
Monitoring of labour using Partograph					X	X	X
Active management of third stage of labour (administration of uterotonic (e.g. oxytocin, misoprostol), controlled cord traction and cord clamping)				X	X	X	X
Induction of labour for prolonged pregnancy					X	X	X
Basic Emergency Obstetrics Care							
Induction of labour to manage prelabour rupture of membranes at term					X	X	X
Management of Eclampsia by parenteral administration of Magnesium Sulphate/other anticonvulsants					X	X	X
Management of puerperal Sepsis by parenteral administration of antibiotics					X	X	X
Assisted vaginal delivery					X	X	X
Management off retained placenta through manual removal					X	X	X
Removal of retained products through Manual Vacuum Aspiration					X	X	X
Administration of rectal misoprostol for PPH	X				X	X	X

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
and referral							
Management of PPH by administration of Parenteral oxytocics				X	X	X	X
Pneumatic anti-shock garments for haemorrhage					X	X	
Pre-referral management of labour complications					X	X	X
C-section and management of other labour complications							X
Blood Transfusion							X
Corticosteroids to prevent respiratory distress in newborns in pre-term delivery							X
Postpartum Care (Mothers)							
Postnatal preventative and curative care (including 6 visits)	X		X	X	X	X	X
Health education - breast and nipple care	X		X	X	X	X	X
Prevent and treat anaemia				X	X	X	X
Detect and treat /refer health problems (mastitis, sepsis etc)	X		X	X	X		
Maternal and Perinatal Death Surveillance and Response		X	X	X	X	X	X

A. Child Health

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
New born Care							
Essential New born Care							
Basic resuscitation					X	X	
Clean delivery and cord care, including administration of chlorhexidine for cord care	X			X	X	X	
Ensure early initiation of breastfeeding	X				X	X	
Thermal protection (prompt drying, delayed bathing and keeping babies clean, dry and warm)	X				X	X	
Kangaroo mother care for low birth weight	X	X	X	X	X	X	X
Care of preterm	X			X	X	X	X
Erythromycin ointment for prophylactic eye care					X	X	X
Detection and management of bacterial infection in newborn							
Emergency new born care							
Comprehensive management of new-born sepsis (parental antibiotic and supportive care)							X
Management of neonatal sepsis with antibiotics (oral) where referral is not possible	X		X	X	X	X	
Early detection and treatment of jaundice	X			X	X	X	X
Prophylactic administration of Vitamin K1 administration to prevent haemolytic diseases of the new-born					X	X	X
Identification and referral of neonatal complications							X
Management of HIV exposed new born							
Nevirapine prophylaxis for HIV exposed new born					X	X	X
PCR at 6weeks							X
Cotrimoxazole prophylaxis for HIV positive child					X	X	X
Birth Registration		X			X	X	
Nutrition							
Promote Infant and Young Children Feeding (IYCF)							

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Ensure Early initiation of breast feeding	X	X	X	X	X	X	
Promote exclusive breastfeeding in first 6months	X	X	X	X	X	X	
Promote adequate complimentary feeding from 6 months, ensuring diversification	X	X	X	X	X	X	
Promote continued breastfeeding up to 24 months	X	X	X	X	X	X	
Vitamin A supplementation			X	X	X	X	
Multiple Micronutrients Powder (MMP) supplementation	X		X	X	X	X	
Growth monitoring	X		X	X	X	X	
Nutrition education and Food demonstration	X	X	X	X	X	X	
Deworming	X		X	X	X	X	
Detection and management of Severe Acute Malnutrition							
Screening for malnutrition	X	X	X	X	X	X	
Detection of acute severe malnutrition	X		X	X	X	X	
Community management of acute malnutrition (including distribution of Ready to Use Therapeutic Food (RUTF)					X	X	
Prevention and Treatment of common childhood Illness							
Prevention, diagnosis and treatment of malaria							
Distribution Long-lasting insecticide net (LLIN) for use by under-fives		X	X	X	X	X	
Diagnosis and treatment of uncomplicated malaria			X	X	X	X	
Management of complicated malaria						X	X
Amodiaquine plus sulfadoxine-pyrimethamine (AQ+SP) chemoprevention for malaria			X	X	X	X	
Detection and management of diarrhoea							
Treatment of diarrhoea with ORS and Zinc			X	X	X	X	
Treatment of severe diarrhoea with IV fluids					X	X	X
Detection and treatment of pneumonia							
Detection of pneumonia and treatment with dispersible amoxicillin			X	X	X	X	X

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Management of severe pneumonia						X	X
Detection and treatment of other childhood illnesses							
Detection and management of other respiratory tract conditions (asthma)				X	X	X	X
Antibiotics for dysentery				X	X	X	
Detection and treatment of topical infections							
Treatment of severe measles					X	X	X
Screening for sickle cell disease					x	x	X
Identification and reporting of Acute Flaccid Paralysis (AFP)	X	X	X	X	X	X	X
Immunization							
Provision of childhood immunizations							
Identification, listing, reconciliation and referral of children in need of immunization	X	X	X				
Health education and counselling on RI	X	X	X	X	X	X	
Routine immunization (BCG, OPV, IPV, Penta, MCV 1 and 2, YF, PCV, MenA, Hep B)			X	X	X	X	X
Monitoring, management, reporting and referral of adverse events after immunisation	X		X	X	X	X	X
Vaccine uptake reconciliation		X	X	X	X	X	
Defaulter tracking	X	X	X	X	X	X	X

B. School Health

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
School health services							
School feeding		X					
Deworming		X					
TT and HPV vaccines to adolescent girls		X					
Monitoring growth and development		X					
Screening for disabilities		X					
Treatment of minor aliments		X					

