



**NATIONAL PRIMARY HEALTH CARE DEVELOPMENT AGENCY
(NPHCDA)**

**MID-LEVEL MANAGEMENT
TRAINING (MLMT) PROGRAMME**

MLMT Curriculum Manual

MODULES 1 TO 3





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HSM
Duke Health Sector Management



FOREWORD

The global health situation is one of immense contrasts: on the one hand we have the resources and technologies to tackle many of the major causes of disease and death, and on the other hand, many health systems are weak, unresponsive and inequitable. However, at the core of these health systems is the health worker who personifies the system's core values. They are the human link between knowledge, resources and health action for results. They act as gatekeepers for effective or wasteful application of knowledge and other resources including drugs, vaccines and supplies.

Over the years the focus of most health workforce training has been on knowledge and skills for clinical care using didactic methods with little impact on the overall health system. Less attention has been paid to the more generic skills needed to make health systems work, such as management, accounting, procurement, logistics and the 'softer' managerial skills such as team building and negotiation. Therefore, developing capable, motivated and supported health workers is essential to overcoming bottlenecks to achieving national and global health goals. Quality improvements are best initiated by the health workforce itself because they are in the unique position of identifying opportunities for innovation.

Health managers and support workers constitute at least a third of the health workforce in Nigeria. Many low and middle income countries (LMICs) receiving large amounts of additional funding support to scale-up services rapidly are facing basic skill deficits in such areas as simple accounting, drug stock and store management and basic personnel management. The Mid-Level Management (MLM) training programme for primary health care (PHC) workers was conceived in a bid to address this gap. The MLM is about getting it right at the beginning, giving the right training to the right people to create an effective workforce for the delivery of health care.

The programme was conceived by the National Primary Health Care Development Agency in strong partnership with the Federal Ministry of Health, Office of the Head of Civil Service of the Federation and Centre for Management Development with technical support from Duke University, North Carolina, USA through an extremely competitive process. Funding was provided by the Office of the Senior Special Assistant to the President on MDGs. The course is six weeks long and residential with participants drawn from all 36 states and the FCT cutting across several disciplines from physicians, through nurses and midwives to community health workers and health administrators. What they have in common is strong health service

qualifications, responsibility for managing divisions, units, and programmes; and many years of PHC work experience in states and LGA PHC departments.

This training manual will be used for the MLM training for PHC workers in Nigeria. However, given the breadth of its coverage, I am persuaded that it is also relevant to other health workers in Nigeria, and also adaptable to the context of other LMICs. The MLM training programme will evidently go on to influence the overall health sector performance in Nigeria and as an Agency we are proud to be on the driving seat of this great transformation. I therefore heartily recommend this manual for the training of PHC and other health workers in Nigeria and beyond.



Dr Muhammad Ali Pate
Executive Director/CEO
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ACKNOWLEDGMENT

The National Primary Healthcare Development Agency (NPHCDA) in collaboration with key stakeholders initiated the Mid-Level Management Training programme for PHC in Nigeria as a response to the paucity of managerial skills especially at PHC level, which has been a key constraint to scaling up of services to achieve the health related MDGs.

The development of this document was made possible with the support of Federal Ministry of Health (FMOH), Office of the Head of Civil Service of the Federation (OHCSF), Centre for Management Development (CMD), and Duke University, USA.

I would like to specially thank Dr. Muhammad Ali Pate the Executive Director of NPHCDA for providing the enabling environment that ensured the success of this project.

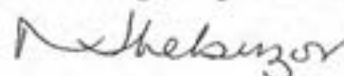
Special recognition and gratitude goes to the Senior Special Assistant to the President on MDGs Hajjia Amina Az-Zubair for providing the funding for this project.

The commitment and support of all the Directors of NPHCDA Dr EA Abanida, Dr E Odu, Dr MJ Abdullahi, Hajia AL Abubakar, Mr D Ashogbon, Alhaji Sa'ad Abdufatah; Prof O Akpala, Technical Consultant and Dr Ibrahim Umar Head of Procurement are acknowledged.

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The NPHCDA appreciates the dedication and commitment of all others who contributed in various ways to the development and production of this document.

Finally, I wish to salute the efforts of the course coordinator Dr D Malgwi for overseeing the production of this document.



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Director Community Health Services

**National Primary Health Care Development Agency (NPHCDA) of Nigeria
Mid-Level Management Training (MLMT) Programme**

MLMT CURRICULUM MANUAL (A): OVERVIEW

Prepared under the leadership of Dr. M.N. Sambo, Department of Community Medicine, Faculty of Medicine, Ahmadu Bello University, Zaria, incorporating suggestions by Professor Will Mitchell, Duke University

March 29, 2011

INTRODUCTION: This document provides an overview of the Mid-Level Management Training (MLMT) programme of the National Primary Health Care Development Agency (NPHCDA). The manual has two goals: First, to outline the philosophy of the MLMT, and second, to document a modular set of materials that programme managers and faculty can draw on when designing sessions for the MLMT.

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Companion document: “MLMT Curriculum Manual (B): Curriculum Detail”

A. OVERVIEW

The National Primary Health Care Development Agency (NPHCDA) was established by Decree No. 29 on the 26th of June, 1992, as the federal government body with oversight function for Primary Health Care (PHC) development in Nigeria. Although the NPHCDA has no direct role in the provision of PHC services, it represents the Federal Government's support to PHC through the development of human resources for PHC models, mobilization of resources, setting of standards and guidelines, supportive supervision monitoring and evaluation, and provision of immunization services, amongst other activities.

Since the advent of democratic governance in 1999, government throughout Nigeria has striven to reposition institutions and enable them effectively deliver needed social services to the populace. As part of this process, the national agenda has focused on the improvements in the health sector, with a major emphasis on primary health care. A major step in the PHC reform process was the merger of the then National Programme on Immunization (NPI) with the NPHCDA in April 2007, thus creating a unique opportunity for the delivery of PHC services in a more holistic and integrated manner. Currently, the Federal Ministry of Health (FMOH) is initiating a National Health Strategic Development Plan (NHSDP) that will help the NPHCDA actively push forward with its mission to support primary health care services and, in turn, improve health outcomes in the country.

In view of the three-tier health care system in the country and the critical need of the local government areas (LGAs) in ensuring the availability of quality health services to Nigerians, the NPHCDA initiated the Middle Level Management Training (MLMT) programme for PHC; the MLMT is a collaboration with partners from multiple entities, including the FMOH, the Office of the Head of the Civil Service of the Federation (OHCSF), OSSAP-MDGs, the Centre for Management Development (CMD), and Duke University. The programme is informed by the critical human resource constraint in Nigeria, which is particularly important at the PHC level.

The MLMT programme targets middle-level PHC Managers at state and LGA levels who are responsible for important day-to-day decisions on human resources, financing, operations, and logistics in resource constrained environments. There is evidence indicating that the lack of managerial capacity at all levels of the health system is a key constraint to scaling up services and achieving the Millennium Development Goals (*Egger D. et al., WHO working papers No 8: Managing the MDGs: The challenge of strengthening management, Geneva 2007*). The MLMT seeks to help fill that gap in capacity.

B. WHAT THE COURSE IS ABOUT

The programme has been designed as an in-service continuing professional development course, consisting of six residential periods each of one-week duration with practical on-the-job exercises and field projects spread over six to ten months of total course duration.

The training approach uses experiential methods that are adapted to adult learning. Studies and course materials have been developed using local resource persons, with some support from Duke University. Participants for the MLM are selected using set criteria based on experience and responsibilities. Graduates of the programme receive a certificate of achievement.

The course emphasizes both concepts and applications, followed by an end-of-course evaluation.

- Focused introduction and explanation of core concepts
- Practical orientation – discussion, skills stations, examples, and action learning
- Assessment based on in-course performance and a formal examination conducted at the end of the training period; a postgraduate diploma certificate will be awarded to successful candidates

C. COURSE GOAL AND OBJECTIVES

Goal: The overall goal of the MLM is to establish a health system management training programme for building management capacity of the primary health care system in Nigeria, as a catalyst to improving health outcomes and attainment of the health-related MDGs.

Objectives: The course has four specific objectives:

- To establish a primary health care management training programme
- To strengthen the technical and general management skills of frontline health managers so as to improve execution of immunization, maternal, neonatal, and child health programmes
- To develop a mechanism for coaching and mentoring practicing managers
- To develop a mechanism for evaluating the impact of health sector management programmes in Nigeria, with particular focus on PHC service delivery

D. COURSE AUDIENCE AND EXPECTED OUTCOMES

Audience: The course is targeted at mid-level managers with substantial experience and responsibilities for primary health care activities at the state and/or LGA level. Participants meet the following criteria:

- Employees of state or local government PHC departments
- Possess basic health-related qualifications, such as community health officer, midwifery/nursing certificate, university degree in medical/paramedical sciences, and/or equivalent health care professional degree or certification
- Head of a department/division/unit or programme officers
- Have at least five years work experience in Primary Health Care or Public Health departments.

Expected outcomes: The course will help participants achieve four major outcomes:

- Improve execution of assigned projects and better programme performance management (M&E)
- Align resources with priorities
- Be recognized by peers, subordinates, and supervisors as effective managers, leaders, and change agents
- Improve intermediate health outcomes such as immunization coverage, outreach services, and supervised deliveries

E. EDUCATIONAL PHILOSOPHY

The course emphasizes four primary elements of educational philosophy:

- **Instructors:** Content and context experts
 - **Session format:** Contextualization in the classroom
 - **Material sequence:** Mix of block and threaded format
 - **Fieldwork:** Inter-period assignments
1. **Instructors: Content and context experts.** Most class sessions will have two instructors, including a "content expert" with experience in management education and/or practice, and a "context expert" who has experience in primary health care practice. The content and context experts will share responsibility equally to present concepts and relevant examples, and to engage the students in meaningful applications of the ideas.
 2. **Session format: Contextualization in the classroom.** Each class session will consist of lecture, discussion, and practical skills activities. The facilitators will lead a presentation on

each session through focused lectures that outline primary concepts. The instructors will stimulate discussion that helps participants understand and apply the concepts in their own contexts by asking the participants pertinent questions and encouraging discussion among the participants. At the end of each lecture period, the facilitators will allow for additional question and answer sessions. After question and answer sessions, a practical skills session will commence. Depending on the nature of the skills session, participants are to be divided into different sub-groups to focus on a particular aspect of the session. They will select a chair and reporter, discuss relevant issues in their organizations, come up with possible ways forward to address the issues, and then present their reports to the plenary.

We expect each class session to include roughly equivalent time for classroom instruction and practical skills applications, potentially with up to 2/3 of the time allocated to practical applications. Most "classroom and skills stations" (CSS) combinations will take about a half day of instruction, with the potential for either one or two sets of CSS combinations for a given topic in a day, depending on the depth that the topic requires.

- 3. Material format: Block and/or threaded organization.** The manual is divided into six modules. Each module includes a set of related subjects, each of which includes several class topics. The modules, related subjects, and topics may be used as a "block" in a single programme period (e.g., a week-long residency that covers all the subjects in a given module) or can be "threaded" in a sequence through a series of residency periods (e.g., building understanding and depth in particular subjects by threading related sessions over a sequence of residencies).
- 4. Fieldwork (inter-period assignments).** Each residency of the course will be followed by a project in which participants apply the ideas from the residency to their home organizations. Participants will document and report on their project during the subsequent course period. Successful completion of the projects will be part of the assessment for successful completion of the course.
- 5. Site visits:** The programme intends to include site visits during residencies to local primary health care facilities and agencies. The site visits provide opportunities for participants to interact with PHC personnel at the front lines of best practices and emerging services and activities.

F. USING THIS MANUAL TO BALANCE THE “CONTENT – INSTRUCTION – PROGRAMME MANAGEMENT” TRIPOD

The underlying assumption of this approach is that a successful course requires balance on three legs of a tripod: Content, faculty, and programme management, each focused on providing instruction that is relevant to a specific audience. The manual provides a guideline to the content leg, with value for both programme managers and instructors as they seek to address participant needs.

First, programme managers can use the manual to help design the content and flow of a course and to identify the instructors that the course will need to deliver the content and flow in a way that meets the needs of a particular set of participants. The modules and components can be combined in different orders, depending on the needs of particular participants and the availability of faculty. In this programme design role, programme managers are the key focal people who need to identify participants, understand their needs, design a course that meets those needs, and identify faculty members who can deliver material in a way that reflects the course design and participant audience.

Second, instructors can use the manual to help them identify the content that the programme managers expect them to deliver during their class sessions and how their content will fit within the broader context of the course. In most or all cases, the programme managers will identify instructors who have extensive conceptual and practical experience, who will teach material that reflects their knowledge and experience. Hence, the manual is primarily a guideline for course content and for identifying faculty members who are capable of teaching relevant content, rather than a rote workbook from which instructors would draw their primary materials.

It is important to recognise that management is dynamic. No manual can fully capture the needs of any set of participants at a given point in time. As a result, the manual provides a base for beginning to design a course that a programme designer can adjust based on participant needs, faculty skills, and current issues in the health care environment.

G. MODULE OUTLINE: MAJOR SUBJECTS

This section summarizes the curriculum content. The “MLMT Curriculum Detail” manual describes the modules in more detail. As we described earlier, programme managers can organise these modules and components in different orders, depending on the experience of the participants. Here, we outline a general sequence and describe the relationship of components of the modules to major management topics.

For convenience, the manual includes six modules of material. Each module includes multiple related subjects, with a total of about 24 subjects distributed across the six modules. In turn, each subject includes multiple topics of related material. Any given class session can include material from one or more topics within a subject.

Module 1: Policy and Planning

- Subject 1.1 Policy Development for Health Service Delivery
- Subject 1.2 Public Sector Reform and National Health Initiatives
- Subject 1.3 Primary Health Care Structures and Functions
- Subject 1.4 Principles of Planning and Project Management in Health Care
- Subject 1.5 Monitoring and Evaluation in Health Care

Module 2: Health Care Financing and Health Economics

- Subject 2.1 Health Care Financing in Nigeria
- Subject 2.2 Economic Evaluation in Health Care
- Subject 2.3 Effective Financial Management Systems in PHC

Module 3: Leadership and Management

- Subject 3.1 Team Building
- Subject 3.2 Effective Motivational Leadership
- Subject 3.3 Human Resource Management
- Subject 3.4 Supportive Supervision in PHC

Module 4: Communication, Decision Making, Advocacy, and Partnership

- Subject 4.1 Communication Skills
- Subject 4.2 Decision Making
- Subject 4.3 Advocacy and Negotiation
- Subject 4.4 Partnership Development

Module 5: Health Care Delivery

- Subject 5.1 Principles and Practice of Epidemiology
- Subject 5.2 Introduction to Biostatistics in Epidemiology
- Subject 5.3 Integrated PHC Delivery
- Subject 5.4 Quality in Health Care Services
- Subject 5.5 Customer Service Delivery

Module 6: Computers, HMIS, and Logistics Management

- Subject 6.1 Computer Knowledge and Applications
- Subject 6.2 Health Management Information Systems
- Subject 6.3 Logistics and Supply Management System

H. Relationship of MLMT Subjects to Major Management Topics

1. General Management Subjects

- M4 Communications
- M6 Computers
- M5 Probability and statistics
- M3 Leadership and management
- M3 Negotiations
- M1 Strategy and project management
- M2 Economics
- M2 Financial management
- M5 Service operations
- M6 Information systems
- M5 Partnerships

2. Health Care Specific Subjects

- M5 Integrated PHC delivery
- M5 Epidemiology
- M1 Health policy

I. INSTRUCTION GUIDELINES: CONTENT EXPERTS, CONTEXT EXPERTS, AND MENTORS

This section briefly sketches guidelines for faculty members and mentors. The MLMT primarily relies on faculty with relevant subject and practical experience, most of whom have substantial classroom experience. Rather than try to “direct” the teaching approach, therefore, the manual outlines the major responsibilities and approaches of the faculty members, with the assumption that faculty members are best suited to design the specific approach to each session.

Sections D and E of this manual also outline the MLMT approach to instruction and classroom organization.

“Train the Trainer (TtT)”: The MLMT plans to undertake training sessions with faculty members and mentors. The TtT sessions will introduce potential faculty – including both content and context experts – to the curriculum and instructional approach of the programme. In addition, TtT sessions for mentors will develop mentoring skills for people who will support participants during the programme and will engage with them after the programme.

Contents

11. Content experts
12. Context experts
13. Mentors

II. Guidelines for Content Experts

Content experts are faculty members who have experience teaching management and policy topics and/or have practical management experience. The role of the content experts is to identify core concepts and structure sessions to highlight the concepts and guide detailed discussion and instruction in the core concepts. Ideally, a content expert should design the flow of material through multiple sessions of the MLMT, so that topics and applications build on themselves over the course of the programme.

The content experts work in partnership with context experts, who have extensive practical experience in the relevant subject matter. Content and context experts need to coordinate their roles in the classroom before the sessions.

Focused content. The course emphasizes learning focused on a small number of concepts. Section B of the manual provides an overview of relevant topics. Faculty should draw from their teaching and practical experience to organize sessions that focus on the limited set of core ideas that will be most relevant for the participants.

Classroom sessions: Classroom sessions should reinforce the focal concepts through lecture, discussion, and practice skills sessions.

- **Contextualisation in the classroom:** The goal for each session is to combine the conceptual framework of each core topic with the practical experience of the faculty and participants, so that participants understand the relevance of each concept to their work and can apply it to their work.
- **Focused content:** Each session should emphasize only a few important concepts.
- **Definitions and examples:** Faculty members should introduce the concepts, define them, explain why they are important, and provide examples in practice. The content and context faculty members should work together at this stage of the discussion to clarify both the conceptual and practical meaning of each concept.
- **Extensive discussion:** Lectures in the sessions should be short, with as much time as possible for discussion with the participants. The best classroom sessions engage the students in providing examples, asking questions, and developing ideas.

Practical skills stations: Each classroom session should have a companion skills station in which students break out into small groups to work on practical applications of the concepts from the classroom session.

- Instructors should prepare practical questions for the group to work on that apply the concepts from the classroom discussions. Context faculty should help prepare the questions.
- In turn, the content and context faculty members should work with the groups to carry out the skills questions. In addition, experienced mentors can work with the groups to help clarify the questions and work through the applications.
- As much as possible, the skills stations should push students to apply the concepts to their own situations. Skills stations can include "homework" that participants can take back to their home organizations.

Summary points

- **Focused content:** Each session should focus on a limited number of concepts, to allow sufficient time to ensure that participants understand each concept and how it applies to their own contexts.
- **Examples:** Each session should provide multiple examples of the concepts.
- **Discussion:** Each session should engage the participants in extensive discussion of the concepts.
- **Applications:** Each session should have a practical application of the concepts, in which participants do problem sets and answer questions about the concepts.

12. Guidelines for Context Experts

Context experts are people with extensive practical experience with the management concepts that the MLMT teaches. The context experts work in partnership with the content experts in each session.

The goal for the context experts who teach in the MLMT is to help motivate and facilitate classroom discussion that brings to bear the practical aspects of the class material. Many of the context experts are staff members of the NPHCDA who have extensive field experience and provide outstanding leadership in the classroom. Other context experts have experience in public agencies, primary health care providers, and other organizations that provide highly relevant practical knowledge and insights that they can bring to the MLMT classroom. Content and context experts need to coordinate their roles in the classroom before the sessions.

One useful role for context experts is to present examples and brief case studies of their experience with relevant topics in the primary health care setting (e.g., MDGs, computers, statistics, and planning) to the class, to illustrate concepts that the content experts present. Context experts can both give examples from their own experience and help draw out examples from the students. The context examples can be verbal and/or brief written illustrations. The examples can be the basis of class discussion, both in the full session and in skills stations. In both settings, context experts can help participants bring forth their own examples.

The "context expert" activity can be both formal and informal during the class discussion.

- **Formal:** The context and content experts should plan ahead of time how they will take turns presenting material and leading discussions.
- **Informal:** It is also useful for the context experts to be able to step in with examples during discussions of the formal material that the content experts are presenting.
- **Skills stations:** Context experts play important facilitation roles for the skills stations, in which participants apply the concepts from the classroom session.

13. Guidelines for Mentors

Mentors play an active role in the MLMT.

- **Agency staff:** Zonal Coordinators (ZCs) and Zonal Technical Officers (ZTOs) from the agency help facilitate classroom sessions, particularly during applied skills stations. In doing so, the ZCs and ZTOs build relationships with participants that can then carry over into their engagement with the participants in the field.
- **Programme graduates:** In addition, programme graduates can serve as peer mentors to each other and by assisting other primary health care staff in their managerial tasks.

The section briefly outlines the skills that underlie effective mentorship.

Overview

1. **Goal: Help primary health care leaders address their management challenges.** As part of their ongoing work, agency personnel and graduates of the MLMT programme have many opportunities to serve as mentors for primary health care leaders who need assistance with their management challenges.
2. **Relevant experience:** The mentors' professional experience and participation in the MLMT management training programme provide valuable experience that will support their role as management mentors.

Management Mentorship Activities

1. **Listen and observe:** Listen as primary health care leaders explain their problems. In addition, be proactive in observing management issues and opportunities that are apparent when you work in health care facilities.
2. **Probe:** Ask probing questions of the health care leaders when they describe their problems, to seek the root causes of their problems.
3. **Connect:** Connect leaders with other people who you know have found solutions for similar challenges.
4. **Support:** Encourage leaders to make their own decisions, based on thoughtful discussion. People often know what they need to do, but need supporting encouragement to take the step to action.
5. **Advise:** Finally, provide your own advice when leaders simply cannot find solutions on their own or in partnership with other leaders.
6. **Alternate between mentoring and coaching:** Mentoring and coaching are complementary parts of the same set of activities. Mentoring focuses on content (suggesting solutions), while coaching focuses on process (encouraging a colleague to find solutions themselves). Both activities require similar skills. In either case, the mentor-coach provides expert advice in a way that has meaning for a colleague and helps the colleague to act.

Key Skills for Mentors and Mentees

Mentoring requires: Listen, summarise, advise, avoid traps

1. **Listen.**

- a. **Be silent:** When you have asked a question, say nothing more. The more penetrating the question, the more likely it is that the speaker will need a few moments to organise the reply.
 - b. **Draw out:** For instance, "Could you tell me a bit more about that?", "Why do you think that happened?"
 - c. **Seek clarification:** For instance, "I'm not sure I understand that?"
2. **Summarise.** Offering a short summary of the situation will ensure that you have really understood what is happening.
 3. **Advise.** Telling stories about what you did in similar circumstances helps to bridge from your experience to theirs. Be careful to offer advice that helps the mentee move forwards from their current level of expertise (one step at a time).
 4. **Avoid traps.**
 - a. **Leading questions:** "So that didn't work because you tried to move too quickly?"
 - b. **Making judgements:** "Well, that would never work for you!"
 - c. **Ambiguous hypotheses:** Keep it realistic.

Being mentored requires: Ask questions, delay reactions, take ownership

1. **Ask questions:** Enough for you to be clear exactly what is being suggested, or if you do not understand what different behaviour or actions might achieve. Ask open questions (e.g., "Can you say more about that?") to try to be clear in your own mind about what is being said.
2. **Delay your reaction to suggestions:** Be sure you understand what is being suggested before you adopt or reject the ideas.
3. **Take ownership.** Take ownership of the ideas. "Thank you for those ideas, I had not realised that..." If after careful consideration you think that the advice won't work, don't be afraid to say so. Your mentor is an expert, but is NOT in your situation, so may not understand everything that is happening. It is OK to refuse advice. Say something like: "I can understand why you might suggest that, however, I believe that..."

Both mentor and mentee: Detail, build, track, embrace, learn, enjoy

1. **Detail:** Focus on actions and behaviours at a good level of detail.
2. **Build:** Be prepared to pick up where the last conversation left off (take good notes) and describe actions and progress in the interim, as the basis for receiving more advice.
3. **Track:** Measure progress.
4. **Embrace missteps:** Accept that mistakes are inevitable and plan from the start how to move past these – and learn from them.
5. **Learn:** Learn from each other.
6. **Enjoy each other:** Have good conversations, be open, and have fun!

National Primary Health Care Development Agency (NPHCDA) Mid-Level Management Training (MLMT) Programme

MLMT CURRICULUM MANUAL

Prepared under the leadership of Dr. M. N. Sambo, Department of Community Medicine, Faculty of Medicine, Ahmadu Bello University, Zaria, incorporating suggestions from Professor Will Mitchell, Duke University

March 29, 2011

Manual purpose: This "Curriculum Detail" manual provides summary information about subjects and topics for MLMT classes. The manual has value for MLMT programme managers, faculty members, and participants.

- **Programme managers:** Programme managers (PMs) can use the manual to identify topics and content for class sessions, as well as help to identify relevant instructors from the network of experienced content and context experts that the MLMT draws on for faculty members. When designing a programme, PMs can decide which subjects and topic from which modules to include at different points in the curriculum.
- **Faculty members:** Faculty members can use the manual to identify expected content and outcomes of their sessions.
- **Participants:** Participants can use the manual as a resource to supplement their classroom instruction.

We stress that the curriculum detail manual provides background for faculty, staff, and participant activity, rather than a rote instruction and learning document. PMs and faculty members have the responsibility to determine the appropriate flow and specific content of the overall programme and of individual classroom sessions. The manual supplements the instructors' knowledge of their subject, providing suggested topics rather than specific detail for the sessions. In turn, participants have the responsibility to apply the material to their own contexts.

This manual supplements "MLMT Curriculum Manual (A): Overview", which describes the format and philosophy of the programme from the point of view of MLMT programme managers and faculty members.

Manual structure: For convenience, the manual includes six modules of material.

- Each module includes multiple related subjects, with a total of about 24 subjects distributed across the six modules. Each subject outlines its aim and objectives, plus learning outcomes that identify key knowledge that students should master by the end of sessions that teach material from the subject.
- In turn, each subject includes multiple topics of related material, including major items and issues, together with examples of skills stations that instructors might adopt or adapt when they are teaching material on the topic. Any given class session can include material from one or more topics within a subject.

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TOPIC SUMMARY WITHIN SUBJECTS

Module 1: Policy and Planning

Subject 1.1 Policy Development for Health Service Delivery

- T1. Definitional issues in policy
- T2. Policy formulation and implementation
- T3. Historical perspectives of policies in Nigeria
- T4. National health policies and ancillary policies

Subject 1.2 Public Sector Reform and National Health Initiatives

- T1. Millennium Development Goals (MDGs) a catalyst for public sector reform
- T2. Public sector reform implementation; lesson learned and next steps
- T3. Health components of the 7-Point Agenda & Vision 20:2020
- T4. The national health sector reform programme
- T5. National strategic health development plan

Subject 1.3 Primary Health Care Structures and Functions

- T1. Historical perspective of PHC in Nigeria
- T2. Principles and Components of PHC
- T3. Structures and Functions of PHC at Federal Level
- T4. Structures and Functions of PHC at State Level
- T5. The Ward Health System
- T6. The minimum Health Care Package

Subject 1.4 Principles of Planning and Project Management in Health Care

- T1. Overview of planning process
- T2. Strategic planning
- T3. Micro-planning
- T4. Project management

Subject 1.5 Monitoring and Evaluation in Health Care

- T1. Overview
- T2. Data quality, indicators, and targets
- T3. Practical application of probability and statistics in PHC (note: Section 5.2, Introduction to Biostatistics in Epidemiology, has a complementary review of basic statistics)

Module 2: Health Care Financing and Health Economics

Subject 2.1 Health Care Financing in Nigeria

- T1. Health care financing options for PHC
- T2. The National Health Insurance Scheme
- T3. Community health care financing option
- T4. Contemporary issues on health care financing

Subject 2.2 Economic Evaluation in Health Care

- T1. Introduction to the uses, methods, and approaches of economic evaluation
- T2. Cost analysis in health care
- T3. Cost effectiveness analysis
- T4. Cost benefit analysis
- T5. Cost utility analysis

Subject 2.3 Effective Financial Management Systems in PHC

- T1. Fundamentals of financial management systems in PHC
- T2. Strategies for reducing and controlling costs in PHC
- T3. Budgeting and expenditure tracking in PHC

Module 3: Leadership and Management

Subject 3.1 Team Building

Subject 3.2 Effective Motivational Leadership

Subject 3.3 Human Resource Management.

- T1. Overview and implementation of strategies for HRM framework.
- T2. Talent management and succession planning
- T3. Recruitment and career progression
- T4. Fundamentals and toolkits for strategic negotiations
- T5. Staff motivation reward systems and sanctions
- T6. Performance evaluation and staff appraisal.
- T7. Overview of strategic human resources management concepts and principles

Subject 3.4 Supportive Supervision in PHC

T1. Introduction

T2. Supervisory styles/methods

T3. Supportive supervision in primary health care

MODULE 1. POLICY AND PLANNING

Subjects

Subject 1.1 Policy Development for Health Service Delivery

Subject 1.2 Public Sector Reform and National Health Initiatives

Subject 1.3 Primary Health Care Structures and Functions

Subject 1.4 Principles of Planning and Project Management in Health Care

Subject 1.5 Monitoring and Evaluation in Health Care

Subject 1.1 Policy Development for Health Service Delivery

Aim: To help participants appreciate the critical role of policy development and implementation in PHC.

Objectives:

- To promote participants' understanding of policy formulation processes
- To acquaint participants on the historical evolution of health policy development
- To enhance leadership for effective management or staff succession
- To enable participants to acquire skills on how to overcome challenges of policy implementation in PHC

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the primary policy initiatives that affect health care in the country
- Know how the initiatives affect their work
- Be able to incorporate the initiatives into their planning and operational activities

Topics:

- T1. Definitional issues in policy
- T2. Policy formulation and implementation
- T3. Historical perspectives of policies in Nigeria
- T4. National health policies and ancillary policies

Policy Topic 1: Definitional Issues in Policy

Definitions

- A policy is a set of clear statements and decisions defining priorities and main directions for attaining a goal.
- Policy is a process of making important organisational decisions, including the identification of different alternatives such as programmes or spending priorities, and choosing among them on the basis of the impact they will have. Policies can be understood as political, management, financial, and administrative mechanisms arranged to reach explicit goals.
- Health policy is a set of clear statements and decisions defining priorities and main directions for improving health and health care in a country.
- Health Policy is intended to be a vehicle for the exploration and discussion of health policy issues and is aimed in particular at enhancing communication between health policy researchers, legislators, decision-makers, and professionals concerned with developing, implementing, and analysing health policy.

Characteristics of Good Policy

- Policies must be clear.
- Policies should be concise and precise.
- They should be general enough to remain valid for a considerable period of time and yet be specific enough to clearly indicate policymakers' aims and priorities.
- A good policy gives a broad agenda and framework for action .
- A good policy provides direction without unduly limiting implementers.
- It is important that a policy be made available as a written document with official status adhered to by high authorities.

Focus of Policy

- Policy is concerned with what is to be done (content).
- It gives a vision on how to solve health problems.
- It gives a ground for planning implementation strategies.
- It creates uniformity and focus in health development.
- It enhances processes for monitoring and evaluation of strategies for accomplishing policy goals.
- Having a health policy further assists authorities with decision-making.
- A policy can indicate a preference for supporting community-based health care.
- Clearly stated policy will help to attract donor support and strengthen the position of government in the face of individual donor agenda.
- Policy development
- Completely revised in line with developments and changing circumstances locally in countries and internationally.

Determinants of policy: Policy is determined by:

- How the agenda was formulated
- How it defines the problems
- What solutions it offers
- Whether midlevel technocrats and bureaucrats who are responsible for translating policy into programmes were involved in the formulation of the agenda

- How well advocacy, facts, and evidence-based information were used to influence decision makers and other stakeholders
- Political climate
- Availability and mobilisation of resources required to achieve the desired policy outcomes

Policy Topic 2: Policy formulation and implementation

Policymaking process

- Policymaking is: 'the process by which governments translate their political vision into programmes and actions to deliver "outcomes" – desired changes in the real world'.
- Public policies are developed by officials within government institutions to address public issues through the political process.
- When it comes to creating public policy, policymakers are faced with two distinct situations.
 - The first situation, and the ideal one, is for policymakers to jointly identify a desirable future condition and then create policies and take actions to move towards that desired future state, monitoring progress to allow for necessary adjustments.
 - The alternative, and less desirable, situation occurs when policymakers are unable to reach consensus regarding a desirable future condition. In this later instance, policymakers try instead to move away from present situations judged as undesirable, even though no consensus exists about the preferred alternative.

Guidance for policymakers

Ideally, policymakers are guided by core principles. For example:

- Politicians and public servants are **accountable** to the public.
- The **elite**, in politics and the private sector, do not have the right to pursue their interests without constraints.
- Government bureaucratic and decision processes must be open, accessible, and **transparent**, as well as being responsive to public concerns.
- Individuals and communities affected by projects have the **right to information** regarding proposed developments; they have the right to challenge the need for, and the design of, projects and the right to be involved in planning and decision-making processes.

There are three stages in the policymaking process:

- The formulation stage
- The implementation stage
- The feedback and/or evaluation stage

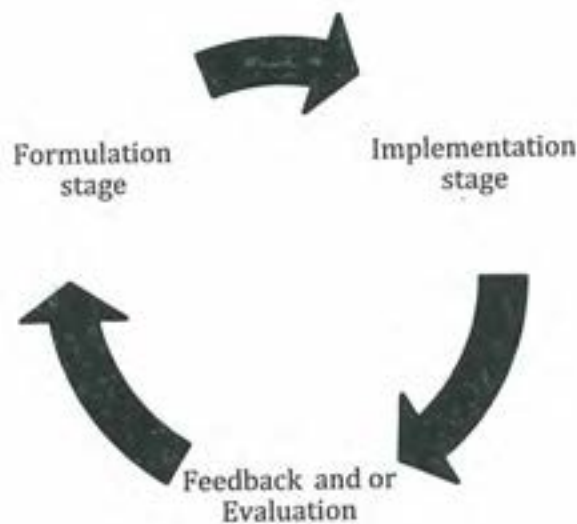


Figure 2: the policymaking process cycle

The formulation stage

This is a stage where government or policy actors take decision as to what to be done, and how it is to be achieved.



The steps in policy formulation

Classical steps in the formulation:

- Problem is identified
- Goals, value, objectives are defined
- List all possible options for achieving the goals
- Analyse the consequence of each option
- Compare the consequence of each option with the goals
- Choose the policy that best fits your goals

The implementation stage

- The implementation stage is the process of interaction between setting policies and actions geared towards achieving them.
- It involves translation of goals and objectives of the policy or choice into concrete achievement through various programmes. Policy implementation is regarded as programme implementation.
- For policy to be implemented, the following are necessary:
 - Institutional arrangement to implement the policy
 - The institutional commitment to implement the policy
 - The capacity of the institution to implement the policy
 - The resources to implement the policy

The feedback and evaluation stage

- This is the stage of comparison between the intended outcome of policy and actual achievements on the basis of experience gained during the implementation stage.
- Evaluation means the ability to locate mistakes and to remedy those errors to avoid serious or adverse consequence.
- Feedback means any information about the impact of present and past policy choices to make new decisions about policy.

Policy Topic 3: Historical perspective of health policies in Nigeria

Before 1988 there was no comprehensive document regarded as National Health Policy. Most of the decisions and direction of health care programmes were encapsulated in the development Plans.

- **First ten-year development plan for development and welfare 1946-1956**
 - The Walter-Harkness Plan (1946-1956) was the first attempt to officially plan for development of health services in the country.
 - It was conceived as a modest framework which the population should be able to maintain financially and which would be capable of being developed gradually into something approaching the real needs of the country.
 - The Plan however did not live its full course. A new constitution was adopted in 1952 which divided the country into three regions and transferred some of the powers of the Colonial government to elected Regional Representatives who were Nigerians.
- **Regional health plans in the period 1952-1962**
 - The first regional policy paper on health was produced by the then-Government of Western Nigeria. The Governments of the Northern and Eastern Regions also produced their health programmes between 1952 and 1962.
 - They were mostly noncommittal on those new issues introduced by the Government of the Western Region. The Federal Minister of Health tried without success in 1963 to introduce the Health Insurance Scheme in Lagos.
- **The Six-Year National Development Plan 1962-1968**
 - This was jointly produced by all the governments of the Federation in 1962 for the period 1962-1968.
 - This was the first post-independence development plan.
- **The Second National Development Plan 1970-1974**
 - The health plan formulated in the second National Development Plan of the Government of the Federation of Nigeria had the main objective to improve health outcomes in the country.
 - Restoration of the health facilities and services which were destroyed during the civil war
- **The Third National Development Plan 1975-1980**
 - Basic Health Services Scheme (BHSS): The Basic Health Services Scheme was the strategy formulated for achieving the objective of improving health outcomes in Nigeria, but it failed to achieve most of its targets.
 - However, some progress was made in the development of health facilities and intermediate manpower training.
- **The Fourth National Development Plan 1981-1985:** The fourth plan continued the previous efforts.
- **The National Health Policy 1988**
 - This was the first time a National Health Policy predicated on the Alma-Ata declaration of 1978 which promoted "health for all by the year 2000"
 - The key elements of the NHP include:
 - National Health Care Systems.
 - National Health Strategy
 - National Health Information System
 - National Health System Management
 - National Health Manpower Development
 - National Health Technology

- National Health Research
- National Health Care Financing
- **The National Health Policy 1996**
 - Primary Health Care as the cornerstone of the Nigerian Health System and the strategic objectives has remained the same.
 - It should be mentioned that the 1996 revision was not formally endorsed (by the National Council on Health and FEC) while the 2004 revision was endorsed and published.
- **The Revised National Health Policy 2004**
 - In line with the health sector reform agenda, the National Health Policy was revised in 2004. The elements of this policy include:
 - The National Health Systems and Management
 - National Health Care Resources
 - The National Health Interventions
 - National Health Information System
 - Fostering Partnership for Health Development
 - National Health Research
 - National Health Care Laws

Policy Topic 4: Nigerian health policy and ancillary policies

Introduction: The overall objective of a national health policy is to improve accessibility of the population to primary health care as well as to secondary and tertiary care.

- The Nigerian *National Health Policy* identified primary health care (PHC) as the main focus for delivering an effective, efficient, quality, accessible, and affordable health services to a wider proportion of the population through four approaches:
 - Promotion of community participation in planning, management, monitoring, and evaluation of the local government health system, i.e., the PHC system,
 - Improved inter-sectoral collaboration in primary care delivery,
 - Enhancing functional integration at all levels of the health system, and
 - Strengthening of the managerial process for health development at all levels.
- This reviewed National Health Policy recognised the Local Government Area as the operational level for primary health care implementation.
- In a bid to institutionalise PHC services and ensure sustainability, a decree was promulgated in 1992 (*Decree No 29*) establishing a National Primary Health Care Development Agency (NPHCDA). This Agency has a mandate to:
 - Periodically monitor and evaluate the National Health Policy, especially as it relates to primary health care,
 - Mobilise resources nationally and internationally for the development of PHC, and
 - Most importantly, provide technical support, co-ordinate and develop strategies for the effective implementation of PHC nation-wide.
- Despite these developments, the desired outcomes of this policy have not been fully realised.
- An attempt to develop and implement a National Plan of Action for Implementing a District (LGA) Minimum Health Care Package for the plan period of 1995 to 2000 was constrained by low level of political commitment at all levels of government.
- In an attempt to improve access to health care, the NPHCDA has reviewed the flaws in the present primary health care system and developed a ward health system through which a minimum health care package would be delivered.

Challenges of implementing the health policies

There were numerous challenges identified as responsible for the variable levels of implementation of the policies. They include, but are not limited to, the following:

- The policies are
 - Fragmented and too many for a period of just over 25 years
 - Reactive rather than proactive
 - Some are not aligned to other national policies
 - Not integrated into a document
 - Not disseminated to stakeholders
 - In some programmes several sub-policies are developed, e.g., reproductive health

Subject 1.2: Public Sector Reform and National Health Initiatives

Aim: To expose the participants on contemporary issues of public sector reform and National Health initiatives.

Objectives:

- To facilitate understanding of participants of Millennium Development Goals, a catalyst for public sector reform
- To enhance participants' understanding of public sector reform and 7-point Agenda
- To facilitate participants' understanding of strategic thrust of health sector reform
- To facilitate understanding of the participants on National Strategic Health Development Plan

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the most important current public sector development initiatives
- Know how the initiatives relate to health and PHC development
- Be able to incorporate the initiatives in achieving PHC goals and targets within the scope of their responsibilities

Topics:

- T1. Millennium Development Goals (MDGs) a catalyst for public sector reform
- T2. Public sector reform implementation; lesson learned and next steps
- T3. Health components of the 7-Point Agenda and Vision 20:2020
- T4. The national health sector reform programme
- T5. National strategic health development plan

Public Sector Topic 1: Millennium Development Goals – a catalyst for public sector reform

- Preamble
 - At the Millennium Summit in September 2000, the largest gathering of world leaders in history adopted the Millennium Declaration, committing their nations to reduce poverty; improve health; and promote peace, human rights, and environmental sustainability – as they all relate to the following points.
 - Transparency and accountability
 - Weak health systems at the three tiers of government
 - Inadequate funding for the health sector: funding decreased between 1996 and 2006 from 7.1% to 3.5%, far below the 15% agreed upon by Africa union heads of governments at the Abuja 2001 declaration
 - Lack of adequate human resource in the sector
 - Weak managerial capacity to carry out basic functions
 - The Millennium Development Goals (MDGs) are a set of eight time-bound, interdependent Goals that set out to commit specific outcomes by 2015. It is in essence a global compact between developed and developing nations.
 - Specifically, the MDGs aim to reduce poverty, reduce child and maternal mortality, ensure access to basic education, empower women, combat HIV/AIDS and other diseases, ensure access to potable water and protect the environment, and address debt, trade, and aid. African countries need to make the most progress if they are to meet these Goals.
- The Millennium Development Goals:

The MDGs are the world's time-bound (2015) set of eight Goals that address extreme poverty in its many dimensions. They include:

1. Poverty reduction	5. HIV/AIDS & Malaria
2. UPE	6. Child mortality
3. Gender equality	7. Maternal mortality
4. Environment	8. Global partnerships
- African leaders have adopted the MDGs as a tool within their wider development-planning framework in order to urgently address poverty, hunger, joblessness, diseases, lack of shelter, gender inequality, and environmental decline.
- MDGs: An International Commitment to Human Development
 - Contained in the 8 goals, 18 targets, and 48 indicators are a number of previous declarations, as well as regional, national, and international initiatives.
 - The MDGs are endorsed by over 180 member states of the UN General Assembly.
- The MDGs are not a "one size fits all" solution to the development challenges of any specific country; it only works to kick-start a development that takes into account linkages between different sectors and need.
- In Africa:
 - The MDGs provide a new impetus to reverse the deterioration in human development evident especially since the major economic crises of the 1980s.
 - Also a platform to accelerate human development and facilitate the gradual but effective integration of the developing world, particularly Africa, into the global economy
- Nigerian Experience-Debt relief Gains (DRG):

- \$1bn released as saving from the Paris Club Debt Deal in 2005, \$750m to FGN, and \$250m States.
 - DRGs set aside within FGN Budget framework and Virtual Poverty Fund Concept used.
 - Emphasis on additionality, scale, and results on the ground.
 - Must illustrate to Nigerians the transparent use of spend through a robust Monitoring and Evaluation Framework that Millennium Development Goals used as an entry point to focus spending.
 - MDG midpoint assessment report for Nigeria illustrated the risk of not achieving the MDGs by 2015 unless investments increased at all levels
 - The Debt Relief Gains (DRGs) fully integrated into the Federal Budget
 - MDG-related MDAs allocated these resources to scale up interventions
 - Conditional Grants to States – to 18 states and FCT in 2007, and to 35 states in 2008
 - Monitoring and Evaluation mechanism in place
 - MDG costing gap identified
- What we have done so far?
 - Mr. President put in place leadership and platform for implementation of the DRG under his direct supervision. (SSAP MDGs and PC MDGs)
 - DRG was integrated into budget cycle 2006-09
 - MDAs steering committee/task teams set up
 - Core Team includes both government and International Development Partners (IDP's)
 - National Committee for CGS under the Hon. Minister of Finance
 - Robust M&E framework (OPEN)
 - A Few Successes
 - OPEN fully integrated into two budgets 06/07
 - Disbursement of conditional grants to 19 states in 2007, and 35 states in 2008
 - M&E Baseline Diagnostic Study
 - M&E field initiative outsourced to CS & consultants
 - MDG committee in the NASS
 - 'Quick wins' projects in all senatorial and federal constituencies
 - Health-specific achievements:
 - 2006
 - 166 new PHCs built
 - 207 PHCs rehabilitated nationwide
 - 400,000 ITNs procured and distributed
 - Over 1 million doses of ACTs and 2m doses of SPs provided
 - 79,000 doses of antiretroviral drugs procured
 - Rehabilitation and equipping of 12 FMC EMOC units
 - 2007
 - Construction and equipping of 111 PHCs
 - Capacity building of PHCs workers
 - Institutional strengthening of NPHCDA
 - Procurement of SPs, ACTs, and ITN
 - 80,000 doses of ARVs procured
 - Increased the proportion of one-year-olds fully immunised

- 2008
 - Free maternal and child health care for 700,000 pregnant women and under-5 children in Oyo, Bayelsa, Imo, Sokoto, Niger, and Gombe states
 - Procurement of 1.25m ARVs, 62m doses of vaccines for routine/supplemental immunisation, 6.7m doses of anti-malarials (ACTs and SPs), and 1.5m long-lasting insecticide-treated nets
 - Procurement of 3,320 midwifery kits
 - Rehabilitation of TB and Leprosy centre in Orji River, NTBL Zaria, leprosy centre, Sokoto
 - Procurement and installation of equipment for NBTS centre in Katsina, which has been functional since Nov. 2008
- 2009
 - Capacity building for the sector in collaboration with OHCOSF and NPHCDA
 - Human resources for health sector through MSS
 - Free maternal and child health care for 500,000 pregnant women and under-5 children in Ondo, Cross River, Katsina, Yobe, Bauchi, and Jigawa states
 - Procurement of ARVs, vaccines for routine/supplemental immunisation
 - Procurement of midwifery kits and mama kits under the MSS programme
 - Health systems strengthening
- Nigeria's progress towards achieving the MDGs
 - Past mid-point to the 2015 target, there are prospects that the MDGs would be met in areas of universal primary education, HIV/AIDS, environmental sustainability, and building of global partnership for development.
 - For the reduction of child mortality and maternal health, the task is still daunting, though still achievable, but not without extraordinary effort
 - Mid-point progress report
 - Goal – Reduce child mortality
 - The emerging trend in child mortality is of great concern:
 - The infant mortality rate actually rose from 81/1000 live births in 2000 to 110/1000 in 2005/06, which is farther away from the global target of 30/1000 live births by 2015.
 - Under-5 mortality increased from 184 per 1000 live births in 2000 to 201 per 1000 live births in 2007.
 - Reported cases of WPV rose from 201 in 2007 to 651 in 2008.
 - Goal – Improve maternal health
 - Major challenge for Nigeria
 - Slightly past midway, MMR should be 440/100,000 live births, but reality is that in rural areas, it was 828 deaths/100,000 live births and 531 deaths/100,000 live births in urban areas. The target is less than 75 live births per 100,000 by 2015.
 - Goal – Combat HIV/AIDS, malaria, and other diseases
 - Decline in prevalence rate of HIV/AIDS from 5/100 in 2003 to 4/100 in 2005
 - Decline in prevalence rate amongst pregnant women from 6/100 in 2003 to 4/100 in 2005

- Prevalence rate of malaria declined from 2,024 per 100,000 in 2000 to 1,158 per 100,000 in 2004
 - TB remains a public health problem. Although incidence declined from 16 per 100,000 in 2000 to 7 per 100,000 in 2004, as of 2007, Nigeria remained among the 22 high-burden countries in the world, one of the highest in Africa.
- Challenges:
 - Good governance is key to attainment of all MDGs
 - Inadequate harmonisation of donor support for the sector
 - Lack of in-country capacity to locally produce vaccines
 - Poor state of infrastructure
 - Insufficient monitoring and evaluation of programmes
- Getting Nigeria on track on the health MDGs
 - Nigeria can still attain the health MDGs within the broader social, economic, and environmental issues, through:
 - Health systems strengthening, particularly at the PHC level for effective strategies for child and maternal health
 - Financing; a strengthened health system will require additional funding
 - Bilateral donors, international financial institutions
 - Increased allocation to health sector
 - Domestic resource mobilisation: PHC fund, etc.
- Getting Nigeria on track
 - Availability of appropriate human resources, particularly at the PHC level
 - Repositioning the PHC systems
 - Equitable and functional health systems
 - Scaling up technical dimensions, including priority settings
 - Effective referral linkages
 - A massive scaling up of public investment
 - Infrastructural development
 - Capacity building
 - Information systems must be strengthened to be appropriate, accurate, and timely

Conclusion

- The health-related MDGs, particularly those of child mortality and maternal health, are attainable in Nigeria, but not without extraordinary efforts.
- The technical interventions for achieving these goals exist; all that is required is the implementation at a scale and in a manner that will reach those who need them most.

Public Sector Topic 2: Public sector reform implementation – lessons learned and next steps

Background

- Articulated on the basis of findings of a diagnostic studies of eight (8) MDAs by the Office of the Civil Service of the Federation (OHCSF)
- Deployed for implementation in pilot MDAs restructuring between 2003 and 2007.
- Pilot speculated to be implemented for about 6–9 months with:
 - Lessons learned at pilot-level implementation to be utilised to revise the strategy within the framework of that methodology
 - Elements of the strategy that worked to be scaled up
- Those that do not work to be fed back into the strategic planning process for redesign in consonance with the strategy's overarching principle of continuous learning and incremental improvement
- Since 2003, reforms have been the federal government's principal policy. The present administration has affirmed its commitment to the policy.

Scope of the reforms: The Reform agenda is wide-ranging and includes areas such as:

- Economic reforms:
 - Privatisation
 - Commercialisation
 - Deregulation of the economy
 - Introduction of public-private partnership
 - Removal of subsidies
 - Public debt management, etc.
- Governance reforms:
 - Anti-corruption
 - Procurement (due process) reform
 - Devolution of functions to other tiers
- Public service reforms:
 - Budget and financial management reform
 - Civil service (Institutional) reform
 - Reform of parastatals
- Sectoral reforms
 - Health system reform
 - Banking consolidation
 - Ports reform
 - Statistical system reform

Institutional framework for the reforms

- National Council on Reforms (NCR): Chaired by the President
- Steering Committee on Reforms (SCR): Chaired by the Minister of Finance
- Sub-committees of SCR:
 - The Economic Team
 - The Governance Team
 - The Public Service Team

Implementation of the reform

- Public service reforms was implemented at three levels:
 - Pilot MDAs reforms

- Service-wide reforms
- Sector-specific reforms
- Implementation between 2003 and 2007 resulted in modest achievements in the areas of:
 - Rightsizing and elimination of ghost workers – underpinned by the introduction and implementation of the Integrated Payroll and Personnel Information System (IPPIS) in 6 pilot MDAs,
 - Monetisation of fringe benefits,
 - Introduction of a consolidated salary structure and pay adjustment,
 - The introduction of contributory pensions system,
 - Establishment of SERVICOM,
 - Introduction of a Fiscal Responsibility Act,
 - The Public Procurement Act, and
 - A new national statistical system

Reform implementation: Lessons from the pilots

- DFID in 2007 conducted an assessment of the Pilot MDAs to document lessons learnt for up-scaling. Deepening and up-scaling the reform requires:
 - Better guidelines
 - Attending to BPSR capacity building needs
 - Information sharing on lessons learned
 - Integrated approach with SERVICOM
 - Linking performance plans to the long-term strategic and budgetary processes
 - De-personalising the reform process
 - Alignment of HR management with the reformed financial management/budget system
 - Introduction of objective performance management system

Things that should be done differently are:

- Better planning with well thought-through integrated approach to implementation
- Communication and stakeholders buy-in
- More emphasis on the 'people' component of reform; their attitudes, their support
- Change management incorporated into design
- Emphasis on training and re-training on an ongoing basis
- A commensurate pay system
- Improvement of staff welfare/work environment
- Appropriate funding and fulfillment of government's obligations
- The importance of rules to encourage resourceful rather being imprisoned by them

National Strategy for Public Service Reforms (NSPSR)

- There has been a lull in further implementation of PSRP with the exit of the last administration. This is partly due to the need to address some of the issues identified from the assessment of 2003-2007 reform activities and also wait for the policy direction of the present administration.
- Against this background, the Bureau partnered with DFID to get the reform process back on track, incorporating lessons learnt from the 2003 PSRP implementation.

- DFID provided the BPSR and Inter Ministerial Technical Team (IMTT) of senior public servants with technical assistance that has helped to deliver the National Strategy for Public Service Reform (NSPSR).
- The development of a long-term National Strategy For Public Service Reforms (NSPSR) was considered a priority by the then Yar'Adua administration because the nation's development objectives cannot be achieved without a vibrant public service.
- NSPSR: Long-term strategic thrust
 - Critical place of Public Service Reform (PSR) in the pursuit of Nigeria's development goals is underscored in the current Administration's Seven-Point Agenda.
 - Among the strategic objectives of the Agenda is the achievement of quality public service delivery through accelerated implementation of, among others, an e-Government project and civil service reforms.
 - NEEDS 2 postulate that 'a professional and results-oriented public service' is one of the five critical success factors in the national pursuit of Vision 20-2020.
 - In this regard, it adds that "achieving the goal of economic transformation depends on how effectively the public service discharges its catalytic role."