C. Adolescent Health

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	primary Health Centre (level 3)	Referral
Comprehensive sexual and reproductive health services							
Prevention of unwanted pregnancies							
Health education and counselling	X	X	X	X	X	X	
Provision of contraceptive services, including emergency contraception to sexually active adolescents)	X	X	X	X	X	X	X
Prevention and treatment of anaemia in adolescents							
Health education and counselling	X	X	X	X	X	X	
Albendazole, Iron and Folic Acid supplementation	X	X	X	X	X	X	
Prevention and management of Sexually transmitted infections							
Health education and counselling (including motivational counselling)	X	X	X	X	X	X	
Immunizations (HPV, Td, HepB)					X	X	
Screening and treatment of Sexually transmitted infections					X	X	
Menstrual hygiene promotion	X	X	X	X	X	X	-
Health education and counselling	X	X	X	X	X	X	
Prevention and management of substance abuse and other mental health conditions							
Health education and counselling	X	X	X	X	X	X	
Screening for alcohol, drug use and internet addiction	X	X	X	X	X	X	
Screening for mental health issues (e.g., depression, self-harm, anxiety, anorexia, etc)	X	X	X	X	X	X	
Prevention and management of rape and other gender-based violence							

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	primary Health Centre (level 3)	Referral
Health education and counselling	X	X	X	X	X	X	
Screening for STIs and Provision of Post-Exposure Prophylaxis	X	X	X	X	X	X	

D. Sexual and Reproductive Health

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Provision of sexual and Reproductive health services							
Family planning							
Health education and counselling	X	X	X	X	X	X	X
Provision of contraceptives	X	X	X	X	X	X	X
Management of side effects of contraceptives					X	X	X
Post abortion Care					X	X	X
Health education and counselling	X	X	X	X	X	X	X
Manual vacuum aspiration					X	X	
Prophylactic antibiotic following MVA					X	X	X
Pre-referral treatment for post-abortal sepsis					X	X	
Management of post-abortal sepsis						X	X
Education, detection, and management of gender-based violence	X	X	X	X	X	X	
Prevention, detection, and treatment of STIs	X	X	X	X	X	X	

E. Communicable Diseases

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Malaria							
Prevention and treatment of malaria							
Health education and counselling including the use of protective clothing, repellents, etc.	X	X	X	X	X	X	
Long lasting Insecticide treated nets, especially for pregnant women and children aged less than 5 years	X	X	X	X	X	X	
Indoor Residual Spraying	X						
Intermittent Preventive Therapy for pregnant women	X			X	X	X	
Seasonal chemoprevention with SP for under-fives in 9 Sahel States	X		X	X	X	X	
Parasitological diagnosis of malaria (RDT)	X		X	X	X	X	
Parasitological diagnosis of malaria (microscopy)					X	X	
Treatment of uncomplicated malaria with ACT	X		X	X	X	X	
Pre-referral treatment of complicated or severe malaria	X		X	X	X	X	X
Treatment of complicated malaria							X
Hepatitis							
Prevention and management of hepatitis							
Health education and counselling	X	X	X	X	X	X	
Immunization				X	X	X	
Screening of high-risk groups (referral of Hepatitis-positive persons)			X	X	X	X	X
Immunization of high-risk groups (health workers)					X	X	X
Screening and diagnosis of chronic Hepatitis infection					X	X	X

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Treatment of chronic Hepatitis infection (with interferon or lamivudine (3TC)/tenofovir (TDF)/emtricitabine (FTC)							X
Tuberculosis/Leprosy							
Prevention and management of Tuberculosis							
Health education and counselling							
Tuberculosis case detection	X	X	X	X	X	X	X
Microscopic diagnosis of TB					X	X	X
Treatment of TB					X	X	X
Contact tracing for TB	X	X	X	X	X	X	X
Diagnosis (with GeneXpert) and treatment of MDR-TB					X	X	X
Prevention and management of leprosy							
Health education and counselling							
Leprosy case detection	X	X	X	X	X	X	X
Diagnosis of leprosy							X
Treatment of leprosy with MDT							X
Management of Leprosy complications and rehabilitation							X
HIV/AIDS							
Prevention and control of HIV/AIDS							
Health education	X	X	X	X	X	X	X
HIV testing and counselling	X	X	X	X	X	X	X
Treatment of all HIV positive people with HAART					X	X	X
Condom distribution	X	X	X	X	X	X	
Prevention of mother-to-child transmission services					X	X	X
Early infant diagnosis							X
Chemoprophylaxis for HIV positive persons (cotrimoxazole)					X	X	X
Monitoring treatment (CD4)							X
Screening of HIV-positive people for TB and referral of positive cases					X	X	X

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Treatment of opportunistic infection					X	X	X
Home-based care	X						
Neglected Tropical Diseases							
Diseases: Schistosomiasis, soil-transmitted helminthic infections (STH), lymphathic filariasis, onchocerciasis, leishmaniasis, yaws, Buruli ulcer, scabies, trachoma, etc							
Integrated vector control							
Health education including the use of protective clothing, repellents etc.	X	X	X				
Indoor residual spraying	X						
LLIN	X	X	X	X	X	X	
Outdoor spraying	X	X					
Larviciding	X	X					
Environmental control measures	X	X					
Periodic mass/targeted Preventive chemotherapy	X	X					
Case management of NTDs							
Albendazole for soil transmitted helminths	X	X	X	X	X	X	
Detect and treat schistosomiasis					X	X	
Detect and treat lymphatic filariasis with Ivermectin or diethylcarbamazine for					X	X	
Detect and treat onchocerciasis with ivermectin					X	X	
Prevent, diagnose and treat trachoma Water and Sanitation (WASH) interventions	X	X	X	X	X	X	
Treatment of snake bites with polyvalent anti-snake venom					X	X	X
Rabies post-exposure vaccination					X	X	X