Highlights of the NSPSR

- NSPSR – Objectives and pillars
 - The National Strategy for Public Service Reform (NSPSR) provides a common vision and a long-term agenda to guide the rebuilding and transformation of the federal public service.
 - The ultimate objective is to have a world-class public service for achieving Nigeria's Vision 20-2020 – to become one of the 20 leading economies in the world by 2020
 - On the basis of the Development and objectives stipulated above, four pillars of the strategy are:
 - Pillar One: Creating An Enabling Governance and Institutional Environment
 - Pillar Two: An Enabling Socio-economic environment
 - Pillar Three: Public Financial Management Reform
 - Pillar Four: Civil Service Administration Reform
 - NB: It is important to stress that there are significant linkages within and across these pillars even as implementation responsibilities lie with different MDAs
 - NSPSR has three distinct phases:
 - A rebuilding phase (2009-2011)
 - A transformation phase (2012-2015)
 - The final phase that is expected to lead to a world-class public service status (2016-2020).

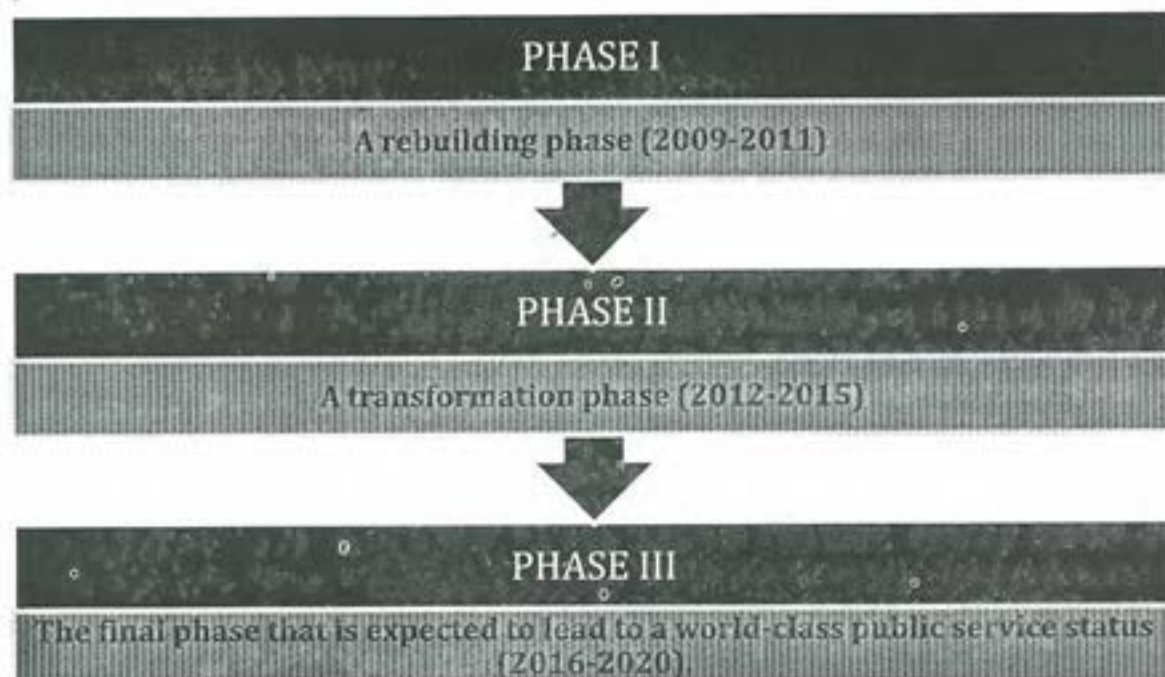


Fig. 1: the phases of NSPSR

Highlight of implementation activities across the 4 Pillars

- Getting the basics and on-going reforms right
- Review of laws that are anti-Federal and restoring proper inter-tier relations in service delivery
- Installing a robust system for policy research, M&E for reporting on development outcomes
- Proper policy and legal frameworks for PPPs
- Instituting a programme/performance-based budgeting system within improved classification aligned to priorities
- Strengthening MTSS/MTEF for predictable and sustainable funding
- Civil service specific next step actions – Getting the basics right: Not a question of best practice; rather, what works for Nigeria
- Building on our strengths and opportunities and minimising avoidable risks
- Better planning, phasing and sequencing to ensure sustainability and avoidable system's disruption
- Build on on-going reform efforts
- Target system improvement and capacity development to support the vision 20: 2020/7-point Agenda

Public Sector Topic 3: The Vision 20:2020 and health components of the 7-point Agenda

Introduction

- The 7-Point Agenda is the driving force of the present administration's policies and programmes. It is the seven priority areas of focus. The government will be judged by the achievements in these seven key areas.
- It is a medium-term policy-based plan (2007-2011).

The seven points are as listed below:

1. Critical Infrastructure: Power and Transport (Rail Transportation, Road Transportation, Marine Transportation, Inter-Modal Transportation, Telecommunication)
2. Niger Delta Development
3. Food Security (Agriculture)
4. Human Capital Development: Health and Education
5. Land Tenure Changes and Home Ownership
6. National Security & Intelligence
7. Wealth Creation

Issues and challenges in the health sector

- Health outcomes in Nigeria lag behind others countries at similar stages of development
- The country's dismal health system is ranked 191 out of 201 in the comity of nations (WHO)
- Life expectancy is estimated at 45 years for males and 46 years for females.
- Infant mortality rate is 260 deaths/1000 live birth in the North West and North East – one of the highest in the world, compared to 180/1000 in other parts of Nigeria
- Maternal mortality in Kano is 2,400/100,000
- About 2.6 million or 4.4% of 15-49-year-olds are living with HIV/AIDS
- Size and diversity of the country
- Stewardship – weak governance system, especially at the LG level, that is responsible for PHC. Each tier has its responsibility and coordination is difficult.
- Service delivery: HCS are fragmented, skewed in distribution, limited in coverage, poor in quality, weak in referral system, and have a dearth of resources.
- Resource generation: There is a dearth of all resources for the health sector – drugs, infrastructure, equipment, and human resources, including scarcity in the number, distribution, mix, and motivation of health care providers
- Health care financing: The health sector is poorly funded in Nigeria. For example, Malaysia and Brazil spend 11 and 20 times (respectively) more on health than Nigeria does.

7-Point Agenda: Proposed policy options

- Develop pro-poor public health expenditure programmes:
 - The need to improve targeting of pro-poor health needs
 - Pro-poor health programme targets are immunisation, antenatal care, malaria treatment, emergency obstetrics care, surgery, etc.
 - State and local governments that translate commitments to pro-poor health spending are to be rewarded through an incentive mechanism set up by the FGN

- Capacity mobilisation:
 - Train community volunteers to manage logistics of vaccine and drug supplies and delivery of mosquito bed nets, freeing up trained nurses and doctors for other needs
 - Retired teachers, civil servants, and local business people could assist to spread health promotion messages
- Systematic engagement with private sector on infrastructure and service delivery
 - Government to engage the private sector to improve the weak health infrastructure
 - Government to set standards and regulate the private sector while promoting the public mission

Vision 20:2020

- Vision: Definition
 - A mental picture of a future state of being, which is better than the present.
 - “Ability to think about or plan the future with great imagination and intelligence” (Advanced Learner’s Dictionary).
- The NV20:2020 encapsulates the collective aspirations and desires of Nigerians and what they want their country to be.
- The NV20:2020 is a ten-year economic transformation blueprint aimed at stimulating Nigeria’s economic growth and launching the country into a path of sustained and rapid socio-economic development.
- The vision articulates Nigeria’s economic growth and development strategies for ten years, spanning 2010-2020.
- For a vision to be realised there is a need for careful planning to determine how to achieve it. Such planning will produce the policies, programmes, projects, and resources required for the realisation of the vision as well as the costing of the projects and programmes.
- In this regard, government has embarked on the preparation of the First NV20:2020 Implementation Plan (2010-2013).
- The key objectives of the Vision 2020:
 - Stimulate Nigeria’s economic growth and launch the country onto a path of sustained and rapid socio-economic development
 - Place Nigeria in the bracket of top 20 largest economies of the world by the year 2020
 - Achieve a GDP of not less than \$900 billion and a per capita income of not less than \$4000 per annum by the year 2020.

Overview of health thematic area

- Currently, health care is delivered by the three tiers of government and the private sector:
 - Primary Health Care is the responsibility of the LG
 - Secondary Health Care – State Government
 - Tertiary Health Care – Federal Government
- Scope of health thematic area in the Vision 20:2020
 - Primary health system is the first level of contact of the individual, family, and community with the national health system. It is delivered in:
 - Comprehensive health centres

- Primary health centres
- Primary health clinics
- Primary health posts
- Primary health care involves the following:
 1. Health education
 2. Nutrition and food supply
 3. Immunisation
 4. Maternal and child health (including family planning)
 5. Basic sanitation and water supply
 6. Control of endemic diseases
 7. Treatment of common diseases and minor ailments
 8. Supply of essential drugs
 9. Primary mental health
 10. Primary dental health
- Secondary health care is the second level in the health care system. The services are delivered in general hospitals.
- Tertiary health care is highest level of health care in the country.
 - It is the ultimate referral, with highly specialised services.
 - Its main functions include teaching, service delivery, and research.

NV20:2020 – objectives for the health sector

- To harmonise the health care policies and programmes of all the tiers of government, paying attention to peculiar geographical health care needs
- To redress the disproportionately poor health indicators in the country
- To improve the level of routine immunisation through primary health care services to cover all children
- To ensure regular access to affordable drugs and vaccines through significant increase in the local production of essential medicines by building Nigeria's capacity to manufacture essential drugs, vaccines, and consumables
- To address the acute shortage of drugs by revamping the drug-revolving scheme, including the Bamako Initiative
- To increase universal access to healthcare through mechanisms such as the National Health Insurance Scheme and the National Community Health Insurance that provides FREE health services to vulnerable groups
- Reduction in the maternal mortality which ranges from 300 per 100,000 live births in the south-west of Nigeria to over 1,200 in the north-east of the country by 75% by 2020 (NDHS, 2008)
- Reduction in under-5 mortality from 189 per 1000 live births (2007, UNICEF) to 75 in 2015 and 50 in 2020
- Reduction in under-5 malnutrition from 53% to less than 20% (NDHS 2008) by the year 2015
- Increased life expectancy of Nigerians from 47 years (2007 UNICEF) to 70 years by 2020
- Reduction in HIV/AIDS prevalence from 4.4% in 2006 to half that by 2015

Strategic initiatives

- Provision of adequate infrastructure and well-maintained equipment through partnership with the private sector
- Expansion of secondary and tertiary health care coverage will require the citing of at least one general hospital in each Local Government Area. Each general hospital will

have specialists to cover a minimum of four major disciplines: Surgery, Paediatrics, Medicine, Obstetrics and Gynaecology.

- Inclusion of family life education should be part of junior secondary school curriculum, with a view to encouraging the citizenry to seek health care knowledge from appropriate health sources.
- The development of adequate and appropriate manpower for the health sector will require thorough assessment of the training needs and the update of in-service training programmes.
- Embarking on training and re-training of all health personnel to update their skills and competence
 - In this regard, the postgraduate medical colleges, colleges/faculties of medicine, and the teaching hospitals will be better funded to help perform their training mandates more effectively.
 - A special fund for the training of house officers and other interns is also necessary.
 - To meet the new, growing demand for health workers, the relevant institutions, such as schools of health technology and midwifery, would be strengthened and empowered to accommodate new intakes.
- Strengthening existing national health information systems and integrating them into a comprehensive national database to improve health database and promote research.
 - This will be supported by ensuring effective vital registration (births, deaths, marriages, divorce) at all levels and the establishment of the mechanisms for **collation, coordination and management of health research** by a well-funded body such as the National Medical Research Council (NMRC).
- Enhancing the availability and management of health resources (financial, human and infrastructural) by
 - Consolidating and expanding the national midwifery scheme.
 - Implementing a competitive Health Workers compensation and motivation package would also be introduced across all levels.
- Strengthening the various health regulatory agencies and accelerating the implementation of the three components of the National Health Insurance Scheme (NHIS) for the attainment of 100% coverage of Nigerians by 2015.

Conclusion

- For every nation, there is need for a vision of an ideal state towards which society should move.
- In the march to the preferred state, it is necessary to set targets and reference points against which short term actions and achievements can be evaluated.
- This is what the ten-year economic blueprint and the 7-point Agenda are set out to achieve.
- Vision 20:2020 is achievable and we have the human and material resources to make it possible.

Public Sector Topic 4: The National Health Sector Reform Programme

What is health sector reform?

Health Sector Reform (HSR) is a sustained process of fundamental change in POLICY and INSTITUTIONAL arrangement, guided by government, designed to improve the functioning and performance of the health sector and ultimately the health status of the population (Source – Sikosana et al., 1997). HSR is a sustained purposeful change to improve the effectiveness, efficiency, equity, and quality of the health sector (Berman 1995).

Characteristics of HSR

- Structural rather than incremental or evolutionary
- Change in policy objectives followed by institutional change rather than redefinition of policies alone
- Purposive rather than haphazard change
- Sustained rather than a single effort
- Political and “top down” process led by national, regional, or local government
- Content is marked by diversity rather than uniformity of measures
- Content is specific to a country and to its health system

Components of Health Sector Reform

1. Enabling/Empowering
 2. Regulation
 3. Financing
 4. Purchasing
 5. Providing
- Enabling/Empowering: by
 - Liberalising laws on private sectors
 - Introducing Incentives for expansion
 - Regulations: by
 - Revising regulatory structure to protect consumers and ensure minimum quality standards.
 - Financing: very critical, particularly as it relates to
 - Community financing
 - Social Health Insurance
 - User fees
 - Purchasing: through
 - Creation of purchasing agencies and management agreements with providers
 - Introduction of competitive non-structural relationship
 - Reforming the payment system
 - Provision: via
 - Decentralisation of health service management
 - Increased autonomy of public hospitals
 - Improved accountability to service users and the population

The key actors in HSR

- Government – provides the structure/regulatory instruments
- Patients/Population – pay for health system and receive services
- Financial Intermediaries – collect funds and pay providers

- Providers of health care services: 1st, 2nd, 3rd – level of care, Public or Private-ownership. For profit or not for profit, formal or informal – degree of organisation-orthodox, allopathic, homeopathic – medical system

Functions/roles of the actors

This is as it relates to the functions of the HSR: regulation, financing, purchasing, providing. The actors include:

- **Government and or professional groups**
 - Safeguarding and promoting public health
 - Enforcing standards
 - Monitoring the behaviour and performance of providers and perhaps insurers
 - Implementing appropriate package of services and or benefits.
- **The citizenry**
 - As patients – knowing their responsibilities and rights
 - As payers – insurance, exemptions etc.
 - As part of reformed managing and policymaking structures
 - Financial intermediaries – collecting payments from patients (users)
 - Making payments to providers, i.e., act as purchases of services
 - Act as providers occasionally
 - Encourage efficient and equitable financing and delivery of services
- **Roles of providers:**
 - Adapting to the spirit and concept of decentralisation, competition, diversity of ownership, and reforms at all levels of care
 - Embracing evidenced-based health care and quality improvement
 - Paying more attention to the most vulnerable groups to enhance their health indicators: MMR, IMR, under-five MR, etc.
 - Maintaining accurate HMIS for system indicators such as waiting period, bed occupancy, admission rates, plans availability, HR system, etc.

Why or when is HSR necessary?

- When a health system is not performing, hence resulting in poor health status of the population. The performance issues include effectiveness, quality, efficiency, accessibility, equity, and sustainability.
- This is measured in terms of
 - Indicators of general health of the population: disability rate, life expectancy, quality of life, etc.
 - Vulnerable groups health indicators: maternal mortality rate (MMR), infant mortality rate (IMR), under-five mortality rate (U5MR), etc.
 - System Indicators: waiting period, bed occupancy, admission rates, plans availability, HR system, etc. (input process and output indicators)

Health Sector Reform (HSR) in Nigeria 2004-2007

HSR goal: To improve the health status of Nigerians as a significant co-factor in the national poverty reduction efforts.

HSR mission: To undertake a government-led comprehensive health sector reform aimed at strengthening the national public and private health system to enable it deliver effective, efficient, qualitative, and affordable health services.

Rationale: Why Health Sector Reform

- National health system: Nigeria's overall health system performance was ranked 187th among the 191 member states by the World Health Organization in 2000.
- Health status:
 - Our maternal mortality rate is one of the highest in the world (making Nigeria the most unsafe place for a woman to be pregnant and go into labour)
 - Some other health status indicators like under-5 mortality rate and adult mortality rates are higher than the average for sub-Saharan Africa.
- Health policy, legislation, and health sector agenda:
 - Limited capacity for policy/plan/programme formulation, implementation, monitoring, and evaluation at all levels.
 - Absence of a National Health Act (to describe the national system and define the health functions of each of the three tiers of government)
- Health service delivery and quality of care:
 - Disease programmes currently implemented are within a weak health system and have had little impact.
 - Routine immunisation coverage rate that reached over 80% in the early 1990s nose-dived to an all-time low level of 15% until the early 2000s.
 - A very high proportion of primary health care facilities serve only about 5-10% of their potential patient load, due to consumers' loss of confidence in them among other causes.
 - Our secondary health care facilities in very bad conditions.
 - Diagnostic and investigative equipment in tertiary health institutions outdated.
 - The referral system between various types of facilities is non-functional or ineffective.
- Pharmaceuticals and medical supplies:
 - Fake, sub-standard, adulterated, and unregistered drugs still prevalent.
 - Erratic supplies and limited availability of drugs and other materials abound.
- Health finance:
 - The health sector is grossly under-funded.
 - There is no broad-based health financing strategy.
- Management and management systems:
 - Management of the limited health resources available is ineffective and inefficient.
 - The culture is one of corruption and self-interest.
- IEC and consumer rights:
 - Consumers' health knowledge and level of awareness of patient rights to quality care remains low.
- International community:
 - Activities of donors and other development partners are poorly coordinated.

Seven Strategic Thrusts of Nigeria's HSR Agenda

1. Improving the stewardship role of government
2. Strengthening the National Health System and its management
3. Reducing disease burden
4. Improving health resources and management
5. Improving access to quality health service
6. Improving consumer awareness and community involvement
7. Promoting effective partnership, collaboration, and coordination

NB: there are two overarching issues (HMIS and Communication) identified with the HS

Approaches to undertaking HSR at any level

- Establishing baseline information to enable the description of the health system:
 - Structure of HS – governance and management
 - Policy and regulation mechanism
 - Financing – services, quality, distribution
 - Human Resources – quality, quantity, performance
 - Private sector – size, quality, relationship with public role, regulation, etc.
 - Disease burden and how it is addressed
 - Accessibility – physical and financial
 - Equity assessment
 - Health infrastructure
 - Health indicators
 - Economic performances and other related government policies
- Diagnosis/Identification of key problems
- Utilise HSR 'control switches' to design responses:
 - Policy/Regulation, i.e., decentralisation, commercialisation, autonomisation, etc.
 - Financing – user fees/IGR utilisation, resource allocation, tax insurance, incentives
 - PPP – contracting, subsidising, regulation
 - Equity measures – exemption, minimum package
 - Consumer education
- Implement response
- Monitor and evaluate

The critical success factors in undertaking Health Sector Reform

- HSR actions must involve both internal and external stakeholders from the earliest possible stage.
- Where HSR initiatives involve significant adverse economic impact on people, efforts should be made to encourage government and businesses to create new opportunities for affected persons.
- Responsibilities for various HSR activities must be defined and allocated among all responsible parties in a clear and definitive way.
- Regulatory considerations should be addressed early in the HSR planning process.

Public Sector Topic 5: National Strategic Health Development Plan (NSHDP)

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

- **Goal, vision, and mission statement of NSHDP**
 - Goal: To significantly improve the health status of Nigerians through the development of a strengthened, coordinated, reinvigorated, and sustainable health care delivery system
 - Vision: "To reduce morbidity and mortality rates due to communicable diseases to the barest minimum; reverse the increasing prevalence of non-communicable diseases; meet global targets on the elimination and eradication of diseases; and significantly increase the life expectancy and quality of life of Nigerians"
 - Mission Statement: "To develop and implement appropriate policies and programmes as well as undertake other necessary actions that will strengthen the National Health System to deliver effective, quality and affordable health"
- The overarching goal of the NSHDP is to significantly improve the health status of Nigerians through the development of a strengthened and sustainable health care delivery system.
- Nigeria operates a pluralistic health care delivery system with the orthodox and traditional health care delivery systems operating alongside each other, albeit with hardly any collaboration.
- Both the private and public sectors provide orthodox health care services in the country.
- In 2005, FMOH estimated:
 - a total of 23,640 health facilities in Nigeria of which
 - 85.8% are primary health care facilities, 14% secondary and 0.2% tertiary.
 - 38% of these facilities are owned by the private sector, which provides 60% of health care in the country.
 - While 60% of the public primary health care facilities are located in the northern zones of the country, they are mainly health posts and dispensaries that provide only basic curative services.
 - The Private Out-Of-Pocket Expenditure (OOPE) in Nigeria accounts for over 70% of the estimated \$10 per capita expenditure on health, limiting equitable access to quality health care.
- The public health service is organised into primary, secondary, and tertiary levels.
- While the constitution is silent on the roles of the different levels of government in health services provision, the National Health Policy ascribes responsibilities for primary health care to local governments, secondary care to states and tertiary care to the federal level. At the same time, a number of parastatals, based at the federal level (for example, the National Primary Health Care Development Agency (NPHCDA)), are currently engaged in primary health care services development and provision; the latter is evidently part of its mandate.

- Although national policies formulated by the Federal Ministry of Health provide some level of standardisation, each level is largely autonomous in the financing and management of services under its jurisdiction.
- The health system is in a deplorable state, with an overall health system performance ranking 187th out of 191 member states by the World Health Organization (WHO).
- Primary Health Care (PHC), which forms the bedrock of the national health system, is in a prostrate state because of poor political will, gross underfunding, and lack of capacity at the LGA level, which is the main implementing body.
- The health system remains overstretched by a burgeoning population; physical facilities are decaying, equipment is obsolete, and there is scarcity of skilled health professionals.
- In addition, the roles of stakeholders are misaligned and coordination systems are weak. These problems are further compounded by the dearth of data, which renders evidence-based planning, policy formulation, and health systems management weak.
- The very weak health system contributes to the limited coverage with proven cost-effective interventions.
 - For example, immunisation coverage is 23%; only 12% of under-fives sleep under ITNs, 20% of children in urban areas and 14% of residents in rural areas with fevers are appropriately treated with anti-malarials at home; contraceptive prevalence rate is 15%, and only 39% of women deliver under the supervision of skilled attendants.
- It is important to note that wide regional variations exist for these indicators, with comparatively worse figures in the rural areas and in the northern part of the country.
- The NSHD Framework has been developed to serve as a guide to federal, state, and LGAs in the selection of evidenced-based priority interventions that would contribute to achieving the desired health outcomes for Nigerians.
- It is expected, therefore, that through the use of this framework, the federal, states and LGAs would respectively develop their respective costed plans through participatory approaches to reflect their context and prevailing issues.
- The end product being a harmonised National Strategic Health Development Plan with its appropriate costing will thereafter serve as the basis for collective ownership, adequate resource allocation, inter-sectoral collaboration, decentralisation, equity, harmonisation, alignment, and mutual accountability in Nigeria.
- It would also stipulate requirements for future health investments towards achieving sustainable universal access and coverage with a defined package of essential services within the planned period of 2009–2015.
- The generic framework discusses eight evidenced-based priority areas identified to improve the performance of the health sector, through a holistic approach at federal, state, and LGA levels. They are: leadership and governance, service delivery, human resources for health, health financing, health information system, community participation and ownership, partnerships for health, and research for health.