F. Non-Communicable Diseases

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Cardiovascular diseases (coronary heart disease, cerebrovascular disease, peripheral artery disease, rheumatic heart disease, congenital heart disease, deep vein thrombosis and pulmonary embolism							
Prevention and management of cardiovascular diseases							
Health promotion on lifestyle modification for cardiovascular diseases	X	X	X	X	X	X	X
Screening for risk factors of cardiovascular disease and referral	X	X	X	X	X	X	X
Assessment of Body Mass Index (BMI) for overweight and obesity, counselling, and support services	X	X	X	X	X	X	X
Detection and referral of CVD				X	X	X	X
Rehabilitation and long-term care	X			X	X	X	X
Hypertension							
Health promotion on lifestyle modification for hypertension	X	X	X	X	X	X	
Screening for hypertension	X	X	X	X	X	X	X
Treatment of hypertension					X	X	X
Monitoring of adherence to treatment	X		X	X	X	X	X
Detection and referral of complications							
Diabetes							
Health promotion on lifestyle modification for diabetes	X	X	X	X	X	X	
Screening for diabetes and risk factors	X	X	X	X	X	X	
Assessment of BMI for overweight and obesity, counselling and support services	X	X	X	X	X	X	
Diagnosis and management of diabetes					X	X	X
Detection and management of diabetic complications and rehabilitation					X	X	X
Monitoring of adherence to treatment	X		X	X	X	X	X

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Chronic Respiratory diseases							
Health education and promotion	X	X	X	X	X	X	
Diagnosis and management of Asthma and COPD					X	X	X
Management of complications of Asthma and COPD							X
Rehabilitation	X		X	X	X	X	
Screening for Endocrine diseases							
Screening for goitre			X	X	X	X	X
Cancers							
Prevention and control of Cancers							
Health education and lifestyle modification for all cancers	X	X	X	X	X	X	X
Radiotherapeutic, chemotherapeutic and surgical cancer services for all cancers							X
Prevention and management of Cancer of the Cervix							
Human Papilloma Vaccine for cervical cancer					X	X	X
Visual inspection of cervix with acetic acid					X	X	X
PAP smears for cervical cancer screening							X
Diagnosis and treatment services							X
Management of Cancer of the breast							
Breast self-examination	X	X	X	X	X	X	X
Mammography to screen for breast cancer							X
Diagnosis and Treatment of breast cancer							X
Prevention and management of Cancer of the liver							
HbV vaccination			X	X	X	X	
Diagnosis and treatment services							X
Management of Cancer of the prostrate							

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Screening using PSA							X
Diagnosis and treatment of cancer of the prostrate							X
Prevention and management of Sickle Cell Disease							
Health education and counselling							
Genetic counselling for general population	X	X	X	X	X	X	
Genotype profiling					X	X	
Provision of analgesics	X		X	X	X	X	
Folic acid supplements and malaria prophylaxis			X	X	X	X	
Diagnosis and management of SSD complications						X	X
Promotion and management of Oral Health							
Oral health education and promotion (proper dental hygiene, nutrition and diet education, alcohol and tobacco reduction etc)	X	X	X	X	X	X	
Regular dental check-up					X	X	
Preventive dental services (e.g. scaling and polishing of teeth, preventive restorations and use of pit and fissure sealants for dental caries)							X
Restorative and orthodontic treatment							X
Diagnosis and treatment of dental diseases					X	X	X
Management of Mental Health Issues (Including substance abuse)							
Health Education and promotion on mental health	X	X	X	X	X	X	X
Promote mental health literacy (in collaboration with other sectors)		X					
Provide community-based youth mental health care services that combines mental health, alcohol and other substances	X	X					

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Community-based mental health care services by lay workers	X	X					
Provision of primary mental health care services							
• Identify mental illness (e.g. Depression and dementia)			X	X	X	X	
• Provision of basic medication and psychosocial interventions			X	X	X	X	
• referrals to specialist mental health services						X	X
Provision of Eye Health Services							
Health education on eye health promotion and disease prevention	X	X	X	X	X	X	X
Diagnosis and provision of basic eye treatment services & referrals				X	X	X	X
Medical and surgical management of eye problems in general and specialist centres							X
Care of the Elderly							
Health promotion activities for elderly	X	X	X	X	X	X	X
Home-based care and support services	X	X					
• Annual medical check-ups for elderly • Screen for nutritional problems, chronic diseases of elderly, CA prostrate, CA colon • Biannual BP checks • Appropriate referrals					X	X	X
Nutrient supplementation (e.g., calcium, Vit B, Vit C)				X	X	X	
In patient treatment services					X	X	X
Management of chronic degenerative diseases (e.g., arthritis)			X	X	X	X	
Referral for Long term care (Old people's home)						X	X

G. Emergency Medical Services

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Management of medical emergencies							
Health promotion and education on accident and Injury, and violence prevention	X	X	X	X	X	X	X
Pre-hospital care (first aid) and management of minor ailments, accidents and Injuries	X		X	X	X	X	
Evacuation (Emergency transportation and first aid by first responders)		X			X	X	X
OPD Emergency hospital care services (triage, Initial Evaluation, Diagnosis & Resuscitation and In-Hospital Care)					X	X	X
Emergency Unit management: Initial Assessment & Resuscitation, Monitoring and Revaluation, Detailed Assessment, Diagnostic Studies, Additional Therapeutics					X	X	X
In -patient care - treatment, surgery and critical care							X
Rehabilitation e.g., physiotherapy	X	X			X	X	X

I. Public Health Emergencies (including Outbreaks Response)

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Management of Public Health Emergencies							
Mitigation							
Information, education, risk communication and disaster preparedness	X	X	X	X	X	X	
Emergency planning							
Stockpile and preposition health supplies					X	X	X
Strengthen surveillance and monitoring of potential hazards to health, including public health laboratory		X		X	X	X	X
Emergency response							
Provide triage, immediate emergency first aid and evacuation services including ambulance services with first responders				X	X	X	X
Triage- emergency medical and surgical services					X	X	X
Pre-hospital care (first aid) and management of minor accidents	X	X	X				
Provide appropriate patient management (surgical and medical) services							X
Provide primary care services		X					
Food and nutrition support services		X			X	X	
Immunizations		X			X	X	
Environmental sanitation services (water, sanitation and disposal of the dead)		X			X	X	
Reproductive and sexual health services		X			X	X	
Psychosocial support services		X			X	X	X
Infection prevention and control					X	X	X
Outbreak response							
Detection of outbreaks (cholera, CSM,	X	X	X	X	X	X	

Lassa, Yellow Fever, Viral Haemorrhagic fever, etc)							
Confirmation of diagnosis					X	X	X
Confirmation of outbreaks					X	X	X
Communication of outbreaks					X	X	X
Investigation of outbreaks					X	X	X
Management of cases	X	X	X	X	X	X	X
Interrupt transmission (health education, vector management, etc)	X	X	X	X	X	X	X
Institute primary prevention (chemoprophylaxis, personal protection)	X	X	X	X	X	X	X
Strengthen surveillance	X	X	X	X	X	X	X

J. Health Promotion

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Health Promotion Services							
Provision of Health Promotion Services							
Promotion of healthy living behaviour and harm reduction (exercise, diet, tobacco use, alcohol, rest, social activities etc.)	X	X	X	X	X	X	X
Development, production and dissemination of IEC on various relevant health issues	X	X	X	X	X	X	X
Provision of segmented behavioural change communication	X	X	X	X	X	X	X
Provision of well women and men clinical services and other services screening for obesity, hypertension, cancer of the cervix, cancer of the prostrate, diabetes, etc.);	X	X	X	X	X	X	X
Promotion of physical activity; exercises, yoga, massage	X	X	X	X	X	X	X
Creation of demand for uptake of health promotive and preventive services	X	X	X	X	X	X	
Promotion of age appropriate healthy eating habits	X	X	X	X	X	X	X

K. Social Determinants of Health (water, sanitation, medical waste management)

Intervention	Household	Community	Health Outreach Post	Primary Health Centre (Level 1)	Primary Health Centre (level 2)	Primary Health Centre (level 3)	Referral
Food Safety and Hygiene Services							
Promotion and monitoring of food safety and hygiene							
Provision of public education and enlightenment on variety of safe foods to meet dietary needs, correct methods of food handling, preparation, consumption, importance of food security and proper nutrition.	X	X	X	X	X	X	X
Training and monitoring of the activities of food vendors and handlers		X			X	X	X
Bi-annual medical examination of food handlers, including screening for typhoid and hepatitis) and issue medical certificate of fitness		X			X	X	X
Inspection, control and regulation of food markets and abattoirs, restaurants and other places of sales of foods to the public, including surveillance		X					
Mobilization of community structures, including Ward development Committees for safe and hygienic nutrition-related activities, from production to consumption		X					
Establishment of early warning system that has the capacity to detect, trace and prevent outbreak of food borne illnesses before they spread		X					
Water and Sanitation Services							
Public education on sanitation	X	X	X	X	X	X	
Promotion of proper hand washing techniques	X	X	X	X	X	X	
Community sensitization on safe water and health risks of unwholesome water	X	X	X	X	X	X	
Provision of tippy tap points	X	X					

Environment, chemical products and medical waste Services							
Promotion of public health education on health impacts of climate change	X	X	X	X	X	X	
Safe disposal of medical waste according to National guidelines	X		X	X	X	X	
Promotion of public education on poisoning	X	X	X	X	X	X	
Poisons surveillance and reporting	X	X	X	X	X	X	
Management of acute and chronic poisoning conditions					X	X	X
Promotion of chemical hazards education	X	X	X	X	X	X	
Promotion of occupational health education and safety	X	X	X	X	X	X	

APPENDIX 5
INDIVIDUAL STAFF APPRAISAL FORM

	Individual Performance Evaluation for Health Staff					
	Criteria	**25% Score**	**50% Score**	**100% Score**	**Max**	**Score**
1	**Professional Awareness includes the following: (20 points)**					
	Timeliness	Arrived frequently late *(at the least four times past month)*	Arrived sometimes late *(1 to 3 times per month)*	Was always on time	8	
	Availability	Has been frequently absent from his/her service without any clear motive (*at the least four times past month*)	Has been a few times absent from his service without clear motive *(1 to 3 times per month)*	Was never absent from his/her service without known and valid motive	8	
	Uniform	Did not wear a uniform during working hours *(even once per month)*	Neglected uniform *(dirty, torn or not ironed)*	Uniform always worn and properly (*washed, ironed and not torn*)	4	
2	**Team spirit includes the following: (30 points)**					
	Interpersonal Relationship	Frequently in conflict with colleagues *(reported more than once to his/her superior during the past month)*	Sometimes in conflict with colleagues *(reported once to his/her superior)*	Never in conflict with colleagues	8	
	Collaborative spirit	Frequently refused to assist colleagues when asked *(more than once per month)*	Sometimes refused to assist colleagues (*even once*)	Never refused to assist colleagues	8	
	Dedication	Frequently left work unfinished without somebody taking over under the argument that official working hours were up *(more than 3 times past month)*	Sometimes left work unfinished without somebody taking overusing the argument that official working hours were up (*1 to 3 times per month*)	Never left work unfinished without somebody taking over	8	
	Initiative	Has never done any additional work	Has always awaited a command from higher up to carry	Has at least once done additional	6	