The priority areas:

1. Leadership and governance
2. Health service delivery
3. Human resources for health
4. Health financing
5. National Health information systems
6. Community ownership and participation
7. Partnerships for health development

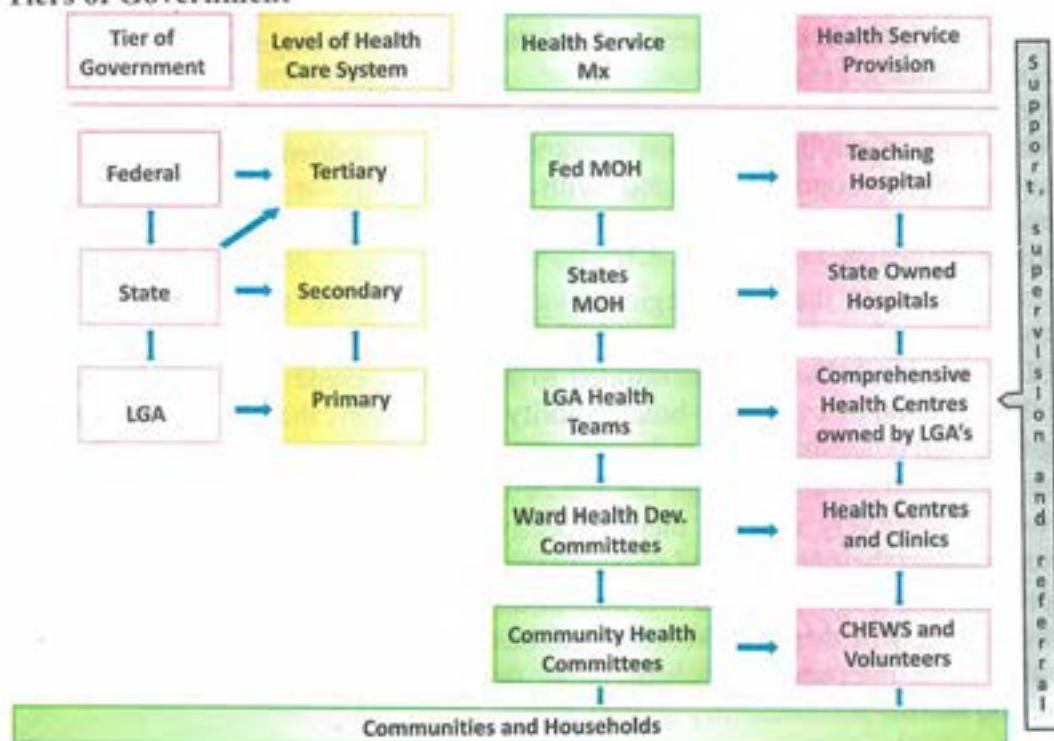
8. Research for health

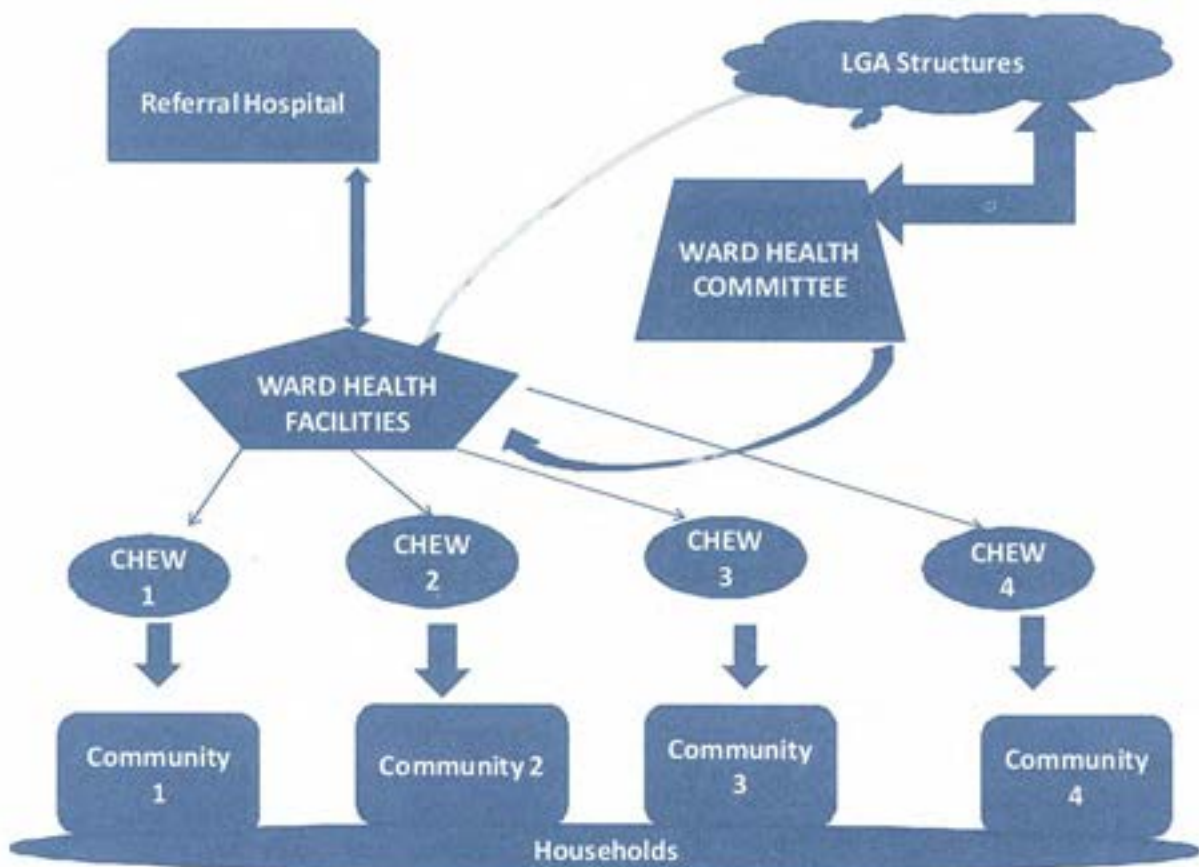
- For each of these priority areas, the framework provides uniform guidance, specifying a goal with strategic objectives and corresponding recommended interventions for the states to consider.
- It is recognised that specific actions are needed to deliver the different interventions, which in turn contribute to the attainment of strategic objectives. Goals may vary by level of government and from state to state, and likewise for LGAs.

Organisation of services at the LGA level

- This entails the reorganisation of health services at the state and LGA levels to deliver on the (NPHCDA) Ward Minimum Package to improve on health indices.

Tiers of Government





LGA Health Services

Subject 1.3: Primary Health Care Structures and Functions

Aim: To update the knowledge and skills of the participants on the existing PHC structures and functions.

Objectives:

- To refresh the knowledge of the participants on the philosophy and principles of PHC
- To update the knowledge of the participants on the emerging structures for PHC
- To acquaint the participants on the new Ward Health systems
- Skill station (Challenges of PHC implementation)

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the existing primary health care structures and functions
- Understand how the ward health system operates as a basic unit of the PHC system in Nigeria
- Be able to utilise the ward health system in provision of effective PHC services within the scope of their responsibilities

Topics:

- T1. Historical perspective of PHC in Nigeria
- T2. Principles and components of PHC
- T3. Structures and functions of PHC at the federal level
- T4. Structures and functions of PHC at the state level
- T5. The Ward Health System
- T6. The minimum Health Care Package

Structures and Functions Topic 1: Historical Perspective of PHC in Nigeria

Background

- Primary Health Care (PHC) is defined as *"the 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 each stage of their development, in the spirit of self-reliance and self-determination"*.
- Primary Health Care is a practical approach to making essential health care universal. It means much more than the mere extension of basic health services, having the aim of using only those technologies that have really proved their worth and can be afforded delivered by community health workers who understand the real health needs of the communities they serve and have the confidence of the people.
- With the global declaration in 1978 of Primary Health Care (PHC) as the key to the attainment of health for all and its reaffirmation by the Africa Health Ministers in Bamako (Mali) in 1985, the Three-Phase Health Development Scenario (TPHS) was adopted as a strategy for strengthening national health systems.
- The TPHS recommended the three-tier levels for health care delivery with PHC forming the primary level and central focus.
- This influenced the formulation of Nigeria's maiden Health Policy, which was developed between 1985 and 1986 and launched in 1988.
- From 1986, Nigeria began the process of reorientation of her health services towards the PHC approach. In a step-wise fashion, beginning with 52 model LGAs at inception, PHC was extended to all LGAs by 1990.
- Prior to this, most states owned and operated PHC facilities within the LGAs. This was considered incompatible with the policy, which outlined a three-tier structure of health service responsibility.
- Consequent to this development, health units at the federal and state levels were re-structured and state governments directed to hand over their PHC facilities and personnel to the LGAs. This was designed to transform the facilities of the LGAs and greatly strengthen their staff position.
- For the first time in the country, planning for health services implementation was done using the bottom-up approach.

Establishment of the National Primary Health Care Development Agency

- Nigeria's efforts at developing primary health care have over time been subjected to critical examinations by external observers, including the WHO Review Team (1992). The crucial question of sustainability has been raised at the time of each examination.
- Reviewers were unanimous that the efforts were commendable and needed to be pursued over the life of subsequent administrations for PHC to take firm root.
- They were unanimous that to ensure sustainability, the efforts would best be pursued outside the setting of the Federal Ministry of Health, albeit with strong government support at all levels.
- Based on the recommendation of the WHO Review Team and other considerations, the National Primary Health Care Development Agency (NPHCDA) was established by Decree 29 of 1992.
- The core mandates of the Agency are to support formulation of national health system, provide technical support for planning, management, implementation, monitoring and evaluation of PHC, mobilise resources, support village health system,

support health manpower development, and support health system research amongst others.

National Health Policy

The National Health Policy (2004) and Strategy to achieve Health for All Nigerians, which is a revision of two earlier health policies, represents the collective will of the government and people of the country to provide a comprehensive health care system based on primary health care. Furthermore:

- It describes the goals, structure, and strategy and policy direction of the health care delivery system in Nigeria.
- It defines the roles and responsibilities of the three tiers of government without neglecting the nongovernmental actors.
- Its long-term goal is to provide the entire population with adequate access to health care services based on the Primary Health Care (PHC) approach as its bedrock and supported by a functioning referral system. PHC is to be used to provide general health services of preventive, curative, promotive, and rehabilitative nature to the population and to serve as the entry point to the health care delivery system. The PHC system was to ensure community participation, improved inter-sectoral collaboration, functional integration, and strengthened managerial processes for health. The policy stipulates that the provision of care at this level, i.e., PHC, is the responsibility of the LGAs with technical support from the state ministries of health and federal government.

Structures and Functions Topic 2: Principles and Components of PHC

Components of PHC

1. Health education
2. Promotion of food supply and proper nutrition
3. Safe water supply
4. Maternal and child care
5. Immunisation
6. Prevention of endemic diseases
7. Appropriate treatment
8. Provision of essential drugs

Principles of PHC

1. Equity of distribution
 - a. Health services must be shared by all people
 - b. Provide access to all people
2. Community participation
 - a. Both financial and manpower participation
 - b. Let them promote their own health
3. Inter-sectoral coordination/collaboration
 - a. Education, housing, agriculture, etc.
4. Appropriate technology
 - a. According to need, not on demand

Structures and Functions Topic 3: Structures for Health Service delivery in Nigeria

Key Goals and Strategies for PHC in Nigeria

The overall goal of the Primary Health Care in Nigeria is to ensure that the Nigerian populace has effective access to equitable, affordable, and quality health care where they live and work. In order to achieve this, the following key strategies have been identified:

- Enactment of the Nigerian Health Act
- Establishment of a minimum (essential) health package in all wards across the country
- Reduction of financial barriers to health services through the establishment of community-based social health insurance schemes
- PHC infrastructural development
- Promote a system of comprehensive and qualitative integrated health services delivery at PHC level
- Ensuring full community participation, ownership and co-management
- Implementing comprehensive human resources for health programme
- Improving evidence-based decision making by strengthening the National Health Management Information System
- Effective mobilisation of resource through partner coordination and development of a national health account
- Operational research

Structures and Functions Topic 4: Structures and Functions of PHC at LGA level

A Local Government Area (LGA) is:

- Clearly defined administrative area covering a defined population at which the LGA takes over many administrative responsibilities from the central and regional government. Its responsibilities are defined in the constitution.
- They are compact and in Nigeria, there are 774 of them, with populations ranging from 100 – 5000 people.
- They are many settlements that include urban and rural areas.
- They have their own systems of administration.
- It is the level of government closest to the people and the most important in terms of local development. In establishing operational levels for implementing socio-economic development activities at local and community levels, the LGAs are in the best position to do that.
- PHC implementation would require decision-making and support structures being brought as close as possible to the people. The LGA, being the administrative unit closest to the people, is in the best position to do that.

Health districts: This is defined as the smallest administrative unit for which health services are organised by trained personnel. It may revolve round a health facility. In Nigeria, we have redefined it as the health wards.

LGA Health Systems

This is a self-contained segment of the national health system. It comprises:

- A self-contained, clearly defined population living within a defined administrative and geographic area
- It includes institutions and personnel providing health care, including systems for referrals

Functions of the LGA Health System

- Provision of the minimum integrated district health care package, which are as follows:
 - Basic Health interventions
 - Maternal and child health services
 - Medical care for the treatment of diseases and injuries
 - Disease control
 - Priority health interventions
 - basic immunisation
 - family planning
 - essential drugs
 - Health-related interventions
 - household food security
 - water and basic sanitation
 - adult literacy

NB: The roles of the different components of the LGA health system in the implementation should be defined.

- Special LGA Health Programmes

These would be determined by need. They are people-centred and community based, focused on health promotion and disease prevention. They may include:

- HIV/AIDS prevention and control

- Community-based revolving funds
- Community-based emergency preparedness and first aid
- Programmes for specific health problems targeted for elimination – neonatal tetanus, guinea worm, polio, goiter from iodine deficiency and Vitamin A deficiency, leprosy, etc.
- Health promotion and protection of specific target groups – adolescent health, geriatric health, workers' health, women's health (breast and cervical cancer, early marriage, MMM, etc.)
- Health promotion and protection of targeted groups/issues – healthy housing, healthy cities, accident prevention, alcohol dependence, substance abuse, tobacco dependence, hypertension, diabetes control, etc.

Developing a district health plan

- A district health plan will involve finding answers to the following questions;
 - Where are we now? – Situation analysis
 - Where do we want to go? – Identifying priorities and setting goals, objectives and targets
 - How will we get there? – Work plan indicating tasks, who/where/when, and resources required
 - How will we know when we have reached the end of the plan and achieved our objectives? – Monitoring indicators and evaluation results
 - The plan will list all the needs according to priority, the objectives and targets, the interventions, the strategies, the indicators for monitoring, the mechanisms for monitoring and evaluation, the resources (material and financial), and the implementation schedule.
- Situation analysis:
 - Brief description of LGA
 - District health infrastructure and staffing – facilities by categories and distribution, same for other resources
 - Catchment area
 - LGA map
 - Demographic data
 - Major causes of morbidity and mortality
 - Problems in the organisation and delivery of health care (organisational and managerial factors limiting efficiency and effectiveness of the system)
- Identify priority health problems
 - Criteria used in ranking:
 - magnitude of problem
 - severity
 - amenability to intervention
 - cost
 - ease of service delivery
 - Develop an LGA health profile from situation analysis.
 - A district health profile covers the following areas: general information; district population; health status; health resources; health programmes and health-related programmes; community health-related initiatives
- Set goal, objectives, targets, strategies, and indicators:
 - Goal – desired state of being. This gives enough focus on the general direction for planning.
 - Objective – intended result

- Strategy – tactics or techniques to be employed in achieving objectives
- Activities – the series of tasks that need to be carried out using earmarked resources so as to achieve the objectives
- Indicators – observable, quantifiable criteria which will be measured as part of monitoring and evaluation to determine extent of attainment of objectives
- Do a detailed programme and budget
- The plan becomes operational when translated into a work plan that shows
 - What activities are to be carried out?
 - How the activities will be carried out (technical, managerial, and administrative actions and procedures)?
 - Who is responsible for ensuring that they are done?
 - When is it to be done?
 - Where is it to be done?
 - How much it will cost?
 - Plotting activities against time – GANNT Chart

Implementation of the Health Care Package

- The management processes for health development would include:
 - Management development support
 - Planning and evaluation
 - Continuing education
 - Operations research
 - Operational management support
 - Operational plan
 - Supportive supervision
 - Monitoring of progress
 - Administrative management support
 - Human resources
 - Budget and finances
 - Supplies and equipment
 - Drug supplies
 - Transport and communication
 - Physical facilities
- There is the need to have a management structure at each level
 - The LGA health committee – multi-sectoral – gives direction
 - The medical officer of health – responsible for programme operations
 - The LGA health team – ensures operation of activities

The LGA Development Committee

- Serves as apex organ for development in the LGA
- Promotes inter-sectoral collaboration
- Facilitates LGA action towards meeting the health needs of the people
- Integrates health and other development activities
- Coordinate sectoral plans
- Identifies and mobilises resources for health action
- Monitors and evaluates implementation of programmes

LGA Health Committee

- Supports general mobilisation for health action

- Organises and supports LGA health education
- Does needs identification and epidemiological profile of LGA
- Develops LGA health policies
- Ensures each community has a plan
- Reviews LGA health plan
- Organises LGA health system
- Monitors and evaluates implementation

LGA Health Team headed by MOH

- The MOH provides leadership and provides operational support for PHC
- Identifies health needs of the population and the measures needed to address the needs
- Develops health plans
- Draws up budget
- Coordinates interventions
- Ensures standards of care are maintained through effective supervision
- Identifies training needs of staff
- Ensures health activities, especially those at community level, are given adequate support
- Supervises health workers
- Manages resources – financial management, logistics management, transport management, personnel management, information management, facilities management, etc.
- Collects, collate, and analyse relevant health information
- Writes report

Structure and Functions Topic 5: The Ward Health System

The overall objective of a national health policy is to improve accessibility of the population to primary health care as well as to secondary and tertiary care. The Nigerian National Health Policy identified primary health care (PHC) as the main focus for delivering effective, efficient, quality, accessible, and affordable health services to a wider proportion of the population through four approaches:

- Promotion of community participation in planning, management, monitoring, and evaluation of the local government health system i.e. the PHC system;
- Improved inter-sectoral collaboration in primary care delivery;
- Enhancing functional integration at all levels of the health system;
- Strengthening of the managerial process for health development at all levels.

This reviewed National Health Policy recognised the local government area as the operational level for primary health care implementation. In a bid to institutionalise PHC services and ensure sustainability, a decree was promulgated in 1992 (*Decree No 29*) establishing a National Primary Health Care Development Agency (NPHCDA). This Agency has a mandate to: periodically monitor and evaluate the National Health Policy, especially as it relates to primary health care, mobilise resources nationally and internationally for the development of PHC, and most importantly, provide technical support, co-ordinate, and develop strategies for the effective implementation of PHC nation-wide.

Despite these developments, the desired outcomes of this policy have not been fully realised. An attempt to develop and implement a National Plan of Action for Implementing a District (LGA) Minimum Health Care Package for the plan period of 1995 to 2000 was constrained by low level of political commitment at all levels of government. In an attempt to improve access to health care, the NPHCDA has reviewed the flaws in the present primary health care system and developed a ward health system through which a minimum health care package would be delivered.

Ward overview

- The ward is the smallest political structure, consisting of a geographical area with a population range of 10,000 to 30,000 people. There are on average, ten (10) wards per LGA, each represented by an elected councilor.
- The main rationale for selecting a ward as an operational area for delivering a minimum health care package was to mobilise political commitment to health service delivery as a requisite for social development.
- Structurally, each ward has a Ward Development Committee composed of the following:
 - A Ward/Clan head as patron
 - An elected chairman
 - A secretary
 - Chairmen of village/community development committees,
 - A school headmaster
 - A senior agricultural extension worker
 - A ward committee development officer
 - Representatives of occupational groups (which includes VHW/TBA, NGOs and international organisations, religious groups, women and youth groups, chairmen of patent medicine and store dealers, traditional healers)
 - Heads of facilities in the area

- Functionally, each Ward Development Committee is responsible for the following:
 - Identification of health and social needs of the ward and planning solutions
 - Mobilisation of resources (human and material)
 - Supervision, monitoring and evaluation of health activities in the ward
 - Mobilisation for community participation in health, and other health-related programmes
 - Liaison with government, NGOs, and other partners in the implementation of health programmes
 - Forwarding plans from villages and the wards to LGA/PHC Development Committee and providing feedback
 - Supervision and support to TBA/VHW/CHEWs
 - Support the establishment of health facilities and overseeing their functions at ward level

Establishment of the Ward Health System

- In view of the size of our LGAs, the federal government in 2000 adopted the ward as the functional unit for PHC delivery by adopting the Ward Health System (WHS).
- The WHS aligns the delivery of health care with the current democratic dispensation and demonstrates in concrete terms the desire of the national government to establish a people-oriented and focused PHC system, which is co-managed by the health staff and community members.
- The homogeneity and the ability to generate grass-root political commitment and support has proven far more beneficial than the former District Health System, which was based on vague boundaries created by the LGA health departments.
- The focal point of WHS is the ward health centres, which serve as the fulcrum around which the WHS is implemented, coordinating all health activities within the ward in partnership with the communities.
- This community-focused health system is being established with the following core objectives of:
 - Promoting full and active community participation at the grass root level in order to sustain an effective and efficient delivery of PHC services in the wards
 - To reinforce political commitment to PHC at grass root level, i.e., the ward
 - Promote local initiative and encourage poverty alleviation activities in the ward
 - To reduce morbidity and mortality from preventable causes, especially amongst women of reproductive age and under-five children

Structure and Functions Topic 6: The Minimum Health Care Package

Concept and Development of the Minimum Health Care Package

- In February 1994, at the 16th WHO Regional Programme Meeting held in Yaoundé, Cameroon, participants from African countries including Nigeria met to discuss issues relating to acceleration of the attainment of Health for all through PHC.
- The meeting recognised the need for each member country of WHO in the African Region to organise a National Programme Meeting (RPM.16C). This was to serve as a forum for presentation of the Minimum District Health for All package, which was extensively discussed at that meeting.
- Strategies for implementing the package were developed. In August 1994, six months after the Yaoundé meeting, the then-Hon. Minister of Health and Social Services, in collaboration with the WHO, Nigeria and the National Primary Health Care Development Agency organised a four-day stakeholders meeting aimed at developing a Minimum District Health Care Package for Nigeria for the acceleration of HFA through PHC.
- The resulting package consisted of thirteen (13) components, each with objectives and strategies to be implemented between 1995 and 2000.
- In 1996, each of the 36 States and selected LGAs developed a plan of action to implement the package.
- In January 1998, report of supervisory visits conducted to ascertain level of implementation indicated that most of the selected LGAs had 4–5 components in their plan of action; however, level of implementation of MHCP was low.
- In June 1998, a National Review Meeting to discuss progress report was convened, and a resolution by the meeting brought the number of components to four, namely:
 - Child survival (IMCI and routine immunisation)
 - Safe motherhood (ANC, delivery, postnatal care, FP)
 - Control of communicable diseases of public health importance (malaria, TB, HIV/AIDS)
 - Health information, education, and communication.
- At a national review meeting held in Port Harcourt in 2001, an additional component was incorporated into the package, namely: **Nutrition**. State and LGAs presentations at the review meeting indicated low implementations of components of the package. The meeting re-emphasised the need for government to fund the package in line with the recommendation of WHO-AFRO of 1994.
- It also observed that socio-economic indicators had worsened; unemployment levels were high, and morbidity and mortality statistics were unacceptably high. Cost of health services had gone beyond the reach of majority of Nigerians.
- The meeting emphasised the need to strengthen budgetary allocation to health. The reviewed package was renamed Ward Minimum Health Care Package (WMHCP) in line with the introduction of the Ward Health System (WHS) in 2001. However, constraints in costing the package undermined its widespread dissemination and utilisation.
- In 2005, the NPHCDA, in collaboration with WHO, convened a meeting to update the WMHCP and adopt instruments for its costing. At this meeting, the control of non-communicable diseases was incorporated as the sixth component.

Costing Of Minimum Health Care Package

- In November 2005, the NPHCDA, in collaboration with WHO, conducted a preliminary field survey in one geopolitical zone to generate data for costing the WMHCP. A health economist was engaged for this purpose, and the outcome was presented to a cross-section of stakeholders, who called for additional data collection in the other geo-political zones prior to the finalisation of the costing exercise.
- Subsequent to this, in March 2007 the NPHCDA, with support from PATHS, conducted a second survey in 5 geo-political zones.
- Data generated from these two surveys was analysed and provided the cost for each of the components of the package. The costed package was adopted at a stakeholders' meeting in July 2007.

Plan of Action for Implementation of the Ward Minimum Health Care Package

- **Overview**
 - The Ward Minimum Health Care Package describes a priority set of health interventions which should be provided in PHC centres on daily basis at all times and at little or no cost to clients, through government financial mechanisms.
 - The operationality of the package requires that government define minimum health manpower requirement, equipment, drugs, infrastructure and services for the primary health centre.
 - To facilitate this process, the package has been costed. It is to be used as a tool for advocacy to all levels of government and to partners within the health sector.
 - This plan of action stipulates that over the plan period, i.e., 2007-2012, government at all levels would demonstrate a high level of political commitment and harness all available resources in collaboration with partners, the private sector, and communities to ensure that the proposed package is instituted in all wards by 2012.
 - At the end of the plan period, a comprehensive evaluation would be conducted to create the evidence base for a possible review. This plan of action acknowledges that many local government authorities and communities may possess enough resources to provide services based on all the components of PHC.

Overall Goal of delivering the Ward Minimum Health Care Package is:

- To contribute to national socio-economic development.
- **Purpose:** To reduce morbidity and mortality; in the Nigerian community
- **Objectives:**
 - To define a ward minimum health care package that would be made available at PHC level.
 - To improve access to quality health care at community level, particularly for the rural population.
 - To address the inequalities between and within wards in health service delivery.
 - To ensure availability of quality interventions that addresses the health needs of the population.
 - To strengthen the monitoring and evaluation indicators of the ward health system as part of the National Health Management Information System.
 - To provide a structure for effective programme integration at ward/primary care level.
 - To provide a minimum health care package as a basis for improved public health expenditure and to guide the investment of all stakeholders.

Implementation of the Ward Minimum Health Care Package

- The minimum health care package includes health interventions and/or services that address health and health-related problems that result in substantial health gains at low cost.
- In defining this package, a number of considerations were made, including disease patterns, economic considerations (e.g., cost of services), and proportion of population affected/benefiting from health services.
- This package targets the grass root level through the delivery of a minimum set of interventions needed to meet the basic health requirement of the people, hence contributing to achieving the global target of Health For All and the attainment of the Millennium Development Goals (MDGs).
- Technically, this package comprises of cost-effective interventions known to promote health and development and reduce mortality and morbidity from major/common illnesses. Based on these and other considerations, a package is proposed.
- During the implementation period of this Plan of Action (2007-2012), the Minimum Health Care Package will include the following health interventions:
 - Control of communicable diseases (malaria, STI/HIV/AIDS, TB)
 - Child survival
 - Maternal and newborn care
 - Nutrition
 - Non-communicable disease prevention
 - Health education and community mobilisation
- In order to implement this set of interventions, communities will be mobilised using appropriate IEC/BCC strategies. Functional health infrastructure, human resources (manpower), and financial resources would also be provided to support health service delivery at the ward level. Therefore, the following services are required:
 - Provision of essential drugs
 - Human resources for health
 - Health infrastructure development

Other Interventions of Public Health Importance:

- Certain services have reasonable effect on the health status of the population, though their provision is not entirely confined to the health sector.
- These services include water, sanitation, and emergency and disaster preparedness.
- The Plan of Action (2007–2012) for the WMHP recognised the role of other sectors in the financing and provision of these services.

Need for Co-ordination and Collaboration:

- To ensure effective implementation and optimisation of resources for the delivery of the Minimum Ward Health Care Package, there is the need for co-ordination among related programmes such as Essential Drugs Programme or Bamako Initiative, Malaria (RBM), CDD/ARI (IMCI), and NASCP.
- Co-ordination will take the form of integrated approach to training, service delivery, supervision, and monitoring.
- In addition to programme co-ordination, development partners and agencies need to be encouraged to collaborate at various levels of service delivery, particularly at the Ward and LGA levels, in the implementation of the Minimum Care Package.

Monitoring and Evaluation:

- The availability of accurate, timely, reliable, and relevant health information is the most fundamental step towards informed public health action (Revised NHMIS Policy, 2006).
- This underscores the fact that Monitoring and Evaluation stands out as an essential component necessary for achieving success in implementing the Ward Minimum Health Package.
- It is mandatory that at the ward level, a primary health care information system for effective monitoring and evaluation be instituted for routine data collection, collation, analysis, and feedback to the communities.
- Data collected from communities within the ward are sent to the Ward PHC centre, where they are analysed together with facility-based data and forwarded to the LGA M&E Office for subsequent transmission to the state and zonal office of the NPHCDA. Data from the state are sent to the Federal Ministry of Health and those from the zonal office of the NPHCDA are sent to its headquarters. At the federal level, the NPHCDA headquarters is expected to forward data to the Department of Health Planning and Research, FMOH. Furthermore, interaction at Data Users' Forum would enhance comparability and feedback and generate evidence for more integrated planning.