	Individual Performance Evaluation for Health Staff					
	Criteria	**25% Score**	**50% Score**	**100% Score**	**Max**	**Score**
			out additional work	work without supervisor asking him/her to do so.		
3	**Technical Competency and flexibility during work: (40 points)**					
	Organization	Never has a daily work schedule *(assessed during internal work supervision)*	Not always has a daily work schedule (*at least once during internal supervision*)	Always has a daily work schedule	10	
	Quality of work	Never adheres to specific work-related norms and standards (*assessed during internal supervision*)	Not always adheres to work related norms and standards (*found at least once during internal supervision*)	Always adheres to specific work-related norms and standards	14	
	Quantity of work	Never finishes his/her daily work based on his/her own daily work schedule (*assessed during internal supervision*)	Not always finishes his/her work based on his/her own daily work schedule (*found at least once during internal supervision*)	Always finishes his/her work according to his/her daily work schedule.	16	
4	**Willingness and aptitude for personal development: (10 points)**					
	Considers advice and recommendations from previous internal and external supervisory visits	Never takes care of such recommendations *(concluded during internal and external supervisory visits)*	Not always takes care of such recommendations (*if this happens once or more*)	Always considers recommendations of internal and external supervisory visits	10	
				TOTAL POINTS	100	
5	**Participation to Results and the Past Monthly Performance Score**					
	Participation to Results and the past month's performance score (quantity and quality) through presence during working days during the past month.			Number of official working days = (N);	100%	P =
	NB: We consider **actual working days without considering, any valid reasons for absence** such as vacation, leave, sickness, absence through disciplinary action, formal trainings etc. An exception to this rule is Rest and Recuperation days			number of days worked = (n);		

	Individual Performance Evaluation for Health Staff					
	Criteria	**25% Score**	**50% Score**	**100% Score**	**Max**	**Score**
	(allocated by the health facility management), which, when accorded, are considered official working days.					
	Percentage of days performed = (P)			**(P) = (n/N) * 100**		
Result of the individual monthly performance evaluation = (Total of the Scores for items 1 to 4) * P						

APPENDIX 6

HEALTH COMMODITIES – ESSENTIAL MEDICINES LIST

ESSENTIAL MEDICINES LIST								
SN	**NAME OF DRUGS**	**DESCRIPTION**	**FORMULATION**	**PRIMARY HEALTH CENTRE LEVEL 3**	**PHC CENTRE LEVEL 2**	**PRIMARY HEALTH CARE CENTRES LEVEL 1**	**PRIMARY HEALTH POSTS**	**HOUSEHOLD LEVEL**
1	**ANAESTHETICS (LOCAL)**							
1.1	Lidocaine	Injection Topical,	**Injection:** 1%, 2% + epinephrine (adrenaline) 1:200,000, vial	X	X	X		
			Cream or ointment: 2 - 5%		X			
			Gel or solution: 2 - 4%		X			
2	**ANALGESICS**							
	Acetylsalicylic Acid*	Tablet		X	X	X		
2.1	Ibuprofen	**C**apsule Tablet,	**Capsule/tablet:** 200 mg and 400 mg	X		X	X	
2.2	Paracetamol	Oral liquid, tablet, suppository	**Oral liquid**:125 mg/5 Ml	X	X	X	X	X
			Suppository:100 mg					
			Tablet:125mg,500 mg					X
			Injection:150 mg/mL					

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
	*Not for children, use with caution in adults							
3	ANTI-ALLERGICS							
3.1	Chlorphenamine	Oral liquid, tablet	**Table**t: 2mg	X		X		
3.2	Hydrocortisone	Tablet, Injection vial, cream	**Table**t: 5mg, 10mg, 20mg **Powder for Injection**: 100mg, 250mg,500mg, 1g **Cream**: 1%	X		X		
3.3	Promethazine	Tablet, oral liquid, Injection	**Table**t: 12.5mg, 25mg **Oral suspension**: 25mg/ml,50mg/5ml,50mg/ml, 6.25mg/ml25mg/25ml **Injection**: 25mg/ml	X		X		
4	ANTICONVULSANTS							
4.1	Diazepam**	Injection	**Injection:** 5 mg/mL in 2-mL ampoule	X		X		
4.2	Paraldehyde	Injection	**Injection: 5ml, 10 ml**					
4.3	Phenobarbital**	Tablet	**Tablet:** 15 mg, 30 mg, 60 mg	X		X		
			**Use with extra caution					

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
5	**ANTIDOTES/ANTIVENOM**							
5.1	Atropine	Injection	**Injection:** (sulphate), 1 mg in 1-mL ampoule 0.6mg in 1-ml ampoule	X		X		
5.2	Charcoal (activated)	Powder	**Tablet:** 1 g **Powder/granules:** 5 g sachet	X		X		
5.3	Polyvalent anti snake venom			X				
6	**ANTIHYPERTENSIVE MEDICINES**							
6.1	Amlodipine	Tablet	**Tablet:** 5 mg,10mg	X				
6.2	Amiloride	Tablet	**Tablet:**5mg, 10mg					
6.3	Amiloride + hydrochlorothiazide	Tablet	**Tablet:**5mg, 10mg	X				
6.4	Hydrochlorothiazide	Tablet	**Tablet :**25mg, 50mg,100m**g** **50mg/5ml**	X				
7	**ANTI-DIABETIC MEDICINES**							
7.1	Metformin	Tablet	Tablet 250mg, 500mg	X				
7.2	Glibenclamide	Tablet	Tablet 5mg	X				

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
		* Not for children						
8	ANTI-INFECTIVE MEDICINES							
8.1	*Antibacterial medicines*							
8.1.1	Amoxicillin	Capsule, dry powder for suspension, dispersible tablets	**Capsule:** (trihydrate),250mg; 500 mg	X	X	X	X	
			Dispersible tablet: 125mg, 250 mg		X			X
			Injection: (sodium salt),500 mg, vial **Powder for oral liquid:** (trihydrate), 125 mg/5 mL					
8.1.2	Ampicillin	Capsule, Injection	**Capsule** 250mg, 500mg **Injection:** Powder for Injection 1g	X		X	X	
8.1.3	Azithromycin	Tablet, Powder for Oral Suspension	**Tablet** 500mg, Oral Suspension	X		X		
8.1.4	Benzathine Penicillin	Injection	**Injection powder**: equivalent to 720 mg (1.2 million units) Vial	X		X		

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
8.1.5	Benzyl penicillin	Injection	**Injection powder:** (sodium or potassium salt), 600 mg (1 million units)	X		X		
8.1.6	Ciprofloxacin	Tablet	**Tablet 500mg** **Ear drop 0.2% + hydrocortisone 1.0%**	X		X		
8.1.7	Co-trimoxazole	Tablet, oral liquid	**Oral liquid:** sulfamethoxazole 200 mg + trimethoprim 40 mg/5 mL	X		X		
8.1.8	Ceftriazone 1g	Injection	1 g /2ml vial	X				
8.9	Cefpodoxime	Tablet, Suspension	**Tablet**:10mg, 200mg, 300mg, 400mg **Suspension**:40mg/5ml	X		X	X	
8.1.10	Doxycycline	Tablet	Tablet 100mg	X		X		

ESSENTIAL MEDICINES LIST								
SN	**NAME OF DRUGS**	**DESCRIPTION**	**FORMULATION**	**PRIMARY HEALTH CENTRE LEVEL 3**	**PHC CENTRE LEVEL 2**	**PRIMARY HEALTH CARE CENTRES LEVEL 1**	**PRIMARY HEALTH POSTS**	**HOUSEHOLD LEVEL**
8.1.11	Erythromycin	Tablet, suspension	**Capsule/tablet, enteric/film-coated:** (stearate or ethyl succinate), 250 mg, 500mg	X				
			Injection powder: (lactobionate), 500 mg , vial	X				
			Oral liquid: (stearate or ethyl succinate),125 mg/5 mL	X				
8.1.12	Gentamicin	Injection	**Injection:** (Sulphate), 40mg/ml in 2ml ampoule	X				
8.1.13	Nitrofurantoin	Tablet	**Tablet:** 50 mg, 100 mg	X				
8.1.14	Nystatin	Oral drops	**Oral drops** 0.3%	X		X		
8.1.15	Ofloxacin	Tablet/Capsule/ oral solution/ear drops	**Tablet/capsule** 200mg, 300mg, 400mg **Oral solution** 40mg/ml, 20mg/ml,4mg/ml	X				

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
			Ear drop 0.3%					
8.1.16	Phenoxymethylpenicillin	Tablet	**Powder for oral liquid 250mg / 5ml (Potassium)**	X	X			
8.1.17	Penicillin	Ointment	**Ointment** **5% ointment**	X				
8.1.18	Tetracycline * Chlortetracycline	Capsule/topical	**Capsule:** tablet, (hydrochloride), 250 mg 5% ointment	X				
8.1.19	Sulfamethoxazole + trimethoprim	Tablet	**Tablet:** sulfamethoxazole 400 mg+ trimethoprim 80 mg	X		X		
9	***Amoebicidal***							
9.1	Metronidazole	Tablet, syrup	**Tablet:** 200 mg, 400 mg Syrup : 200mg/5ml	X		X		
10	***Antihelminthics***							
10.1	Albendazole	Oral liquid, tablet	**Oral liquid:** 100 mg/5 mL **Tablet:** 200 mg	X		X		

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
10.2	Praziquantel	Tablet	**Tablet: 600mg**					
10.3	Pyrantel pamoate	Oral liquid, tablet	**Oral liquid:** 50mg/ml **Tablet**: 180mg (pamoate)	X				
11	***Antifilarial***							
11.1	Diethylcarbamazine	Tablet	**Tablet:** 50 mg	X				
11.2	Ivermectin	Tablet	**Tablet:** 3 mg, 6 mg	X				
	Antiretroviral drugs#							
12	***Antimalarials***							
12.1	Artemether + lumefantrine	Oral liquid, tablet	**Tablet:** 20 mg + 120 mg **Oral** :15/5ml, 3mg/ml	X		X	X	
12.2	Artesunate	Injection, Suppositories	**Injection: 60 mg/ml** **Suppositories**: 100mg	X				
	Artemisinin	Injection	**Injection** : 150mg/ml					
12.3	Artesunate + amodiaquine	Tablet	**Tablet:** 25 mg + 67.5 mg, 50 mg+ 135 mg, 100 mg + 270 mg	X		X	X	
12.4	Quinine**	Injection	**Injection:** (dihydrochloride), 300 mg/mL in 2-mL ampoule	X				
12.5	Dihydroartemisinin+piperaquine phosphate	Tablet, Oral suspension	**Tablet: 120mg + 960 mg, 40 mg + 320 mg** **Oral suspension 80ml/ 80mg +640mg**					