Implementation of the Primary Health Care Information System:

- The PHC information system is a sub-set of the NHMIS. It 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, VHW/TBA pictorial and tally sheets, M&E forms, Health Facility Registers, etc.
- The revised NHMIS was revised in 2008. It is the current guiding policy and should be used strictly. However, other parallel reporting formats such as the Integrated Disease Surveillance and Response IDSR with its forms (IDSR 001 for immediate notification; IDSR 002 for weekly notification; and IDSR 003 for monthly notification) should be used as appropriate. It is currently in use and should continue to feed into the relevant reporting systems.
- However, it must be emphasised that basic training, retraining, and necessary logistics must be given to the PHC staff at the ward level to be able to collect, analyse and use data for informed decision making and provide a feedback to both the communities and the next level of reporting.
- This coupled with active-supportive supervision is an effective strategy for achieving desired results in the operation of PHC at the ward level.
- Regular supervision not only emphasises management's commitment to an issue but is also supportive, it provides the necessary feedbacks for evidence-based decision making, planning, and achievement of desired outcome.

Challenges to PHC Implementation in Nigeria

Although significant successes were made in the implementation of PHC in Nigeria, there is still a lot that still need to be done. Several challenges were encountered in the process and these include:

- Funding gaps: inadequate funding at all levels.
- Three-tiered health systems: Over the years, the health policy has been acclaimed as a sound document; however, because it was never backed by legislation, some stakeholders were not fully committed to its implementation. It is envisaged that the

National Health Act currently in the National Assembly will provide necessary legal backing.

- Inadequacies in HR for PHC, particularly in the rural areas (quality and quantity)
- Fragmentation of programmes due to multiplicity of implementing partners
- Inadequacies in the HMIS
- Poor coordination/inter-sectoral collaboration; multiple sectors and partners.

Example of a skills station for this topic

Having had a brief introduction and reminder of the various level of implementation of PHC in Nigeria, it is time to chart the way forward. Break into groups and each group will be given one of the tasks below.

- Task one: Identify the ten major challenges to the full-scale implementation of PHC in Nigeria and arrange them in the descending order of their magnitude.
- Task two: Identify five key stakeholders in the effective implementation of PHC in a LGA in Nigeria. For each stakeholder, identify at least three strategies to be used for their mobilisation and sustained commitment to the implementation of PHC at the LGA level.
- Task three: Having received renewed political will and commitment from the newly sworn-in Executive Chairman of Wazobia LGA, as the Head of the Health Department, prepare a short-term work plan for the period January–July 2050 for the scale-up towards full implementation PHC activities in the LGA.

Subject 1.4: Principles of Planning and Project Management in Health Care

Aim: To expose the participants to practical knowledge of planning and project management in PHC

Objectives

- To acquaint the participants with basic concept of planning process
- To promote participants' understanding of strategic planning
- To expose the participants to knowledge on how to develop and manage projects

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the basic steps in the strategic planning process
- Know how apply the planning process in the developing PHC projects and activities
- Be able to incorporate project management techniques in carrying out PHC programmes and activities within the scope of their responsibilities

Topics:

- T1. Overview of planning process
- T2. Strategic planning
- T3. Micro-planning
- T4. Project management

Planning Topic 1: Overview of Planning Process

Basic definitions and concepts of planning

- Planning is a *systematic process* of identifying and specifying desirable future goals, outlining appropriate courses of action, and determining the resources required to achieve them.
- Strategic planning is establishing a master plan that shapes the *future direction* of a programme. It may also be defined as a dynamic and deliberate process that allows the programme or hospital to invent the future.
- Operational planning is establishing plans that relate to running a programme or hospital on a *day-to-day*, short-term basis.
- Planning is essential for the efficient achievement of all human endeavours. Individuals as well as organisations need to plan because of the uncertainties in a constantly changing environment.
- Whether we plan for a party, a workshop, a health facility, or a health service, planning is that process which we use to select our goals and objectives and to determine how best to achieve them. Put simply, the process involves using knowledge of past and prevailing circumstances to make decisions on what needs to be done in the future to attain objectives.
- Planning is the most basic of all management functions and precedes all the others. Indeed, it is considered to be the most strategic of all management functions as it establishes institutional objectives and determines how the other major functions of the manager will be executed towards the attainment of the objectives.
- The manager, in order to ensure the attainment of objectives which have been experienced in health plan, organises resources. In particular, he or she decides what types of staff are required to fulfill the objectives of the organisation and chooses the most appropriate leadership.

Rationale and Purpose of Health Planning

- Efforts at health planning have been traced to the beginning of this century when the National Tuberculosis Association of the United States of America began to stimulate the development of programmes for the control of tuberculosis.
- These early efforts consisted largely of intuitive, spontaneous and subjective projections of activity based on past experience (Waterston, 1987).
- Since that time, however, health planning in the developed world has now progressed to become a much more deliberate, systematic, objective and scientific process of mobilising exact information and deciding how best to organise resources.
- Modern health planning is a systematic decision-making process during which objectives are set and decisions are taken on how, when, and where to deploy resources in order to achieve these objectives.
- The purpose of health planning is to facilitate the accomplishment of the objectives of the organisation in the most efficient manner; i.e., without undue wastage of resources.
- The health-planning process involves an assessment of health needs and of tasks that must be accomplished in order to satisfy those needs.
- In other words, health planning is deciding in advance, what to do, who is to do it, how to do it, and when.

- Planning bridges the gap between the present health situations, i.e., where we are, and the desired health situation, or where we want to be with regard to health.
- Planning makes the desired health situation more certain by not leaving it entirely to chance.
- Furthermore, planning ensures that the most cost-effective and cost-efficient health-care activities are pre-selected and thus rationalises the use of scarce resources.
- Fig. 2 illustrates the differences in what is likely to be achieved in terms of improvement in health status by an unplanned health programme whose outcome is left to chance (A) and a planned one (B). It is assumed that health programmes are carried out within the same period and using the same resources. The marked fall in disease incidence attained by the well-planned programme (B) as compared with the unplanned programme (A) is attributable to good planning.

NB: Health planning minimises the negative effects of future uncertainty and of change in both the external and internal management environment.

- The act of planning focuses attention on the objectives to be attained, and galvanises purposeful action towards the attainment of these objectives.
- Thirdly, it minimises cost and establishes standards, planning facilities control, monitoring, and evaluation.

Classification of Health Plans

Several criteria have been used for the classification of formal health plans. The major criteria of practical significance include:

- The flexibility of the plan,
- The duration of the period covered by the plan, and
- The nature and scope of the plan.

Nature and Scope of the Plan

- Planning is a function of all health managers.
- However, the nature and scope of planning does vary according to the level of management at which the plan is being formulated, i.e., whether at top (strategic) management level, middle (tactical, executive, or administrative) management level or at junior (operational or supervisory) management level.
- Accordingly, two broad categories of health plans have been distinguished:
 - *Strategic, corporate, or comprehensive* health plans, and
 - *Operational, tactical, or functional* health plans (DUSS, 1976).

NB: Like management itself, each type of health planning takes place at all levels of management, but at varying degrees.

- The top- and middle-level management is primarily concerned with strategic planning.
- The supervisory management level is more preoccupied with the formulation of operational health plans prepared at the departmental or unit level.
- It must be emphasised that strategic and operational planning are NOT two separate and entirely unrelated processes; rather, they are closely interrelated.
- Strategic health planning is the process of determining the health goals and general objectives (intended achievements) of the health-service organisation, formulating policy guidelines to all decision-making, and selecting strategies or general

approaches in which the goals can best be attained in the light of current circumstances and future projections.

- A strategic plan provides a general framework and a sense of direction for more detailed tactical and operational planning of specific function programmes with specific operational targets at the lowest levels of the health service organisation, thus creating a hierarchy of plans as described below.

A Hierarchy of Plans and Objectives

Strategic Level	Subject Matter	Examples of Goals/Objectives
Strategic	Broad goals Policies Strategies Outcomes Impacts	1. To increase the well-being of the rural population within 20 years through primary health care. 2. To reduce the health problems of the rural population. 3. To reduce mortality and morbidity of the rural poor. 4. To reduce maternal and infant deaths in the rural poor by 50% in 10 years through the promotion of the health of mothers and children under 5 years.
Tactical, Operational	Service Output Targets Service Processes Resource Inputs	1. To increase the proportion of pregnant women attended by trained health workers by 50% in 5 years. 2. To recruit and train at least 2 traditional birth attendants for 20% of all villages within 1 year. 3. To design manuals of procedures for traditional birth attendants within 1 month.

Thus, the two levels of planning are complementary.

Seven steps of planning

1. Problem identification
2. Stakeholder's analysis and analyse strengths and weaknesses (SWOT)
3. Establish goals and objectives
4. Develop action plan (road map)
5. Develop budgets
6. Implement plans
7. Monitor plans

Problem identification

Step 1: Define the present situation in your programme (situational analysis)

- Where are we now?
 - Geographic coverage
 - Target population
- What is the magnitude of the problem?
- How visible is it?
- Is it new or old?
- Are there effective interventions?

NB: In defining the problem operationally: Identify **why** the problem exists. For example, if the problem identified is 'TB treatment programme in X state has poor coverage', the **whys** may include:

- Increased cost of care
- Downsizing number of doctors
- Severe shortage of nurses
- Limited outreach preventive activities
- Shrinking budget due to slow economic growth
- Low morale among staff

Step 2: SWOT analysis

- **Strengths:** What are the strengths of the existing program? What do we do well?
- **Weaknesses:** What are the weaknesses of the program? What do we need to improve? Who needs to improve?
- **Opportunities:** What are the external trends that offer opportunities?
- **Threats:** What are the local, national, and international threats that pose risks?

SWOT Analysis Matrix	Strengths (S)	Weakness (W)
Opportunities (O)	S-O Strategy	W-O Strategy
Threats (T)	S-T Strategy	W-T Strategy

How do you apply the matrix?

- S-O strategy: Guides the organisation to pursue opportunities that are good fit for the organisation strength.
- W-O strategy: Overcomes organisational weakness to pursue opportunities.
- S-T strategy: Identifies ways to use the existing strength to reduce the vulnerability of the organisation to external threats.
- W-T strategy: Establishes a defensive plan on the organisational weakness from making it highly vulnerable to external threats.

Stakeholder management

- Stakeholder management is critical to the success of every project.
- By engaging the right people in the right way in your project, you can make a big difference to its success.

Stakeholders' analysis

1. You can't do it single-handedly
2. Identify those that will ask **why** and **why not** and at **what cost**?
3. Gain support and resources

4. Communicate the benefit of the project
5. Anticipate people's reaction to your project

How to identify stakeholders

1. People affected by the project
2. People who have influence or power over it
3. People who have interest in its success
4. People who will be against the project
5. Source of funds

NB: A stakeholder could be an individual or individual representing an organisation.

Tools for stakeholders analysis (1)

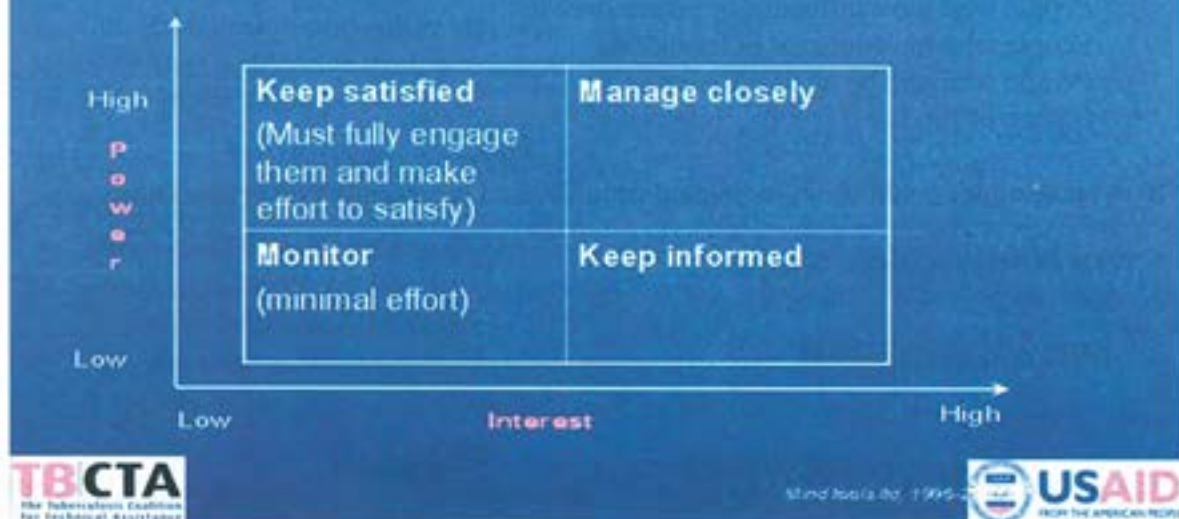
Force field analysis model



Paul Hesse, Kenneth H. Blanchard & Dewey E. Johnson (2000)

Tools for stakeholders' analysis (2)

Tools for stakeholders analysis (2)



Understanding the stakeholders

- Financial and emotional interest on the outcome
- What motivates them?
- What information do they want?
- How to communicate with them?
- What is their current opinion on the project?
- Who influences their opinion generally?

Relating stakeholders analysis to the work plan and M&E plan

Relating stakeholders analysis to the workplan and M&E plan

	USAID	World Bank	WHO	Government	Total
Budget Line	42%	17%	29%	12%	100%
Personnel & Fringe	70,000	30,000	50,000	20,000	\$ 170,000
Travel	3,000	2,000	4,000	1,000	\$ 10,000
Office supplies	1,500	400	600	-	\$ 2,500
Communications	4,000	500	2,000	1,000	\$ 7,500
Other expenses	5,000	1,000	2,000	2,000	\$ 10,000
Total expenses	83,500	33,900	58,600	24,000	200,000

Priority setting: key criteria to select the 'whys' to address

- Affordability
- Feasibility

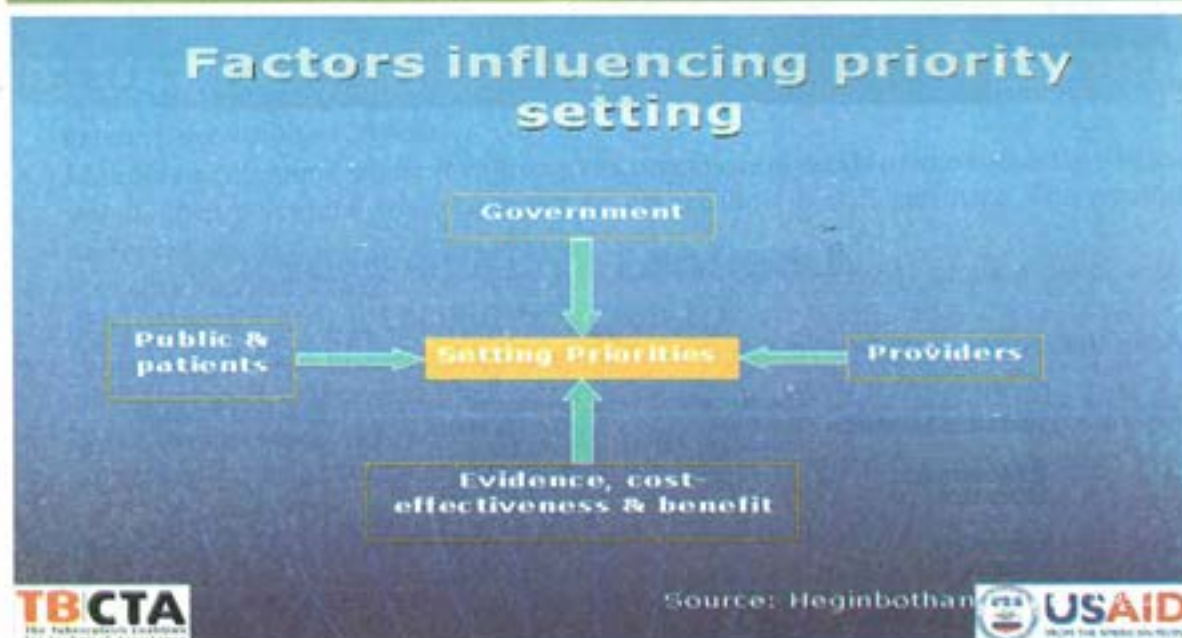
- Visibility or prevalence of problem
- Risk if no action is taken
- Importance
- Severity
- Management and community support
- Efficiency/effectiveness

Example of a priority-setting matrix

TB treatment program has limited coverage

Criteria Problem	Importance	Management Support	Risk if no action	Feasibility	Cost effectiveness	Total Score

Score: 1 = low to 5 = high

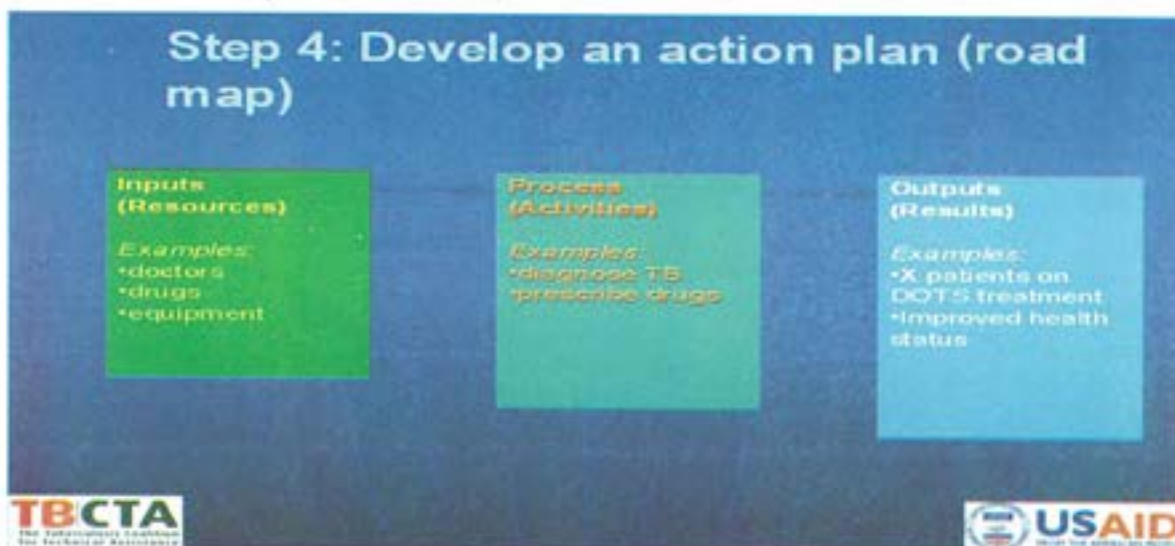


Factors influencing priority setting

Step 3: Establish goals and objectives

Always make your objectives **SMART**

- **Specific:** What is the specific change desired? Who is the target group? What is the location?
- **Measurable:** What is the measure (number or percentage) to monitor progress/performance?
- **Appropriate:** to goals and strategies
- **Realistic:** given the limited amount of resources
- **Time-Bound:** What is the date by which the change will occur? This will help with resource allocation and activity planning.
- **Examples of programme objectives – are these SMART?**
 - To establish 10 PLHA support groups in Zaria
 - To increase TB case detection from 5% to 95%
 - To build the capacity of community volunteers in TB-DOTS and ART adherence



Logical framework (LogFrame)

Narrative Summary	Objectively Verifiable Indicators - OVIs	Means of Verification - MOVs	External Factors (Assumptions)
Development Objective			
Immediate Objective			
Outputs (Results)			
1.			
2.			
3.			
Activities	Inputs		
1.	1.1		
2.	1.2		
3.	1.3		
4.	1.4		

Planning Topic 2: Strategic Planning

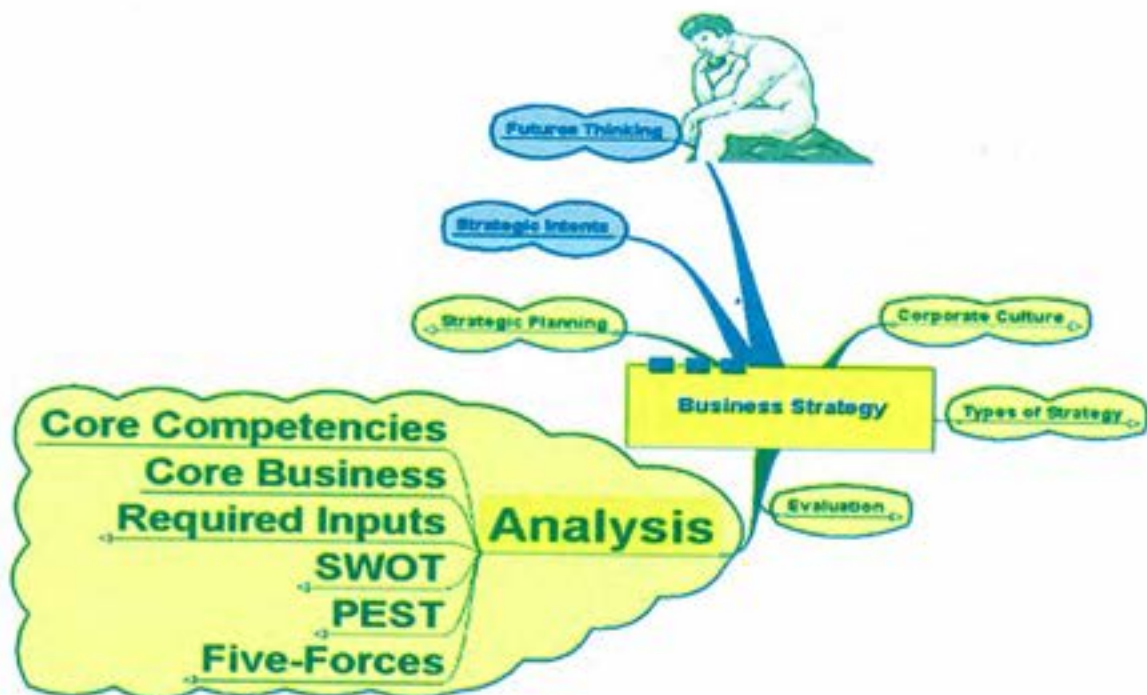
Introduction: Strategic planning is an organisation's process of defining its strategy, or direction, and making decisions on allocating its resources – including capital and people – to pursue this strategy.

- Strategic or comprehensive health planning involves the preparation of broad policies and strategies. Strategic planning takes a broad overview over an extended period of time, usually ten or more years.
- Also, strategic plans usually cover a large service area, such as a country.
- In other words, they are long-range plans for comprehensive health development covering a broad scope and extending over a long period of time.
- Strategic health plans set priorities for general health development and plot the general course of decision (strategies) to be taken towards the attainment of health goals.
- Various business-analysis techniques can be used in strategic planning, including:
 - SWOT analysis (Strengths, Weaknesses, Opportunities, and Threats),
 - PEST analysis (Political, Economic, Social, and Technological),
 - STEER analysis (Socio-cultural, Technological, Economic, Ecological, and Regulatory factors), and
 - EPISTEL (Environment, Political, Informatics, Social, Technological, Economic, and Legal).
- Strategic planning is the formal consideration of an organisation's future course. All strategic planning deals with at least one of three key questions:
 - "What do we do?"
 - "For whom do we do it?"
 - "How do we excel?"
- In business strategic planning, the third question is better phrased as "How can we beat or avoid competition?"
- In many organisations, this is viewed as a process for determining where an organisation is going over the next year or more – typically 3 to 5 years, although some extend their vision to 20 years.
- In order to determine where it is going, the organisation needs to know exactly where it stands, then determine where it wants to go and how it will get there. The resulting document is called the "strategic plan".
- It is also true that strategic planning may be a tool for effectively plotting the direction of a company.
- However, strategic planning itself cannot foretell exactly how the market will evolve and what issues will surface in the coming days.
- Therefore, strategic innovation and tinkering with the 'strategic plan' have to be a cornerstone strategy for an organisation to survive the turbulent business climate.

- First stage of strategic planning may involve:
 - Future Thinking: Thinking about what the business might need to do 10–20 years ahead
 - Strategic Intent: Thinking about key strategic themes that will inform decision making
 - "The thicker the planning document, the more useless it will be" (Brent Davies: 1999)

- **The Vision:**
 - Communicating to all staff where the organisation is going and where it intends to be in the future
 - Allows the firm to set goals
- **Aims and Objectives:**
 - Aims: Long-term target
 - Objectives: The way in which you are going to achieve the aim
 - An example of aims and objectives:
 - Aim: For a chocolate manufacturer to break into a new overseas market
 - Objectives:
 - Develop relationships with overseas suppliers
 - Identify network of retail outlets
 - Conduct market research to identify consumer needs
 - Find location for overseas sales team HQ
- Once the direction is identified:
 - Analyse position
 - Develop and introduce strategy
 - Evaluate: Evaluation is constant and the results of the evaluation feed back into the vision

ANALYSIS



PEST

- **Political:** local, national, and international political developments – how will they affect the organisation and in what way(s)?
- **Economic:** what are the main economic issues – both nationally and internationally – that might affect the organisation?

- **Social:** what are the developing social trends that may impact on how the organisation operates, and what will they mean for future planning?
- **Technological:** changing technology can impact competitive advantage very quickly!
- **Examples:**
 - Growth of China and India as manufacturing centres
 - Concern over treatment of workers and the environment in less developed countries who may be suppliers
 - The future direction of the interest rate, consumer spending, etc.
 - The changing age structure of the population
 - The popularity of 'fads' like the Atkins Diet
 - The move towards greater political regulation of business
 - The effect of more bureaucracy in the labour market

Five forces plus three (developed by Michael Porter and added to by Will Mitchell)

- Forces that shape and influence the industry or market the organisation operates in

Five forces

- **Customers:** What are the major characteristics of customers and clients in your environment?
- **Rivals:** What are the key characteristics of your current competitors?
- **Potential entrants:** How easy is it for new rivals to enter the industry?
- **Substitutes:** What alternative product and services are there and what is the extent of the threat they pose?
- **Suppliers:** What are the major characteristics of suppliers of component goods and services for your products and services?

Plus three

- **Partners:** What organisations are partners or potential partners in helping to develop and deliver your goods and services?
- **Social forces:** What laws, regulations, social trends, and other social forces are shaping your environment?
- **New strategies:** What new ways of developing and delivering goods and services are other organisations experimenting with?

Required inputs

- Changing strategy will impact on the resources needed to carry out the strategy
- Specifically, the impact will be on:
 - Land – opportunities for acquiring land for development – green belt, brown field sites, planning regulations, etc.
 - Labour – ease of obtaining the skilled and unskilled labour required
 - Capital – the type of capital and the cost of the capital needed to fulfil the strategy

Evaluation



- Data from sales, profit, etc. are used to evaluate the progress and success of the strategy and to inform of changes to the strategy in the light of that data.
- Information from a wide variety of sources can help to measure and inform the impact and direction of the strategy.
- **A good strategic plan should...**
 - Address critical performance issues.
 - Create the right balance between what the organisation is capable of doing and what the organisation would like to do.
 - Cover a sufficient time period to close the performance gap.
 - Be visionary – convey a desired future end state.
 - Be flexible – allow and accommodate change.
 - Guide decision-making at lower levels – operational, tactical, and individual.