ESSENTIAL MEDICINES LIST								
SN	**NAME OF DRUGS**	**DESCRIPTION**	**FORMULATION**	**PRIMARY HEALTH CENTRE LEVEL 3**	**PHC CENTRE LEVEL 2**	**PRIMARY HEALTH CARE CENTRES LEVEL 1**	**PRIMARY HEALTH POSTS**	**HOUSEHOLD LEVEL**
12.6	Pyrimethamine + sulfadoxine	Tablet, Oral liquid	**Tablet:** 25 mg + 500 mg	X		X		
13	***Anti-tuberculosis medicines***							
13.1	Ethambutol	Tablet	**Tablet:** (hydrochloride), 100 – 500 mg	X				
13.2	Isoniazid	Tablet	**Tablet:** 100 – 300 mg	X				
13.3	Pyrazinamide	Tablet	**Tablet:** 400 mg	X				
13.4	Rifabutin	Capsule, tablet	**Capsule:** 150 mg	X				
13.5	Rifampicin	Capsule, tablet	**Capsule/tablet:** 150 mg, 300 mg	X				
14	***Antileprosy***							
14.1	*Dapsone*	Tablet	**Tablet:** 100mg	X				
14.2	Clofazimine	Tablet	**Tablet** :50mg	X				
14.3	Minocycline	Tablet	**Tablet:** 50mg, 75mg, 100mg	X				
		***Not recommended for children and pregnant women**						

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
			**** Intramuscular, for pre-referral treatment only**					
			***** Use only with Quinine in first trimester of pregnancy**					
14	**ANTISEPTICS AND DISINFECTANTS**							
14.1	Benzoin	Compound tincture	Compound tincture of benzoin	X		X		
14.2	Benzyl benzoate	Emulsion	**Emulsion:** 25%				X	
14.3	Chlorhexidine	Solution/gel	**Gel:** (umbilical cord application) **Solution:** (gluconate), 5% for dilution	X		X	X	
14.4	Gentian violet							
14.5	Iodine	Solution	**Weak solution of iodine:** 1%	X		X		
14.6	Povidone iodine	Tincture	**Tincture**: 2-7%				X	
14.7	Methylated spirit	Solution	**Solution**: 10%	X		X	X	
14.8	Sodium hypochlorite	Solution	**Solution:** different prep preparations with available chlorine from 1-10%	X		X		

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
15	**DERMATOLOGICAL MEDICINES**							
15.1	Benzoic acid + salicylic acid (Whitfield's)	Ointment	**Cream/ointment** containing benzoic acid, 6% and Salicylic acid, 3%	X		X	X	
15.2	Benzoyl peroxide	Cream/gel	**Cream:** 2.5%, 5%, 10% **Gel:** 2.5%, 5%, 10%	X		X		
15.3	Benzyl benzoate	Emulsion	**Emulsion:** 25%					
15.4	Calamine lotion	Lotion	**Lotion:** Zinc oxide + 0.5% ferric oxide	X		X	X	
15.5	Gentamicin	Ointment	**Ointment:** 0.1%					
15.6	Griseofulvin	Ointment/cream	**Ointment:** 5% **Cream:** 1%					
15.7	Methyl salicylate	Ointment	**Ointment/liniment:** 4 - 20%	X		X	X	
15.8	Neomycin + Bacitracin	Ointment, powder	**Ointment:** : 5mg neomycin + 500 bacitracin zinc/g **Powder**	X				
15.9	Nystatin	Ointment, cream	**Cream: 100,000 USp unit**	X				

ESSENTIAL MEDICINES LIST								
SN	**NAME OF DRUGS**	**DESCRIPTION**	**FORMULATION**	**PRIMARY HEALTH CENTRE LEVEL 3**	**PHC CENTRE LEVEL 2**	**PRIMARY HEALTH CARE CENTRES LEVEL 1**	**PRIMARY HEALTH POSTS**	**HOUSEHOLD LEVEL**
15.9	Zinc oxide	Ointment	**Cream: 100g**	X		X		
15.10	Zinc oxide plaster	Dressing					X	
16	**MEDICINES AFFECTING THE BLOOD**							
16.1	Iron Tablets	Oral liquid, tablet	**Tablet:** 200mg **Oral suspension:** 400 unit/2ml	X		X	X	
16.2	Folic acid	Tablet	**Tablet:** 5 mg	X		X	X	
17	**DRESSINGS AND MEDICAL DEVICES**							
17.1	Absorbent gauze bandages		Dressing	X		X	X	
17.2	Cotton wool (absorbent)			X		X	X	
17.3	Disposable gloves			X		X	X	
17.4	Disposable syringes	2 mL with needles (19, 21Gauge)		X		X		
		5 mL with needles (19, 21Gauge)						
17.5	Elastic plaster dressings			X		X	X	
18	**EAR, NOSE AND THROAT MEDICINES**							
18.1	Chloramphenicol	Ear drops	**Ear drops:** 0.5%,5%	X		X		

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
		Ointment	**Ointment:** 0.1%, 1%					
18.2	Gentamicin	Eye/Ear Ointment	**Ear drops:** 0.3% **Ear Ointment:**	X	X	X	X	
19	**GASTRO-INTESTINAL MEDICINES**							
19.1	Hyoscine N-butylbromide	Tablet Oral liquid	10mg, 2Omg 1mg/ml	X		X		
19.2	Magnesium trisilicate	Compound tablet, oral liquid	**Mixture:** 250 mg/5 mL **Tablet:** 500 mg	X		X		
19.3	Oral Rehydration Salts	Low Osmolarity Oral Rehydration Salts, co-packed with Zn	**Low Osmolarity Oral Rehydration Salts, co-packed with zinc sulphate tablets:** 20.5 g ORS (sodium chloride) 2.6 g, potassium chloride 1.5 g, sodium citrate 2.9 g, dextrose 13.5 g)+ 20 mg dispersible zinc sulfate	X		X	X	
19.4	Zinc gluconate	Oral liquid, dispersible tablet	**Oral liquid**: 12g/60ml **Dispersible tablet**: 20, mg, 20mg	X		X	X	
20	**HORMONES AND SYNTHETIC SUBSTITUTES**							
20.1	Barrier methods	Male and female Condoms with or		X		X	X	