Strategic Planning Model A B C D E



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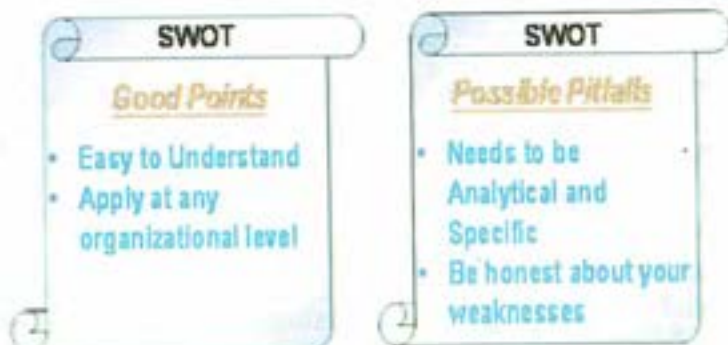
Pre-Requisites to Planning

- Senior leadership commitment
 - Who will do what?
 - What will each group do?
 - How will we do it?
 - When is the best time?

Assessment Model: SWOT

Internal Assessment: Organizational assets, resources, people, culture, systems, partnerships, suppliers, ...

External Assessment: Marketplace, competitor's, social trends, technology, regulatory environment, economic cycles.



Strengths

- Strengths – those things that you do well, the high value or performance points
- Strengths can be tangible: loyal customers, efficient distribution channels, very high quality products, excellent financial condition
- Strengths can be intangible: good leadership, strategic insights, customer intelligence, solid reputation, highly skilled workforce
- Often considered “Core Competencies” – best leverage points for growth without draining your resources

Weaknesses

- Weaknesses – those things that prevent you from doing what you really need to do
- Since weaknesses are internal, they are within your control
- Weaknesses include: bad leadership, unskilled workforce, insufficient resources, poor product quality, slow distribution and delivery channels, outdated technologies, lack of planning

Opportunities

- Opportunities – potential areas for growth and higher performance
- External in nature – marketplace, unhappy customers of competitor's, better economic conditions, more open trading policies...

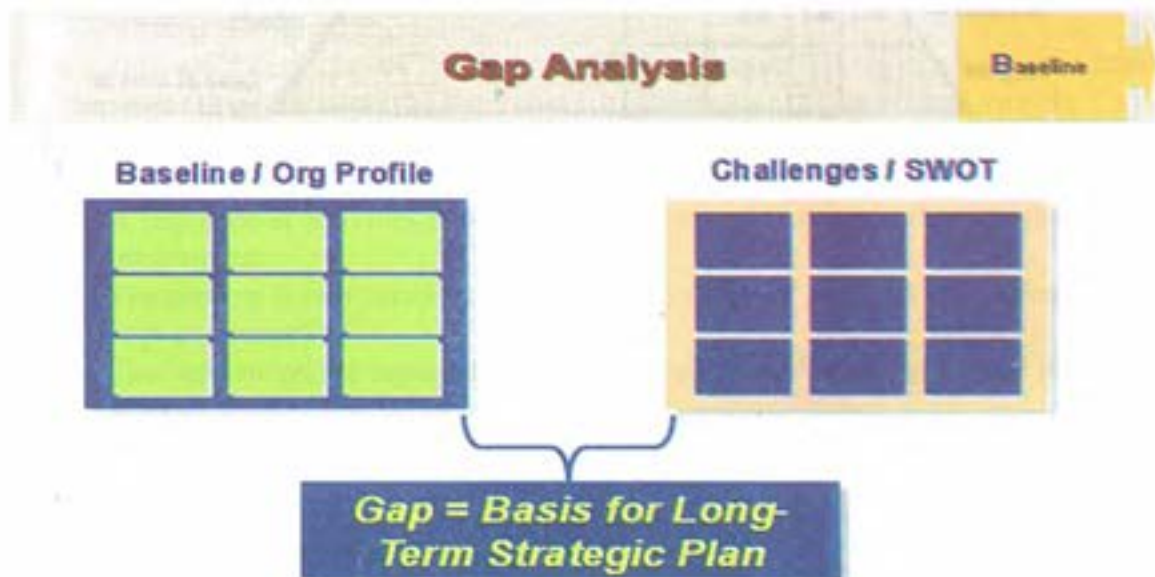
- Internal opportunities should be classified as strengths.
- Timing may be important for capitalising on opportunities.

Threats

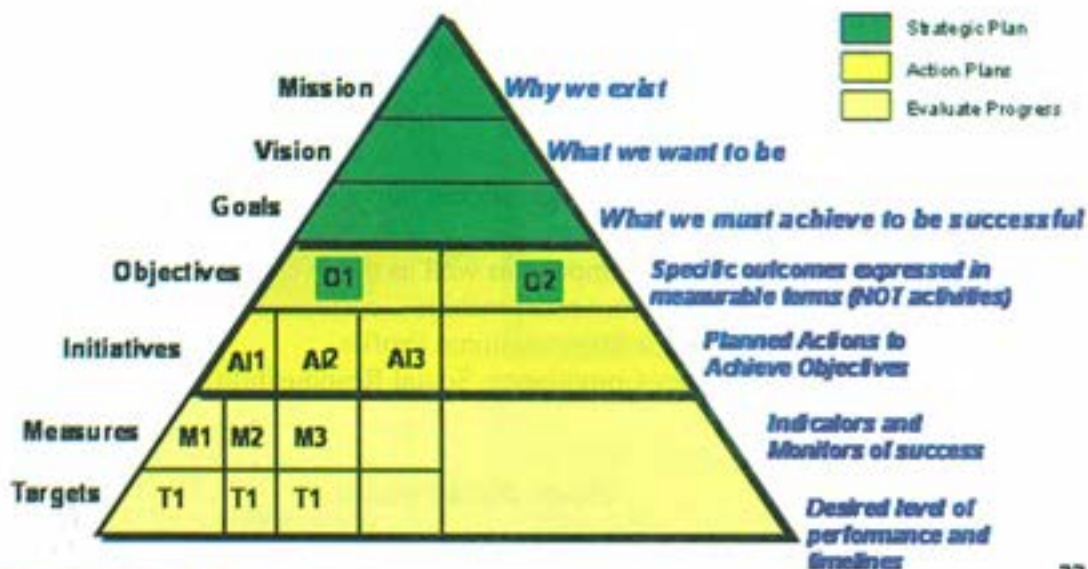
- Threats – challenges confronting the organisation, external in nature
- Threats can take a wide range – bad press coverage, shifts in consumer behaviour, substitute products, new regulations...
- May be useful to classify or assign probabilities to threats.
- The more accurate you are in identifying threats, the better position you are for dealing with the “sudden ripples” of change.

Baseline

- **Why create a baseline?**
 - Puts everything about the organisation into a single context for comparability and planning
 - Descriptive about the company as well as the overall environment
 - Include information about relationships – customers, suppliers, partners...
 - Preferred format is the Organisational Profile
 - External (Regulatory Compliance, Social Responsibility...)



Major Components of the Strategic Plan / Down to Action



Muller, Evans, and ...

Planning Topic 3: Micro Planning

Introduction: Micro planning is planning at the lowest level of development.

- It brings the planning process to the grass-root level to tackle specific problems at the micro region.
- Development of local resources and provision of infrastructure facilities receives due attention during the process of micro planning, along with local tradition, history, values, and practices.
- Lack of people's participation in the planning and implementation of programmes has been one of the reasons for unsuccessful implementation of different development schemes.
- It was assumed that without the active cooperation and support of the local people, identification of genuine needs and available resources at the local level would not be possible. This was termed as "planning at the grass-roots level" or "micro planning".
- Planning at micro level means:
 - The participation of the beneficiaries, the local people, in identifying need
 - Generating available resources in terms of (i) material inputs (ii) co-operative action (iii) creation of more resources through supportive efforts, and
 - Reparation of village plan, keeping in view the available resources.
- Micro planning is a comprehensive action planning procedure for producing development plans for upgrading settlements.
- Originally designed for use in developing countries, it is based on regular intensive workshops which involve a minimum of preparation, materials and training.
- The micro-planning procedure involves 8 to 12 community representatives working closely with a small team of experts and facilitators for several days.
- A sequence of activities is worked through to arrive at a development plan and work programme.
- The process is structured by charts on large sheets of paper which are completed and kept as a record.
- The workshops are repeated every year or so to monitor progress and plan the next stages.
- Micro-Level Planning (MLP): Making The Invisible Visible.

NB: MLP is a process whereby each individual household dwelling in a hamlet gets a fair chance to participate and design the plan.

- The beauty of the plan lies in people's approval and flexibility that gives a scope to revisit the steps and rectify the mistakes.
- When people of various categories with an individual focus are involved thoroughly in all the stages, i.e., right from problem analysis to resource allocation and role-defining, the process itself challenges the existing power structure without resorting to any violent means.
- Hence, probability of change in power equation, assertion of rights assigned to each individual under constitutional framework, and finally the development programmes (as designed by the people and approved by the state) do work out in tandem.
- For this very reason MLP is often defined as a people's empowerment process. As the communities get involved in the analysis of problems for formulation, execution and monitoring of MLP they get empowered in the process.
- The basis of MLP is people-centred and emphasising on people's decision.

- It gives opportunity to people to define "development" as per their own perception and do their planning accordingly so as to play the major role and become accountable in its implementation. Here, the bias of the planner is reduced to a large extent. The local resources are put into optimal use and the communities as critical support only to complement the local resources and initiatives mobilise external resources.
- The resources from various support agencies are pooled together to solve different village problems, thereby avoiding duplicity of efforts.
- It entails a more integrated development process, which is different from the present watertight departmental developmental programmes.
- The main reasons for undertaking local/micro-level planning are as follow;
 - Specific attention may be given to the needs of the targeted groups
 - Programmes are geared more towards the specific needs of the area
 - To decentralise the planning process
 - A closer partnership with the people and the planners can be established
 - The lowest echelons of the administration can be organised and coordinated.

Planning Topic 4: Project Cycle Management (PCM)

Participatory Planning

- Project cycle management (PCM) is the term given to the process of planning and managing projects, programmes and organisations. It is used widely in the business sector and is increasingly being used by development organisations.
- Development projects sometimes fail because they are badly planned and do not take account of some important factors, particularly the needs and views of stakeholders.
- PCM is based around a project cycle, which ensures that all aspects of projects are considered. A central value of the PCM method is that aspects of the project are reconsidered throughout the project cycle to ensure that any changes which have occurred are included in the project design. As a result, projects are more likely to be successful and sustainable.
- The starting point in discussing how projects should be managed properly is to first understand what a project is and just as importantly what it is not.

What is a Project?

- The word "project" was first used in or around the sixteenth century and derives from the Latin *projicere* (= throw forward). The Latin root thus suggests movement, a trajectory, a certain relationship with space and time.
- The implied process involves point of departure used as a base, from which one throws oneself forward towards a goal.
- The Oxford English dictionary defines 'project' as an individual or collaborative enterprise that is carefully planned and designed to achieve a particular aim, e.g., a nationwide project to encourage business development.
- A project is a method which enables us to move from an idea to action, structuring the various stages in the process.
- Projects represent the commitment of human and physical resources to produce specific outputs in a given time and budget framework.
- Projects vary in scale, purpose and duration. They may be initiated within a community, requiring modest inputs and producing tangible outputs within a relatively short timeframe.
- At the other extreme, projects may require substantial financial resources and only generate benefits in the long term. For example, the former could be an adult literacy project in a village; the latter may be the provision of universal primary education for all children of school age in a country. Whilst the former needs one trainer and a few teaching materials, the latter requires numerous schools, teachers, equipment and administration.
- Projects may stand alone or be integrated into a programme, with several projects contributing to one overall goal. Despite the difference in scale and nature of projects, there are aspects of sound project management that are universal.
- Types of project: development projects can vary significantly in their objectives, scope and scale.
 - Smaller projects might involve modest financial resources and last only a few months.
 - A large project, on the other hand, might involve many millions of Euro and last for many years. Examples of projects could include:

- A health service reform and expansion project, implemented primarily by the Ministry of Health of the partner government and with financial support of other donors, costing Euro 30m over 10 years;
- An emergency relief project, coordinated by the UN and implemented by international NGOs, costing Euro 5m over 1 year;
- Business promotion projects, providing grants to non-profit organisations of up to Euro 200,000 over a maximum time line of 2 years.
- A road and bridge building project, using a contracted project manager, costing Euro 50m over 5 years.

Characteristics of Projects

1. Projects have a purpose: Projects have clearly defined aims and set out to produce clearly defined results. Their purpose is to solve a "problem", and this involves analysing needs beforehand. Suggesting one or more solutions, a project aims at lasting social change.
2. Projects are realistic: their aims must be achievable, and this means taking account of requirements of both the financial and the human resources available.
3. Projects are limited in time and space: they have a beginning and an end, and are implemented in a specific place and context.
4. Projects are complex: projects call on various planning and implementation skills, and involve various partners and players.
5. Projects are collective: Projects are the product of collective endeavour. They are run by teams, involve various partners, and cater to the needs of others.
6. Projects are unique: All projects stem from new ideas. They provide a specific response to a need (problem) in a specific context. They are innovative.
7. Projects are an adventure: every project is different and ground-breaking; they always involve some uncertainty and risk.
8. Projects can be assessed: projects are planned and broken down into measurable aims, which must be open to evaluation.
9. Projects are made up of stages/phases: projects have distinct, identifiable stages/phases

Project Cycle Management

- A generic project cycle has six (6) different identified stages.
- In practice, the duration and importance of each stage may vary for different projects. This stages include:
 1. Identification – generation of the initial project idea and preliminary design
 2. Preparation – detailed design of the project addressing technical and operational aspects
 3. Appraisal – analysis of the project from technical, financial, economic, gender, social, institutional, and environmental perspectives
 4. Proposal preparation, approval and financing – writing the project proposal, securing approval for implementation, and arranging sources of finance
 5. Implementation and monitoring – implementation of project activities, with on-going checks on progress and feedback
 6. Evaluation – periodic review of the project with feedback for next project cycle
- Each stage of the cycle is essential and should be given the same amount of attention.

- Firstly, it is important to acknowledge that change is the only constant, aspects of humanitarian work are constantly in flux whether it is needs, people of concern, organisations, social and political relations, finance, and other activities.
- Secondly, it allows learning from the successes and challenges of completed work. Learning organisations have imbedded structures and systems to support institutional learning through project cycle management.
- Examples from the European Commission's (EC) external Aid Programme:
 - The generic project cycle within all European commission's (EC) programmes share three common themes:
 - Key decisions, information requirements, and responsibilities are defined at each stage.
 - The stages in the cycle are progressive – each phase needs to be completed for the next to be tackled with success.
 - New programming draws on evaluation to build experience as part of the institutional learning process.
 - Aid co-operation and partnership programmes with non-member states involve often-complex processes that require the active support of many parties.

PCM reflects the decision-making and implementation process; the methodology applied for planning, managing, evaluating projects is the Logical Framework Approach.

- PCM helps ensure that the stakeholders support the decisions, and that decisions are based on relevant and sufficient information.
- Project management methods and PCM tries to ensure that:
 - Projects respect and contribute to overarching policy objectives of the EC such as respect of human rights and poverty alleviation, and to cross-cutting issues such as gender equality and protection of the environment (relevance to and compatibility with these issues in the broad sense).
 - Projects are relevant to an agreed strategy and to the real problems of target groups/beneficiaries
 - Projects are feasible, meaning that objectives can be realistically achieved within the constraints of the operating environment and the capabilities of the implementing agencies
 - Benefits generated by projects are sustainable. For that purpose, PCM
 - Uses the Logical Framework Approach to analyse the problems, work out suitable solutions, i.e., project design, and successfully implement them.
 - Requires the production of good-quality key document(s) in each phase, to ensure structured and well-informed decision-making (integrated approach).
 - Requires consulting and involving key stakeholders as much as possible.
 - Puts emphasis on a clear formulation and focus on one Project Purpose, in terms of sustainable benefits for the intended target group(s).
 - Incorporates key quality issues into the design from the beginning.

The Project Cycle:



Project Design Matrix (PDM)

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumptions
Overall Goal			
Project Purpose			
Outputs			
Activities	Inputs		
			Pre-conditions

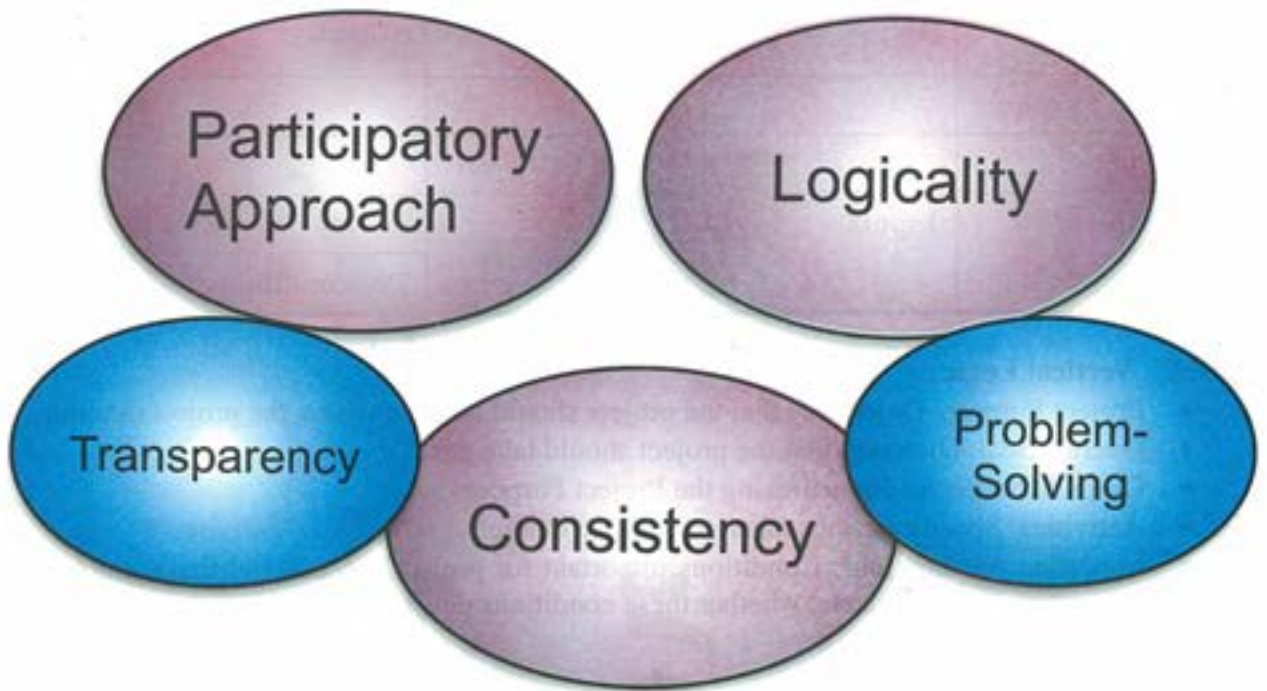
PDM Vertical Logic

- Project Purpose: Objectives that the project should achieve within the project duration
- Overall Goal: Direction that the project should take next
- Outputs: Strategies for achieving the Project Purpose
- Activities: Specific actions taken to produce Output
- Important Assumptions: Conditions important for project success, but that cannot be controlled by the projects; whether these conditions develop or not is uncertain.

PDM Horizontal Logic

- Objectively Verifiable Indicators: Standards for measuring project achievement
- Means of Verification: Data sources from which indicators are derived
- Inputs: Personnel, materials, equipments, facilities, and funds required by the project
- Preconditions: Conditions that must be fulfilled before a project gets underway

CHARACTERISTICS OF PCM



Subject 1.5: Monitoring and Evaluation in Health Care

Aim: To enable participants understand the basics of monitoring and evaluation in the context of primary health care for effective decision making and programme management

Objectives:

- To identify the basic purposes and scope of monitoring and evaluation
- To identify the differences between monitoring and evaluation
- To describe the functions and components of monitoring and evaluation plan
- To describe how to use statistical tools to collate and analyse data for decision making
- To describe the quality of good data and indicators for effective monitoring and evaluation

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the most important elements of data quality
- Be able to identify key data indicators and targets for activities within the scope of their responsibilities.

Topics

T1. Overview

T2. Data quality, indicators, and targets

T3. Practical application of probability and statistics in PHC

M&E Topic 1: Overview

Introduction

- Monitoring and evaluation (M&E) is an essential component of any intervention, project, or programme
- **Monitoring** of a programme or intervention involves the collection of routine data that measure progress towards achieving programme objectives.
 - It is used to track changes in programme performance over time.
 - Its purpose is to permit stakeholders to make informed decisions regarding the effectiveness of programmes and the efficient use of resources.
- Monitoring is sometimes referred to as **process evaluation** because it focuses on the implementation process and asks key questions:
 - How well has the programme been implemented?
 - How much does implementation vary from site to site?
 - Did the programme benefit the intended people? At what cost?
- **Evaluation** measures how well activities have met expected objectives and/or the extent to which changes in outcomes can be attributed to the programme or intervention.
- The difference in the outcome of interest between having or not having the programme or intervention is known as its "impact", and measuring this difference is commonly referred to as "**impact evaluation**".

Basic Monitoring and Evaluation Concepts

- **Monitoring:** process of continuous data collection and observing implementation of activities to ensure they follow plans and to take early remedial actions
 - Inputs=>Process=>Outputs = Quality of Service
- **Evaluation:** process of assessing a programme to see if purpose has been achieved and programme was relevant. The process of evaluation highlights
 - The effectiveness of programme or Intervention
 - Research methods – needed
 - Can either be summative or formative
- **Why do we need M&E?**
 - To show how programme is working
 - To strengthen programme
 - To institutionalise programme
 - To sharpen decisions of funding agencies
 - To contribute to global understanding of what works
 - To mobilise communities to support programme
 - To improve programme performance
- Planning stage is integral to overall plan

What are the key parts of the M&E plan?

- Schedules
- Monitoring check list
- Resources – financial and people

What kind of data do we need?

- Financial
- Medical and health status
- Programme results
- Coverage data

M&E Topic 2: Data Quality, Indicators, and Targets

Indicators

- **Indicators** are clues, signs, or markers that measure one aspect of a programme.
 - They show how close a programme is to its desired path and outcomes.
 - They are used to provide benchmarks for demonstrating the achievements of a programme.
- One of the most critical steps in designing an M&E system is selecting appropriate indicators.
- The M&E plan should include descriptions of the indicators that will be used to monitor programme implementation and achievement of the goals and objectives.

Characteristics of indicators

A good indicator should:

- Produce the same results when used repeatedly to measure the same condition or event
- Measure only the condition or event it is intended to measure
- Reflect changes in the state or condition over time
- Represent reasonable measurement costs; and
- Be defined in clear and unambiguous terms.

What are the Targets of M&E?

- They are levels of objectives to be achieved in stated time
- Examples:
 - Cut malaria burden in half by 2011
 - Reduce prevalence from 4.5% to 3.0% by 2011

What are the Indicators of M&E?

- Measurable statements of programme objectives and activities
- Formulated from programme objectives and activities
- Examples
 - Contraceptive prevalence rates
 - Maternal mortality rates
 - Percentage of births attended by skilled personnel

M&E Topic 3: Practical Application of Probability and Statistics in PHC

Statistics

- Statistics is the scientific way of collecting, organising, summarising, analysing, interpreting, and presenting data.
- Statistics deals with inferences in trying to make conclusions out of the whole populations.

Probability

- The likelihood of the occurrences of events
- Helps in predicting outcomes and in taking decisions (inferential statistics)

Basic probability – Dice: Toss one fair die and observe the number of dots on the top face.

- The probability of an outcome must lie between 0 and 1, inclusive.
- The sum of the probabilities of the outcomes MUST equal 1.
- The probability of a *certain* event is 1.
- The probability of an *impossible* event is 0.

Practical application of probability

- Rates/Ratio/Proportion
- Assessment of PHC services
- Sampling Methods
- Research
- Investigation of outbreak
- Community diagnosis
- Data presentation

Relevance of statistics

- Medical outcomes
 - Morbidity rates
 - Mortality rates
- Social Acceptability
 - Quality of services (Technical quality)
 - Client satisfaction
 - Equity/Equality
- Economic Efficiency
 - Achieving the same objectives by the cheapest methods
 - Using the same means to achieve the greatest benefits

Use of statistical tools to collate and analyse operations data

- Sources of health data and Information for PHC
 - Population and household census
 - Vital events register – records of vital events such as births, deaths, marriages, and divorces
 - Routine health services data dealing with morbidity and mortality data, immunisation, disease treatment, outpatient attendance and admission
 - Epidemiological surveillance data – including immunisation records and notifiable diseases
 - Disease registers for specific morbidity and mortality

- Community surveys undertaken by government agencies, international agencies, Non-Governmental Organisations, research groups, etc.

Core areas of statistics

- Measures of central tendencies (mean, median, mode, mid-range)
- Measures of dispersion (variance, standard deviation, range, coefficient of variation)
- Normal distribution
- Concept of P-Value
- Confidence intervals
- T-test (paired and unpaired)
- Chi square
- Correlation and regression
- Sampling methods

Data presentation

- The appropriate statistical tools commonly used in presenting descriptive statistics include
 - Frequency tables
 - Diagrams or graphs, e.g., bar charts, pie charts, histogram
 - Summary statistics

Data summarisation

- There are two well-known summary measures for the numerical description of any data:
 - Measures of central tendency
 - Measures of dispersion

Challenges of data collection

- **What are the challenges of data collection at PHC level?**
 - Lack of interest
 - Inadequately trained personnel
 - Funding
 - Over-dependence on donors
 - Non-availability of data-collection tools
 - Multiple data-collection tools from various international organizations require different processes and take substantial time

Way forward

- Strengthening the PHC HIS structure at the bottom
- Staff training and orientation towards HMIS
- Provision of appropriate information technology for data and information
- Strengthening of data flow
- Data and information dissemination
- Data collection from private health institution

Example of a skills station for this topic

You have been asked to present basic statistics that will reflect the activity of your clinic over the past week. You have the following data available to you:

Indicator	Monday	Tuesday	Wednesday	Thursday	Friday	
Patient visits	150	70	90	80	70	
Number of staff	10	7	9	10	8	

Questions

1. What is the arithmetic mean (average), the median, and the mode of the daily patient visits for this week?
2. What is the standard deviation of patient visits per week?
3. Explain the practical meaning of the difference in the mean and median of patient visits per week.
4. What is the mean and median number of staff per day during this week?
5. What is the average number of visits per day per staff member for the week?
6. Prepare at least two useful charts and graphs that depict the relationship between patient visits and number of staff members.