ESSENTIAL MEDICINES LIST								
SN	**NAME OF DRUGS**	**DESCRIPTION**	**FORMULATION**	**PRIMARY HEALTH CENTRE LEVEL 3**	**PHC CENTRE LEVEL 2**	**PRIMARY HEALTH CARE CENTRES LEVEL 1**	**PRIMARY HEALTH POSTS**	**HOUSEHOLD LEVEL**
		without spermicide						
20.2	IUCDs	Copper, Lipple's loop						
20.3	Implants	Levonorgestrel, Etonogestrel releasing						
20.4	Injectables	Levonorgestrel, Medroxyprogesterone acetate, Norethisterone enantate						
20.5	Ethinylestradiol + Levonorgestrel	Tablet	**Tablet:**30mcg + 150mcg	X				
21	**OPHTHALMOLOGICAL MEDICINES**							
21.1	Chloramphenicol	Eye drops, ointment	**Eye drops:** 0.5% **Eye ointment:** 1.0%	X		X		
21.2	Tetracycline	Eye ointment	Ointment: 1%	X		X		

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
22	**OXYTOCICS**							
22.1	Ergometrine	Tablet, Injection	**Injection:** (maleate), 0.5 mg/mL **Tablet:** (maleate), 500 micrograms	X		X		
22.2	Misoprostol	Tablet, vaginal tablet	**Tablet:** 200 micrograms	X		X	X	X
22.3	Oxytocin	Injection	**Injection:** 5 units, 10 units / mL in ampoules	X		X		
23	**PSYCHOTHERAPEUTIC MEDICINES**							
23.1	Chlorpromazine	Injection Oral liquid Tablet	25mg/ml in 2ml ampoule 25mg/5ml 100mg	X				
24	**RESPIRATORY AND EMMERGENCY MEDICINES**							
24.1	Adrenaline	Injection	**Injection** :1mg/ml	X				
24.2	Aminophyline	Tablet, Injection	**Tablet**: 100mg, **Injection:** 25mg/ml hydrate	X				
24.3	Beclomethasone	Inhaler	40mcg/actuation, 250mcg	X		X		
24.4	Betamethasone	Tablet, Injection	**Injection**:100mg/10ml, 4mg/ml **Soluble solution**: 5000ug	X				

ESSENTIAL MEDICINES LIST								
SN	**NAME OF DRUGS**	**DESCRIPTION**	**FORMULATION**	**PRIMARY HEALTH CENTRE LEVEL 3**	**PHC CENTRE LEVEL 2**	**PRIMARY HEALTH CARE CENTRES LEVEL 1**	**PRIMARY HEALTH POSTS**	**HOUSEHOLD LEVEL**
24.5	Dexamethasone	Tablet	**Table**t: 1mg, 4mg, 0.5mg **Injectionection**:1mg/ml, 4mg/ml, 8mg/ml, 10mg/ml	X				
24.6	Hydrocortisone	Tablet	**Tablet**: 5mg, 10mg, 20mg **Solution for Injection**:500mg/5ml **Powder for Injection**: 100mg	X				
24.7	Salbutamol	Tablet, Inhaler	Tablet: 2mg Inhaler: 100mcg/dose	X		X		
24.8	IVF	Ringer's Lactate Normal saline Dextrose saline 5% Dextrose Paediatric saline	500ml, 1L 500ml, 1L 500ml, 1L, 500ml, 1L 500ml, 1L	X				
28	**VITAMINS, MINERALS AND SUPPLEMENTS**							
28.1	Ascorbic acid (Vitamin C)	Tablet	**Oral liquid:** 100 mg/5 mL **Tablet:** 100 mg	X		X		
28.2	Calcium gluconate	Injection	**100mg/ml in 10ml ampoule**	X				
28.3	Calcium lactate	Capsule	**Capsule**: 650mg	X		X		
28.4	Vitamin A	Capsule	100,000iu, 200,000iu	X		X		
28.5	Vitamin B complex	Tablet, Injection	**Tablet:** 10/4/40/4mg/ampoule	X				

ESSENTIAL MEDICINES LIST								
SN	NAME OF DRUGS	DESCRIPTION	FORMULATION	PRIMARY HEALTH CENTRE LEVEL 3	PHC CENTRE LEVEL 2	PRIMARY HEALTH CARE CENTRES LEVEL 1	PRIMARY HEALTH POSTS	HOUSEHOLD LEVEL
			Injection: 100/2/100/2/2mg/ml					
28.6	Vit. K1 (Phytonadione) Prophylaxis for Haemorrhagic Disease of Newborn (HDN)	Injection	**Injection:** 2mg/ml	X		X		
28.7	Micronutrient powder	Sachet		X		X	X	
28.8	Ready to use therapeutic food	Sachet		X		X		
29	**MISCELLANEOUS**							
29.1	Water for Injection	Injection	**Injection:** 2 ml, 5 mL, 10 mL, 20 mL, 50-	X		X		
			ml ampoule or, vial	X		X		
29.2	**Acetic acid**	**3-5%**		X				

#List of anti-retroviral drugs

Tenofovir+Lamivudine+ Efavirenz	**Tablet:**300mg+300mg+600mg.
Tenofovir+Lamivudine+ Efavirenz	**Tablet:**300mg+300mg+400mg.
Tenofovir+Lamivudine+ Dolutegravir	**Tablet:**300mg+300mg+50mg.
Abacavir+Efavirenz+ Lamivudine	**Tablet:**600mg+300mg+600mg.
Abacavir+ Lamivudine	**Tablet:**60mg(sulfate)+30mg; 120mg(sulfate)+60 mg.
Lamivudine+Nevirapine+ Zidovudine	**Tablet:**30 mg+50mg+60mg.
Lamivudine+Nevi+Zidovudine	**Tablet:**300 mg+150 mg+200mg.
Lamivudine+Zidovudine	**Tablet:**30mg+60 mg.

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