MODULE 2: HEALTH CARE FINANCING AND HEALTH ECONOMICS

Subjects

- 2.1 Health Care Financing in Nigeria
- 2.2 Economic Evaluation in Health Care
- 2.3 Effective Financial Management Systems in PHC

Subject 2.1: Health Care Financing in Nigeria

Aim: To update the skills of the participants on effective and sustainable methods of mobilisation of resources for PHC

Objectives:

- To update participants' knowledge of the various strategies for financing PHC
- To describe the health care financing functions
- To identify the advantages and disadvantages of the financing options
- To update the participants' knowledge of mechanisms of health care financing

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the various financing options available for PHC within the country
- Know how to harness these options in enhancing financing for PHC activities within the scope of participants' responsibilities
- Know how to pool resources for PHC activities within the scope of participants' responsibilities
- To know how to expend resources effectively and within policy guidelines for activities and programmes within the scope of participants' responsibilities

Topics:

- T1. Health care financing options for PHC
- T2. The National Health Insurance Scheme
- T3. Community health care financing option
- T4. Contemporary issues on health care financing

Financing Topic 1: Health Care financing option for PHC

Definition:

- **Definitions:** Health care financing refers to the strategies or means of paying for health care expenditure, i.e., goods and services whose primary aim is to promote health and well-being.
- **Functions:**
 - Collection of revenue from the various sources
 - Pooling of funds
 - Purchase/payment: This is the transfer of pooled resources/funds to health care providers
- **Mechanism :** Basically, there are 3 main mechanisms for health care financing:
 - Funding mechanisms
 - Public: through taxes, loans, grants, insurance, etc.
 - Private: through fee for service, employer-financed schemes, etc.
 - Allocation mechanism: based on service package, matching grant mechanism, supply-side Vs demand side mechanism, etc.
 - Payment mechanism: either per case, per capita, global budgeting, or diagnoses-related payment

Example of a skills station for this topic

Today inadequate funding has been identified as a major challenge to the delivery of comprehensive and quality health care services.

1. List ALL the possible sources from which funds can be made available for financing the health care delivery services in Nigeria.
2. From the list above, choose the source(s) you deem appropriate considering the peculiarity of the present Nigerian society.

10 minutes

Salient features of some Health Care financing options

Community financing

- **Advantage**
 - It builds the spirit of self-reliance, self-development, and ownership. It also addresses perceived needs of the community and improves the utilisation of services, the organisation capacity of the community, and accountability. Furthermore, it has the potential for generating a huge amount of resources.
- **Challenges**
 - Top-down approach in public health planning may limit community participation; due to the lack of cohesion and scattered nature of settlement in rural areas, at times the need of the community may be a basic need and not a health need; low orientation of health workers on community financing, etc.
- **Strategies for generating resource for community financing**
 - Private donations from individuals, health agencies, or organisations; income-generating activities/project (e.g., cooperatives, communal labour); special fundraising events: dinner, festivals, shows, bazaars, etc.
 - **Strategies for payment under community financing:**
 - Prepayment; co-payment; standard rate of payment for services; payment for only cost of material used, etc.

- **Health Insurance**
 - **Advantages:** Pooling of resources; sharing of risk; protects members against catastrophic health expenditure; a defined benefit package; a defined annual premium, etc.
 - **Challenges:** Tendency of over-provision of services by the provider; adverse selection; moral hazards; cost escalation, etc.
- **Donor fund:** Can generate substantial input for health care finance; provides additional funds for service provision (e.g., PEPFAR, Bill and Melinda Gate Foundation, Carter Centre, etc); has potential to distort national programmes; potential for imposing donor agenda, etc.
- **Government funding:** Potential to provide huge-based capital for health infrastructure; potential to promote equity; can be used for funding public goods; can be subjected to inefficiencies and bureaucracies of the public sector; can be subject to abuse and corruption
- **User charges:** May prevent wasteful utilisation of services and procedures; does not promote equity (the poor who need services may be denied based on their inability to pay for the service); pauperising effect (it impoverishes the poor), etc.

Financing Topic 2: National Health Insurance Scheme

Overview

- Oftentimes, illnesses/injuries are unpreventable. When they occur the cost may be high and there may be little or no time to mobilise the needed resources for the needed cure. Thus the need to pool these risks so that Health Insurance (HI) refers to an insurance against loss by illness or bodily injuries through the pooling of health risk.
- Therefore, National Health Insurance (NHI) is the pooling of resources by groups of individuals to take care of health needs by legislation, involving employers and employees. Usually, NHI has an in-built mechanism to cover the unemployed, poor, and aged.

NHIS: The Nigerian experience:

- The search for a comprehensive, cost-effective healthcare plan began in the 60s at the inception of self-government in Nigeria.
 - Public health insurance was first considered an administrable policy in 1962 by the Halevi Committee and acquired legal teeth through the Lagos Health Bill.
 - However, it was not until 22 years later that the government, driven in part by a dwindling revenue profile and a spiraling birth rate, set up a committee headed by Professor Diejomoah to advise it on the desirability or otherwise of a National Health Insurance Scheme. The committee's positive recommendation set the ball rolling.
 - Two more committees, with wider public and organised private sector participation, were set up in 1985 to further study the subject, while a harmonisation committee was inaugurated to work out a feasible model in 1988.
 - In 1988, Professor Olikoye Ransome-Kuti commissioned the National Committee on Establishment of the NHIS, chaired by Mr Emma Eronmi.
 - In 1989, the Eronmi committee report was submitted and approved by the Federal Executive Council.
 - The United Nations Development Programme (UNDP) and International Labour Organization (ILO) consultants conducted their own studies in Nigeria to provide costing, draft legislation, and implementation guidelines for establishing the NHIS in 1992.
 - The Federal Executive Council, which had given its approval in 1989, directed the Federal Ministry of Health in 1993 to start the scheme.
 - In 1999, the enabling decree – Decree 35 was promulgated May 10, 1999 – finally creating the NHIS.
 - Several meetings of the National Council on Health, the country's broadest health policy formulating body, deliberated on the recommendations of these committees, fine-tuning contentious proposals until they finally convened the Special meeting of July 2001, where the Council set up an Implementation Planning Committee upon whose report the scheme finally took off.
 - The scheme aims to harness private-sector participation in healthcare delivery, freeing public funds for other social services while ensuring standard service delivery.
 - On the 6th of June 2005, the formal sector of the Social Health Insurance Scheme was flagged off by then-president Chief Olusegun Obasanjo
- **Benefits of health insurance:** these are the rights of the beneficiaries of the scheme.
 - Cash payment: in form of compensation paid for loss of income or expenses to patients, e.g., sickness allowance, maturity allowance, funeral grant, etc.

- Health service benefits: these refer to the categories or the range of services available to the members of a scheme.
- **Delivery system in Health Insurance**
 - The delivery of health insurance has undergone transition through several phases from: fee for service payment, then indemnity insurance coverage, managed care, etc.
 - **Determinant of a Delivery System in a Health Insurance:** cultural factor; making of capital; level of private health care service; maturity of health insurance care, etc.
 - **Modes of delivery:** through government-sponsored NHI; employer plans (e.g., employer-sponsored group policies); prepayment plan (individuals join a group to which they make payments in return for needed health care); private insurance to cover fees, etc.
- **Health Maintenance Organisation (HMO)**
 - An HMO is an organisation that offers pre-paid, comprehensive health care coverage.
 - They manage rather than actually provide health care services to individuals.
 - An HMO provides health care service to its members through a network of doctors, hospitals, and other health care providers.
 - Implement utilisation management controls
 - There may be co-payment (direct or indirect) for use of certain services.
 - HMOs bear some of the financial gain.
 - Proper referral system is mandatory: primary care providers act as "gatekeepers"
 - HMOs can cover a large variety of services at a significantly low cost.
 - The financial burden of risk of over-using health services are borne by the HMO, its service providers, or a combination of both.
 - The member must receive health care from an HMO-approved provider.
 - HMOs assume contractual responsibility for assuring the delivery of stated range of health care service.
 - HMOs serve a voluntarily enrolled population.
 - The premium is fixed, regardless of utilisation.
 - Costs associated with HMO can be in the form of
 - Premium: monthly amounts paid for coverage.
 - Co-payment: amounts paid each time a member receives a covered medical service, e.g., doctor visits, prescription drugs, etc.
- **NB:** HMO does not pay for medical care received outside its network except where it is stated in the contract, e.g.,
 - Medical emergency and treatment sought in an emergency facility as defined by the HMO
 - Medically necessary services not available from providers within the HMO network
 - The member has a point of service option.

Example of a skills station for this topic

Enumerate the challenges facing the implementation of the NHIS in Nigeria and proffer a solution to each challenge identified.

Financing Topic 3: Community Health Care Financing/Community Health Insurance Schemes

Background:

- A large portion of the total expenditure on health (THE) is private, and most of this flows directly from households to the private-for-profit health care sector.
- Unfortunately, the poor lack the resources to pay for health care. As such, they are far more likely to avoid seeking care, or are likely to become indebted or impoverished trying to pay for it.
- The World Health Report 2000, for example, noted that pre-payment schemes represent the most effective way to protect people from the costs of health care, and called for investigation into mechanisms to bring the poor into such schemes.
- In recent years, community health insurance (CHI) has emerged as a possible means of:
 - Improving access to health care among the poor and
 - Protecting the poor from indebtedness and impoverishment resulting from medical expenditures.
- Various other terms are used in reference to community health insurance, including: 'micro health insurance', 'local health insurance'
- We define CHI as "any not-for-profit insurance scheme that is aimed primarily at the informal sector and formed on the basis of a collective pooling of health risks, and in which the members participate in its management." CHI schemes involve prepayment and the pooling of resources to cover the costs of health-related events.
- They are generally targeted at low-income populations, and the nature of the 'communities' around which they have evolved is quite diverse: from people living in the same town or district, to members of a work cooperative or micro-finance group.
- Often, the schemes are initiated by a hospital, and targeted at residents of the surrounding area. As opposed to social health insurance, membership is almost always voluntary rather than mandatory

Types of CHIS:

- In Type I (or HMO design), the hospital plays the dual role of providing health care and running the insurance programme.
- In Type II (or Insurer design), a voluntary organisation is the insurer, purchasing care from independent providers.
- In Type III (or Intermediate design), a voluntary organisation plays the role of an agent, purchasing care from providers and insurance from insurance companies.

Rural Community Health Insurance Programme in Nigeria

- **Operation:**
 - Under the RCHIS programme, community members
 - make a monthly payment of between N120 and N150 for the most common of ailments like malaria, typhoid fever, diarrhoea, etc.
 - only need to present an NHIS participant's card at an approved healthcare service centre to receive medical care, no need for deposit.
 - Participants requiring specialist or longer treatment would need to pay for the balance from what they are entitled from the common pool

- - NB: Participants under the RCHI programme need not belong to any occupational group but must belong to same community.
- The RCHI Programme was expected to cover Nigeria's rural folks, who constitute over 50% of its then-120 million population.
- The Rural Community Social Health Insurance and the Under-5 Children Health Programmes of the scheme were flagged off in Ijah, a rural community in Niger state.
- Four more flag-offs have since taken place in Aba, Abia state, South-East zone; Jada, Adamawa State, North East zone and for the South West zone, it was in Ogun State. The North West Zonal flag off took place at Zangon-Aya, in Kaduna state, while that of the South-South zone was done later on.
- The RCHI programme, when fully operational, will allow contributors to reap the gains of quality healthcare services at reasonable costs.
- **Some other examples of Community schemes include:**
 - Bayelsa Health Services scheme in Bayelsa State
 - Ndo Nwanne Health Insurance scheme in Enugu State
 - Leguru I (Ala-Idowa) Health Insurance Scheme in Odogbolu LGA in Ogun State
 - "The Lawanson Community Partners" Insurance Scheme in Surulere LGA, Lagos State
 - The Oriade Initiative in Oriade LGA of Osun State
 - The Mumunye Health Project, Yakoko, Zing LGA in Taraba State.

Example of a skills station for this topic

- Identify the factors in your individual host communities that will enhance a RCHIP
- Similarly, identify likely challenges to the smooth take off of a RCHIP in the same communities
- Propose a plan of action for the introduction of a RCHIP

Financing Topic 4: Contemporary Issues in Health Care Financing

Global Fund

- **Background**
 - The Global Fund was created in 2002 to help the world battle three killer diseases (malaria, TB, and HIV/AIDS), and its accomplishments have been spectacular, making it arguably the most successful innovation in foreign assistance of the past decade.
 - The Global Fund programmes' remarkable successes result from its operational procedures.
 - Disease-specific committees, called the Country Coordination Mechanism (CCM), are constituted in each developing country. Each CCM is chaired by the national government, but incorporates input from non-government organisations to formulate national-scale, disease-specific plans for submission to the Global Fund.
 - Once the Global Fund receives these plans, they are sent to a Technical Review Panel (TRP) to check that the plans are scientifically sound and feasible.
 - If the TRP approves, the plan is sent to the board of the Global Fund, which then votes to approve financing.
 - Once the programme gets underway, the Global Fund follows the implementation of the programme, undertaking audits, monitoring, and evaluation.
- Since 2002, the Global Fund has approved around \$19 billion in total funding.
- There are two huge challenges now facing the Global Fund, and especially the donor countries that support it.
 - The first challenge is lack of financing. The Global Fund has been so successful that countries are submitting increasingly ambitious programmes for consideration. Unfortunately, the Global Fund is already in a state of fiscal crisis.
 - It needs around \$6 billion per year in the next three years to cover expansion of programmes for the three diseases.
 - It has only around \$3 billion per year from donor countries, leaving a \$3 billion gap.
 - Unless this is corrected, millions of people will die unnecessarily.
 - The second challenge is to broaden the Global Fund's mandate.
 - So far, the Global Fund has addressed MDG 6, which is focused on the control of specific killer diseases.
 - Yet control of these three diseases inevitably requires improvement of basic health services – community health workers, local clinics, referral hospitals, emergency transport, drug logistics – that play a fundamental role in achieving MDG 4 (reduction of child mortality) and MDG 5 (reduction of maternal mortality).
 - All three health MDGs are interconnected; all are feasible with an appropriate scaling up of primary health services.
 - The obvious step to address MDGs 4 and 5 is to explicitly expand the Global Fund's financing mandate.
- Many programmes, such as those in the Millennium Villages project, already show that a scaling up of primary health systems at the village level can play a decisive role in reducing child and maternal mortality.

- Expanding the Global Fund's mandate to include financing for training and deployment of community health workers, construction and operation of local health facilities, and other components of primary health systems could ensure the development of these local systems.
- Many countries – including France, Japan, Norway, the United Kingdom, and the United States – have recently recognised the need to move beyond the financing of control of AIDS, TB, and malaria to financing improvements in primary health systems more generally.
 - But they seem to view the issue of health-system financing as an either-or choice: scale up control of AIDS, TB, and malaria, or scale up financing of primary health systems.
 - The truth, of course, is that both are needed, and both are affordable.
- The annual cost of specific disease control in the next three years is perhaps \$6 billion, and another \$6 billion per year for health-system expansion.
- The total, \$12 billion per year for an expanded Global Fund, might seem unrealistically large compared to the \$3 billion per year spent now.
- But total annual funding of \$12 billion is really very modest, representing around 0.033% (three cents per \$100) of the donor countries' GNP. This is a tiny sum, which could be easily mobilised if donor countries were serious.

Medium Term Expenditure Framework (MTEF)

- MTEF was adopted in 1998 as part of a broader package.
- MTEF is a tool for linking policy, planning and budgeting over a medium term (3 years) at the government-wide level, although only the single upcoming year is voted on by the parliament, each year.
- It consists of a top-down resource envelope and a bottom-up estimation of the current and medium-term costs of existing policy.
- Matching of policy priorities and budget is done in the context of the annual budget process; it involves rolling over this exercise every year by incorporating policy changes and government presents the numbers for the following two years as well.
- It is a tool to encourage cooperation across ministries and planning over a longer horizon rather than just the upcoming fiscal year.
- **Objectives of MTEF**
 - Improved macroeconomic balance, especially fiscal discipline
 - Integrating policy priorities (identified in NEEDS) into annual budget: resources allocated to priorities to ensure credible policy
 - Better inter- and intra-sectoral resource allocation
 - Greater budgetary predictability for line ministries by providing mid-term perspective (3-5 yrs)
 - Enhancing operating efficiency: high quality, low cost
 - Greater accountability for public expenditure
- **Advantages/benefits/potentials of MTEF**
 - Enhances stability by letting MDA know what resources will likely be available to them
 - Emerges investment by making taxation, interest rates, and government spending more predictable
 - Improves transparency: cutting future spending provides a signal to the public about the government's priorities and how it intends to implement its vision

- Facilitates programme evaluation; the future predictions also provide a baseline for assessing the effectiveness of the past year's programme

Experience in Africa			
Countries	Year of initiation	Scope and format	Government level & length of period
Ghana	1996	All sectors/recur/cap	Central, 3 years
Kenya	1998	All sectors/recur/cap	Central, 3 years
Malawi	1996	All sectors/recur/cap	Central, 3 years
Rwanda	1999	15/20 sectors/recur	Central and regional
S. Africa	1997	All sectors/recur/cap	Cen/prov/local, 4yrs
Tanzania	1998	7 sectors/recur/cap	Central, 3 years
Uganda	1992	All sectors/recur/cap	Central/local, 3 yrs
Nigeria			

Source: Hoyerou and Taliercio (2002)

- **Preconditions for implementing MTEF**
 - Strong political support
 - MOF /NPC's willingness/commitment: clear understanding of MTEF and incentives; strong leadership within MOF
 - Compliance of line ministries: proper incentives (discretion and policy prioritisation)
 - Capacity building for MOF and line ministries

Sector-Wide approaches (SWAp)

- SWAp is an approach to international development that 'brings together governments, donors and other stakeholders within any sector. It is characterised by a set of operating principles rather than a specific package of policies or activities. The approach involves movement over time under government leadership towards: broadening policy dialogue; developing a single sector policy (that addresses private and public sector issues) and a common realistic expenditure programme; common monitoring arrangements; and more coordinated procedures for funding and procurement.' (*World Health Organization, World Health Report 2000*).
- Another definition for SWAp is provided by Foster (2000:9) as: 'All significant funding for the sector supports a single sector policy and expenditure programme, under government leadership, adopting common approaches across the sector, and progressing towards Government procedures to disburse and account for all funds.'
- Traditionally, aid to developing countries has been provided in the form of self-contained projects, each funded by their own donor.
- In the 1990s this approach began to attract criticism for being donor-driven (i.e., reflecting donor rather than country priorities) and leading to fragmentation and duplication.
- It was recognised that many individual projects posed unrealistic demands on developing countries' limited economic and human resources.
- In response, the international community began to reform its methods of aid delivery and the Sector-Wide Approach (SWAp) emerged.
- Under the SWAp, project funds contribute directly to a sector-specific umbrella and are tied to a defined sector policy under a government authority.

- In essence, a SWAp calls for a partnership in which government and development agencies change their relationships (to clearer government leadership). They interact more together in the formulation of policy, and less on the details of its implementation.
- Key characteristics of the SWAp should include:
 - The partner government clearly leads and owns the programme; and
 - A common effort by external partners to support that programme, including provision of all or a major share of funding for the sector, in support of the government's unified policy and expenditure programme.
- Over time, some SWAp progress towards using government procedures for implementation and the disbursement of funds.
- In practice, most programmes are in the process of drawing in diverse channels of funding, making the coverage of the sector more comprehensive, bringing ongoing projects into line with sector priorities, developing common procedures, and placing increased reliance on government for management. Where SWAp are appropriate, they can help to promote greater local involvement, accountability, and capacity in partner countries.
- However, SWAp are not possible in all cases: certain preconditions in the macroeconomic, policy, and institutional environment are necessary.

Key issues and challenges

- First and foremost, a SWAp explicitly mandates the ministry of health with the leadership. However, this role has been partly problematic owing to limited leadership capacity (e.g., Rwanda), poor relationship with the ministry of finance (e.g., Mozambique), slow shift of ownership (e.g., Cambodia), change of senior management (e.g., Zambia), little ministry of health leverage to secure additional funds (e.g., the United Republic of Tanzania), and low priority of cross-sectoral collaboration.
- Second, a SWAp emphasises strengthened health sector management through the development or adaptation of management tools, combined with strengthening of implementation capacity. For example, under SWAp, greater attention is given to health sector planning, financial management, and improved health information systems. SWAp also tend to emphasise strengthening district-level management capability within existing decentralisation policies (e.g., Ghana, Uganda, and the United Republic of Tanzania).
- Third, under a SWAp, recipient governments and donors only fund activities in the national health sector plan. Donor funds are pooled and earmarked for high-priority activities, such as essential health packages (e.g., Uganda, Tanzania). Importantly, pooled donor funding supports government budgets, giving a much-needed boost to recurrent expenditures. Furthermore, donors are responsible for synchronising their own planning, review, and monitoring processes with government systems, and give long-term projections of aid pledges.
- Fourth, monitoring and evaluation of the health sector become institutionalised under a SWAp. The "one voice" of donors has strengthened their position to create conditions. The once- or twice-yearly joint review meeting is an important instrument providing an open forum to review the progress and performance of the health sector. These large meetings are complemented by more frequent meetings with key development partners. The success of these processes depends mainly on the people involved and their experience, expertise, and sensitivity to developing partnerships.

Global Economic Recession

- The health sector in Africa is financed from a multiplicity of sources, both public and private. The public sources include government revenue, loans and grants, insurance, and donor financing, while the private sources include user charges, private insurance, and employer-financed schemes.
- In most African countries, particularly in sub-Saharan Africa, donor financing has constituted a huge part of health sector financing, particularly for key public health interventions for HIV/AIDS, tuberculosis, malaria, immunisations, etc.
- Recession simply means decreased economic activity marked by reduced spending, decline in a country's GDP, and a negative economic growth for two or more quarters.
- A full-blown American recession began in early 2008, sending reverberation and shock waves around the world. The subsequent collapse of the economic industries has sent shock waves to other sectors, including the health sector.
- The onset of the global economic recession has posed a threat to health sector financing due to declining government revenue, reduced donor commitment in fulfilling donor obligations (since donor countries are worst hit by the recession), low coverage rate of social health insurance, etc. The resultant charging of user fee will deny access to health care for the impoverished population who are also hit by unemployment or employment loss, reduced remittance from relatives abroad, etc., which are also caused by the recession
- Consequently, this may retard or even reverse the progress towards attainment of development goals; e.g., millennium development goals (MDG), global polio eradication initiatives (GPEI), Roll Back Malaria (RBM), etc.

Subject 2.2: Economic Evaluation in Health Care

Aim: To update the skills of the participants on effective and sustainable and efficient methods identification alternatives in management of resources.

Objectives:

- To introduce participants to the use and application of economic evaluations in PHC
- Enhance participants' knowledge of cost analysis, cost effectiveness analysis, cost benefit analysis, and cost utility analysis

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the basic application of economics in health care and PHC
- Understand the basic elements of different means of assessing health care effectiveness, including cost effectiveness analysis, cost benefit analysis, and cost utility analysis
- Be able to apply the different methods of economic analysis in managing scarce resources for PHC activities within the scope of their responsibilities

Topics:

- T1. Introduction to the uses, methods, and approaches of economic evaluation
- T2. Cost analysis in health care
- T3. Cost effectiveness analysis
- T4. Cost benefit analysis
- T5. Cost utility analysis

Economic Evaluation Topic 1: Introduction To The Uses And Applications Of Methods Of Economic Evaluation

Objectives:

- To help participants describe the methods of economic evaluation
- To describe how the three methods can be used in PHC programmes
- To help participants to understand the role of economic evaluation in PHC

Definition: Economic evaluation is the use of applied analytic methods to identify, measure, value, and compare the cost and outcome of alternative interventions.

Why use Economic Evaluation methods?

- Resources are scarce, but wants are unlimited
- Trade-off must be made
- Opportunity cost is what you give up in order to gain something else

The objective of Economic Evaluation is

- To facilitate the use of scarce resources to maximise health outcomes
- To give value to decision making
 - Planning phase
 - Choose between competing alternatives
 - Determine whether the programme might provide value for money
 - Inform efficient allocation of resource between programmes
 - Evaluation phase
 - Determine whether a programme provides good value
 - Decide whether to continue, expand, reduce, or end a programme or health intervention to make best use of resources

Advantages of economic evaluation

- Forces the allocation and quantification of information
- Organises and systematises information
- Integrates the economic and epidemiologic aspects of intervention to provide understanding of trade-offs
- Emphasises the scarcity of resources
- Makes explicit the returns on the health interventions

Disadvantages of economic evaluation

- Requires the quantification of factors that may not be easily quantified
- Can only incorporate a limited number of factors
- Involves methodological challenges for rigorous application

Core principles of economic evaluation:

- Assesses:
 - Cost of intervention
 - Outcome or benefit of an intervention
- Adopts a perspective to understand cost and benefit
 - Patient: cost of not feeling well, medicine, consultation fees, transportation to clinic, duration of the visit, travel time to and from the clinic

- Employer: cost of lost productivity at work because of sick leave
- Health authority: cost of treating the patient
- Society: cost of all the above

Common application of economic evaluation in public health

- **Cost studies**
 - **Programme cost analysis**
 - Estimates the total cost of a programme
 - Reported as cost per patient, cost per service provided
 - Uses: budgeting, accountability (programme cost, efficiency)
 - Basis for a full economic evaluation
 - **Burden-of-disease analysis**
 - Is the cost of illness or infection
 - Estimates the total cost attributable to a disease/event: direct (medical and non-medical costs); productivity losses
 - Reported as total annual cost, average cost per patient, cost per infection or episode
 - Can indicate the potential benefit of public health intervention
- **Cost-outcome studies**
 - **Cost effectiveness analysis**
 - Compares net cost of an intervention to net outcome achieved
 - Measures effectiveness in health outcome achieved;
 - E.g., per cases of HIV infection averted, per case of pneumonia successfully treated
 - Allows comparison of interventions that achieve the same health outcome
 - Note: "cost effectiveness \neq cost savings"
 - **Cost-utility analysis**
 - Expresses measure as the number of life years saved or adjusted to account for loss of quality or disability
 - Allows comparison of different interventions
 - E.g., provision PMTCT and polio vaccination
 - **Cost-benefit analysis**
 - Expresses all benefits, such as health outcomes and lives saved, in monetary terms
 - Allows comparison of disparate programmes with a wide range of health and non health outcomes; e.g., VCT and secondary education

Economic Evaluation Topic 2: Cost analysis

Aim: to improve participants' knowledge and understanding of cost analysis

Objective:

- To list the various types of costs needed to be counted in calculating the cost of a programme
- To identify the sources of cost data
- Explain the importance of adjusting cost
- Describe the ways of adjusting costs

• Definitions

- **Cost:** cost has been defined from various perspectives:
 - Financial cost: expenditures financial inflows and outflows, observed costs
 - Economic cost: true resource consumption and real cost
- **Economic cost analysis:** The systematic collection, categorisation, and analysis of costs associated with a disease or an intervention, and its outcome to inform decision making.

• Uses of cost analysis

- Accountability: To learn how available resources are being utilised
- Assessing efficiency:
 - Are outputs appropriate, given the level of input?
 - Comparing interventions that are equally effective, e.g., number of HIV cases averted through VCT is equal to the cases averted through screening of blood products
- Assessing priorities: Do spending levels reflect health priorities?
- Projecting cost: What resources are needed to achieve public health objectives?
- Assessing equity: to examine how health resources are distributed across the population (e.g., urban/rural expenditure per capita)
- Establishing basis for full economic evaluation: in combination with effectiveness measure

• Steps in conducting a cost analysis

- Frame the cost analysis:
 - Define the problem to be analysed
 - There are six key items to identify: the problem, the audience, the perspective of the evaluation, the intervening option, the health outcome measure, and lastly, the time frame or analytic horizon
- Conduct a cost inventory:
 - Ensure accurate and complete collection of relevant cost data
 - Develop a classification system that is relevant, recognisable, mutually exclusive, exhaustive
 - Decide what to include and what to exclude
- Choose a costing method
 - Ingredient approach and micro-costing: using a cost inventory (a list of all individual items to be included in costing)
 - Activity-based costing: first make a list of all the activities that make up the intervention, then proceed with the ingredient approach

- Macro-costing: here the cost inventory is a list of budget categories or other large cost categories
- Collect cost data
 - Primary data collection: medical records, accounting and payroll system, questionnaires, observational surveys
 - Published literature
 - Expert opinion

NB: always determine which cost is considered (perspective): provider, public sector, employer, patient and family, society, etc.

- Adjust costs:
 - Adjustment are made to have comparable costs
 - Often related to changing values of cost over time
 - Adjustment methods
 - Inflation: an increase in price over time
 - Time preference, e.g., N1000 is preferred now to N1000 next year
NB: discounting is important when you know the discounting rate
 - Annuitisation of costs: to evaluate the cost attributable to an intervention during a year

Economic Evaluation Topic 3: Cost-Effectiveness Analysis

Objectives:

- To help participants understand and describe the information needed to conduct cost-effectiveness analysis, CEA
- To describe the cost effectiveness ratio measures
- To understand when to use cost-effectiveness ratios

Cost-Effectiveness Analysis, CEA

- **What is CEA?**
 - Estimates the cost and outcomes of an intervention (discounted from present value)
 - Expresses outcomes in natural health units: infections averted, years of life saved
 - Derives a cost-effectiveness ratio:
 - Numerator: net cost (costs- any savings)
 - Denominator: unit of health outcomes
- **Why do a CEA?**
 - Inform decision makers: when resources and priorities must be set and choices must be made
 - To determine the efficient use of resources in terms of cost for a specific health outcome
 - To maximise the total aggregate health benefit conferred on a society
 - To determine if:
 - a programme provides value for money spent
 - strategies within a programme provide more value for the money spent
 - a more expensive programme is worth the additional cost

Identifying and measuring outcomes

Programme	Intermediate measures	Final measures
Morbidity	Number of persons screened	Number of diseases cases
Mortality	Number of hospital re-admissions	Number of deaths
Disability	Number of assisted living days	Number of chronic disabilities

- **Cost effectiveness ratios (CERs)**
 - It is the net cost divided by net health outcome
 - CERs provide information to decision makers
 - Given quantified cost and benefits, is the programme worthwhile?
 - Important because CEA is subjective, relative
- **Types of CERs**
 - Average cost-effectiveness ratio (ACER)
 - Used to evaluate the average cost per health outcome for a **single** disease programme
 - Used to allocate resources between **independent** programmes, e.g., hepatitis vaccination vs. HIV testing
 - Not used to evaluate mutually exclusive (competing) strategies
 - Marginal cost effectiveness ratio (MCER)
 - Ratio of additional cost to outcomes obtained from one additional unit of an intervention
$$\frac{\text{Cost of strategy A}^+ - \text{Cost of strategy A}}{\text{Outcome of strategy A}^+ - \text{Outcome of strategy A}}$$

- Examine effects of scale (within a single program): to determine if cost per health outcome increase or decrease as the programme changes size
- Incremental cost effectiveness ratio (ICER):
 - Ratio of additional costs outcomes obtained when one intervention is compared to the next most effective intervention
$$\frac{\text{Cost of strategy B} - \text{Cost of strategy A}}{\text{Outcome of strategy B} - \text{Outcome of strategy A}}$$
- Suitable for mutually exclusive interventions
 - Patient level: e.g., BP monitoring
 - Global level e.g., targeted vs. universal HIV screening
- Suitable for allocation of resources

Economic Evaluation Topic 4: Cost Benefit analysis, CBA

CBA puts a monetary value on both the cost of the programme and its output. This produces information that is more appealing to policymakers, especially those concerned about assuring value for money.

- Expresses all benefits, such as health outcomes and lives saved, in monetary terms
- Allows comparison of disparate programmes with a wide range of health and non-health outcomes:
 - Voluntary counselling and testing programme vs. secondary education
 - Provision of anti-malarials vs. building of houses
- However, the greatest problem with this approach is that it is very difficult to assign a monetary value to changes in a person's health; e.g., should the value of someone's life in a developing country be worth less than the life of someone living in a developed country?
- There are currently two primary economic methods of measuring benefits within a CBA:
 - The cost of illness (COI) approach
 - The contingent valuation (CV) approach
- The COI approach involves the measurement of benefits by using two components.
 - Averting direct cost: which values the benefit of treating or preventing the disease by the change in the net cost of health care associated with its treatment
 - Aversion of indirect cost: which is the value of lost earnings attributable to that disease
- Limitations of COI:
 - Direct cost analyses generally ignore the fact that cost of care does not reflect the full benefit of care to the patient.
 - COI may inaccurately recommend that life-prolonging treatment should never be pursued, since allowing a patient to die is frequently the least expensive alternatives
 - Indirect cost are poor measures of a human being's value, especially of work that is not compensated (e.g., education, home-making, child rearing)
 - Assigning monetary values to a human being's life may lead to the assumption that a wealthier individual's life has a greater value than a poor person's life.
- The CV approach, on the other hand, allows the user of the service (and in some cases the community as a whole) to indicate for themselves how they value a particular service by asking people's willingness to pay (WTP) to obtain that service (or, less commonly, their willingness to accept (WTA) the lack of the health service)
- Limitation of CV:
 - Philosophical challenges: desire of individual should not be the major determining factor in choosing to publicly subsidise a good or service
 - It's easy to say you would be willing to pay substantial sum to obtain a service, but when actually asked to pay that amount, many people will not
 - Logistical challenges: carrying out surveys of sufficient size may be too expensive and sophisticated

Economic Evaluation Topic 5: Cost-Utility Analysis (CUA)

Objectives:

- To describe cost-utility analysis
- To explain how cost-utility analysis relates to cost-effectiveness analysis
- Define quality-adjusted life years (QALYs) and disability-adjusted life years (DALYs)
- To explain how QALYs and DALYs are used in cost-utility analysis

Cost-utility analysis

- A non-monetary measure
- It measures:
 - Benefits as expressed as the number of life years saved, adjusted to count for the loss of quality from morbidity of the health outcome or side effects from the intervention
 - Cost per life years saved to account for the different levels of quality or disability, e.g., QALY gained

Cost-utility analysis (CUA) vs. cost-effectiveness analysis (CEA)

- Outcomes:
 - CEA measures cost related to a specific health-related outcome, e.g., cost per life years saved
 - CUA measures cost related to quality-adjusted health outcome, e.g., cost per QALY saved
- Comparability:
 - CEA allows comparison of strategies that have the same health outcome
 - CUA allows comparison of strategies that may have different health outcome

QALYs: What are they?

- Quality-Adjusted Life Years:
 - Life years adjusted for less-than-perfect quality of life
 - A year of life in a health state adjusted by the utility (quality of life) associated with that health state
 - Estimated using quality of life weights: weight from 0 to 1, where 0 is the value associated with death, and 1 is the value associated with perfect health

Methods of calculating QALY

- Time trade-off: Choose between living X years in less than optimal health or living fewer years in perfect health
- Standard gamble: choose between living in less than optimal health or taking a treatment that will give them perfect health (with probability p) or death (with probability 1-p)
- Ranking exercise: compare different health states with each other and with death
- Indirect elicitation of preferences: using data from a population sample to measure utilities associated with different combinations of conditions, ask people to classify health states according to conditions associated with them, and apply the utilities accordingly

- **NB:**
 - Methods to generate QALY should yield a continuum of different health states with utility weight from 0 to 1.
 - The utility weight of each health state expresses the fraction of a healthy year that is equivalent to a full year in the health state.
 - It's not safe to assume that QALYs from different studies can be used together.
 - Sources of QALY weights include published studies, CUA databases, surveys with health utility instrument, or your own research.
- **Advantages of QALY**
 - Estimated to reflect people's preferences
 - Often used in European and US CUAs
- **Disadvantages of QALY**
 - Often not comparable across countries
 - Not available for many conditions

DALYs: What are they?

- **Disability-Adjusted Life Years:**
 - 1 DALY= 1 year of healthy life lost
 - Includes healthy life lost as a result of premature death and disability from different health outcomes
 - Estimated using disability weights: weight from 0 to 1, where 0 is perfect health and 1 is death

DALYs: where do they come from?

- Goal: to measure how disabled people are by a disease or condition
- DALY + years lost from premature death + years lived with disability
- Years lived with disability = years X disability weight of the condition
- Disability weights are generated by a panel of experts who compare the value of condition of different amounts of time in different health states for different numbers of people
- Sources of disability weights: global burden of disease study, Dutch and Australian burden of disease studies
- **Advantages of DALYs**
 - Readily available disability weight for many conditions
 - Endorsed by the United Nations and the World bank
 - Often used in CUA in developing countries
- **Disadvantages of DALYs**
 - Not designed to reflect some individuals' specific circumstances
 - May be misunderstood
- **Limitations**
 - Discounting rates: social vs. Individual
 - Age weighting: young vs. adult individuals
 - Good vs. bad health: inequity
 - Gender inequality

Example of a skills station for this topic

- What do the following cost effectiveness ratio terms mean?
 - Average cost effectiveness ratio (ACER)
 - Marginal cost effectiveness (MCER)
 - Incremental cost effectiveness (ICE)
- Syphilis is a sexually transmitted infection (STI) which, if not detected and treated early, in pregnancy, can result in the infection affecting the fetus. Thus the need for screening for syphilis very early in pregnancy for early treatment, if detected. The table below shows some screening strategies (A, B, C, and D), the various yields of the screening strategies, and to the cost of screening.
 - Complete the table below
 - Advise the government, which is about to adopt a new screening strategy, considering the cost implication

Strategies ranked in order of effectiveness	Cases per client	Cost per client	Additional cost per client (A)	Additional cost (savings) per client (B)	ICER (cost [savings] per case averted)(B/A)
Strategy A	0.031	N4.06	-	-	-
Strategy B	0.017	N7.51			
Strategy C	0.014	N7.27			
Strategy D	0.004	N9.29			

Subject 2.3: Effective Financial Management Systems in PHC

Aim: To update the knowledge and skill of the participants on methods to ensure probity and accountability in managing PHC funds.

Objective:

- To identify the major rules and regulations that govern financial activities in PHC
- To identify and define key financial management concepts
- To help participants use existing financial resources as effectively as possible
- To increase participants' awareness of the types and uses of cost control and reduction
- To enhance participants' capacity to plan, prepare, analyse, and critique PHC financial activities

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the primary rules and regulations that govern financial activities in PHC
- Be able to incorporate the techniques in the expenditure process for PHC activities within the scope of their responsibilities
- Know the key elements of basic financial statements (budgets, income statements, balance sheets, cash flow statements)
- Know the basic techniques in financial management, including cost and revenue forecasts and tracking
- Be able to distinguish between and utilise different cost categories (e.g., fixed and variable costs, operating costs, overhead costs, direct and indirect expenses)
- Be able to distinguish between and utilise different income categories (e.g., current income, deferred income, programme income, donor sources, public income)
- Know the basic differences between cash and accrual accounting
- Be able to distinguish between and utilise different balance sheet categories (e.g., assets, liabilities, equity, and retained income)
- Be able to track and allocate key financial items (e.g., tracking variable costs, calculating depreciation schedules for capital expenditures, tracking and allocating fixed costs within periods and over time)
- Calculate basic key figures from financial data (e.g., percentages, ratios, and trends), as well as calculate and summarise changes in key figures
- To be able to conduct basic budgeting for PHC activities within the scope of their responsibilities, including creating initial budgets and adjusting budgets over time
- Be able to prepare basic budgets and financial reports for relevant authorities (e.g., internal use, public agencies, donors)

Topics:

- T1. Fundamentals of financial management systems in PHC
- T2. Strategies for reducing and controlling costs in PHC
- T3. Budgeting and expenditure tracking in PHC

Finance Topic 1: Fundamentals of Financial Management Systems In PHC

Aim: by the end of this session, participants should be able to

- Understand the concepts and define key terms used in financial management
- Identify the various types of financial information needed in PHC

Definition of terms:

- Accounting is concerned with collecting, analysing and communicating economic information.
- Finance is concerned with the ways in which funds are raised and utilised.
- Management accounting is concerned with the provision and use of accounting information by managers within organisations.
- Financial management:
 - Involves controlling, conserving, allocating, and investing the organisation's resources, including personnel, equipment, supplies, and the non-monetary contributions of volunteers and donations.
 - It goes beyond the traditional accounting focus on recording and reporting of financial transactions, to focus on analysis and decision making

Financial information

- Users of financial information:
 - The users can be divided into internal and external.
 - Users include: owners, donors, analysts, managers, employees, government regulatory bodies, and members of the public.
- Qualities of financial information
 - Relevance: predictive value, confirmatory value, timeliness
 - Faithful representation: verifiable, neutral, and complete
 - Understandable: to users who have a reasonable knowledge of economic activities and financial accounting
 - Comparability: (including consistency)
 - Constraints:
 - Materiality
 - Benefit and cost
- Elements of financial statement:
 - Balance sheet: measures and reports financial position (Assets and Liabilities)
 - Statement of operations: measures and reports financial performance (Income and Expenses)
 - Statement of cash flow: measures and reports financial position (Movement between the opening and closing cash balance)
- Tools for comparing financial statement
 - Trend: comparing increase/decrease between periods
 - Ratios: relates one figure to other figure, e.g., amount expended on health care/number of people accessing the facility

Some rules in accounting

- Going concern concept: assumes that the organisation will continue operation for foreseeable future
- Accrual concept: matching revenue with expenses

- Consistency concept: consistent is better than precise
- Prudence concept: holds that the financial statement should err on the side of caution

Instrument for the control of government funds:

- Finance (control and management) act, 2004
- Financial regulations revised to 2008
- Public procurement act amended 2009
- Public service rule
- Allocation of revenue act, 1982
- Annual appropriation law
- Issuance of warrant before expenditure
- Establishment of anti corruption agencies

Example of a skills station for this topic

- Enumerate the various sources of government revenue in the federal government of Nigeria
- Are the revenue sources of the state and the federal government the same? Please give reason(s) for your answer.

Finance Topic 2: Strategies For Reducing and Controlling Costs In PHC

Objectives: at the end of this topic, participants should be able to

- explain the concepts of cost control and cost reduction.
- identify various elements of costs to be controlled.
- discuss major techniques used in cost control and cost reduction.
- apply the techniques to various cost elements.

Definition of terms

- Cost is the value of goods purchased or services rendered.
- Control: restraint, authority, a check, command, regulation, etc.
- Reduce: to bring back, to restore to an old state, to bring into a new state, to put back into a normal condition or place, to change to another form, etc.
- Reduction: act of reducing or state of being reduced, diminution, lowering of price,
- Subjugation: changing of numbers or quantities from one denomination to another.
- Cost control or cost reduction is the executive regulation or actions to minimise cost of operations through the use of cost accounting. It is an integrated activity set up by management to minimise costs without reducing product quality or service delivery.

Cost control versus cost reduction

- **Similarities:**
 - Focus on minimisation of cost
 - Concern for efficient use of resources
 - Both require target setting
- **Differences:**
 - Cost control involves provision of guidelines to incur cost; authority for approvals, expenditure limits, administrative structure, and top management responsibility.
 - Cost reduction is the actual activities concerned in minimising cost according to management policy or guidelines provided.

Objectives of cost reduction and cost control

- To reduce service costs
- To reduce volume of expenditure
- To improve activities in other areas
- To meet competitive pressures
- To reduce wasteful spending
- To improve productivity or efficiency
- To comply with organisational objectives

Process of cost reduction

- A clear definition of the organisation structure
- Properly defined power and authority
- Functional budgetary control system
- There must be a defined standards set.
- Defined procedures for purchasing
- There should be monitoring system.
- There must be adequate tools.

- There must be budget discipline.
- Necessary staff must be put in place.
- Defined methods of investigation
- Product/service reviews
- Create awareness among staff.
- Analysis of competitive activities and cost structure
- Classification of cost elements
- Define the reporting system.

Techniques in cost reduction/control

- **Accounting control:**
 - Quantitative measures of cost control. Figures and mathematical models or probabilities are used to interpret the effect of control on various activity levels. Thus:
 - Budgeting
 - Cost-benefit analysis
 - Marginal costing and break-even analysis.
 - Classification of costs.
 - Cost accumulation, apportionment, and absorption
- **Administrative control:**
 - This method relates to qualitative measures required for cost control.
 - It describes the basic things to do during cost control exercise. Thus:
 - Management policies, rules, and regulations.
 - Planning
 - Identification of cost drivers
 - Classification of costs
 - Inventory policy
 - Pricing of products/services
 - Purchasing/procurement of system
- **Planning as a control technique**
 - Define management policies.
 - Set administrative structures.
 - Define cost centres.
 - Preparation of job descriptions
 - Initiate awareness campaign
 - Identify principal budget factors.
 - Design relevant forms.
 - Set performance standards.
- **Identifying cost drivers**
 - Managers are to identify factors responsible for operation cost or service delivery to determine the best factor mix. Thus, operation or service cost may be driven by competition, government policies, cost structure, demand, technology, economic climate, market conditions, exchange rates, nature, etc.
- **Classification of cost**
 - Costs may be classified into:
 - Controllable and uncontrollable
 - Fixed and variable costs
 - Direct and indirect costs
 - Direct cost: materials, purchases, resource utilisation

- Indirect cost: plant and equipment, overhead ratios, allocation methods
 - Operation and overhead costs
 - Capital and revenue costs
 - Production, selling, distribution, and administrative costs
- **Capital expenditure**
 - Adequate approval procedures, authorisation acquisition and allocation.
 - Record keeping (use fixed assets register)
 - Good internal control system
- **Tools**
 - These are pieces of technical equipments used by staff for daily maintenance operations. The administrative controls:
 - Create separate tools store.
 - Assign reliable staff to the store.
 - Tools must be signed for.
 - Maintain register of tools.
 - Insure maintenance store.
- **Material control**
 - Co-ordination of departments for buying, receiving/inspecting, storage/issue of materials
 - Centralisation of purchasing and appointment of competent staff
 - Planning and scheduling of material requirements
 - Standardisation materials specification should be encouraged.
 - Classification and coding of materials
 - Form design for materials
 - Provide good storage facilities.
 - Set minimum and maximum stock reorder levels.
 - Set good internal control system.
 - Feed back/feed forward
 - Apply Pareto 80/20, ABC, FIFO/ LIFO, weighted average, etc.
 - Review alternative source of supply, substitutes, product life cycle, market structure, etc.
- **Perpetual inventory control**
 - Inventory records kept by the stock control department in respect to each stock. It is usually maintained in loose leaf or card showing:
 - Description of the material
 - Code number of components or parts
 - Location and unit of measurement
 - Quantity received and issued
 - Outstanding orders or appropriation
 - Balance in stock.
 - Stock taking and surprise checks
- **Measures to reduce stock:**
 - Determine stock levels using statistical methods.

- Compare stock or turnover with those of competitors
- Stop ordering for stagnant materials
- Relate stock movement with production schedule

Pricing: Wrong pricing/costing strategies or policies can make product prices too high. Activities required are review of:

- Product state
- Analysis of market position
- The cost structure
- Management policy
- The marketing mix
- Competitive activities
- Government and other environmental factors
- Operation/Product design or workflow

Investment appraisal

- Payback period
- Return on capital invested
- The net present value
- Internal rate of return
- Weighted average cost of capital, etc.

Labour cost

- Authentication of payroll
- Ensure all staff have relevant employment papers.
- Use clock cards or time sheets.
- Segregate payroll duties.
- Use appropriate remuneration system.
- Reduce idle time.
- Introduce good incentive scheme.

Budgeting as an accounting control

- Compare current budget with actual performance.
- Note the variances and investigate them.
- Maintain budget discipline.
- Ensure participation.

Problems of cost control

- Lack of commitment and management will to the right thing
- Inadequate manpower for the job
- Measurement of success cannot be determined easily.
- Assessment of improvement facilities in relation to output is difficult to make.

Example of a skills station for this topic

The national TB manager has just been asked by the FMOH to review the budget from the National Centre for TB to avoid a repeat of last year's crisis. Last year, the Centre had budget

of \$300,000 but ran out of money before the year was over. As a result of the budget shortfall, the Centre failed to pay for training activities, outreach activities, and basic supplies. The accountant justified the budget crisis by saying that a lot of expenses came from paying bonuses and miscellaneous expenses that he did not explain. The TB manager did not believe the accountant's explanation because the budget level has stayed stable or decreased in the 3 years. In addition, the patient load has stayed also stable. This year, the TB manager wants to make sure that the situation does not repeat itself.

The hospital accountant has just prepared this year's budget for the TB programme and wants you to review it before sending to the MOH. This year, the National Centre for TB is going to receive money from 5 different donors to pay for drugs, equipment, and training workshops for TB doctors, as well as supplies and supervision visits. All the donors have clearly spelled out how they want their money to be spent. The accountant is very concerned that if FMOH sees all the sources of funding, they might reduce the government contribution to the TB budget. However, he does not know how to proceed with this issue given that the donors have already told MOH how much money they are contributing to the programme. Here is a draft budget for your review.

Discussion questions

1. What are the key things that the national TB manager should pay attention to?
2. Based on this draft budget, identify 2-3 critical questions for the accountant.
3. What other places of information do you need in order to understand the appropriateness of this budget?

Line Item	Total Budget Required for Activities	Amount Committed from Donors					Total
		GTZ	European Union	WHO	Red Cross	USAID	
Travel for Supervision visits	\$100,000	\$0	\$0	\$10,000	\$0	\$30,000	\$40,000
Supplies	\$50,000	\$0	\$0	\$0	\$0	\$0	\$20,000
Communication	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Drugs	\$70,000	\$50,000	\$40,000	\$0	\$0	\$0	\$90,000
Microscopes	\$20,000	\$0	\$0	\$0	\$20,000	\$10,000	\$30,000
Salaries & Benefits	\$300,000	\$50,000	\$0	\$0	\$0	\$0	\$50,000
Training Workshops	\$80,000	\$0	\$0	\$10,000	\$0	\$10,000	\$20,000
Consultants	\$10,000	\$0	\$15,000	\$0	\$0	\$20,000	\$35,000
Miscellaneous	\$70,000	\$0	\$0	\$0	\$0	\$0	\$0
Total	\$700,000	\$100,000	\$75,000	\$20,000	\$20,000	\$30,000	\$500,000

Finance Topic 3: Budgeting and Expenditure Tracking

Objectives:

- To enhance participants knowledge of the concept and practice of budgeting
- To identify and discuss areas of challenges in budgeting

Budgeting

The main purpose of any management is to ensure that the resources of its organisation are effectively and efficiently utilised for the accomplishment of the organisational goals and objectives. To carry out this purpose, detailed plans of action are prepared for the functions, activities, and departments of an organisation, etc.

Definitions:

- The process of preparing these detailed plans of action is called budgetary planning.
- When monetary or financial values are attached to the developed plan of action, it becomes a budget.

Tips in budget preparation

- The budget and proposal copy must be mutually reinforcing. A reader should never be surprised by finding any line item in the budget not referred to in the narrative plan of operations.
- Budgets should be reasonable.
- Create a budget by analysing the tasks needed to complete each activity.
- Avoid lump sum requests; be as detailed as possible.
- Allow for inflation.
- Follow the funding source guidelines. Do not hesitate to call a funding source with specific questions about allowable costs.
- Include in-kind contributions as a legitimate budget item.
- Don't forget basic budget items: personnel, fringe benefits, travel, equipment, materials, other facilities and administrative costs.

Communicating the budget

- Managers should talk to all their staff and involve them
- What does the budget contain and why?
- What part does each stakeholder have to play?
- A need to inform the team which way we should be heading

Budget Manual

It is a document that sets out:

- The responsibilities of the persons engaged in budgeting and budgetary control
- The budgeting routine
- The forms and records required for budgeting and budget control

Types of budget

- Long-Range Budgets – e.g., capital budgets dealing with the acquisition of building and equipment normally cover several years.
- Operating/Recurrent Budget – the annual operating budget may be divided into quarterly or monthly budgets.

- Continuous or Rolling Budget – this budget is usually a 12-month budget that rolls forward one month as the current month is completed.

Budgeting techniques

- Static Budgeting
- Flexible Budgeting
- Incremental Budgeting
- Zero Based Budgeting

Purposes of a budgeting system

- Planning
- Facilitating Communication and Coordination
- Allocating Resources
- Controlling Profit and Operations
- Evaluating Performance and Providing Incentives

Problems related to budgeting

- Variances are due to changing circumstances
- Poor forecasting: managerial performance
- Well-documented plan may inhibit flexibility
- Because of delays and lags in the budget-planning process and approval, it may have little values as a guide to current operations.
- During inflationary period, if there is no enough room for flexibility, the whole budget becomes meaningless.
- Budgetary Slack: padding the budget

International aspect of budgeting

- Firms with international operations face special problems when preparing a budget. The likely problems are:
 - Fluctuations in foreign currency exchange rates
 - High inflation rates in some foreign countries
 - Differences in local economic conditions

Dos and Don'ts of budgeting

- Do involve the whole team in budget process
 - The more that people are involved, the more they are committed
- Do invest sufficient time to do it properly
 - Don't underestimate its importance
 - If budgets are too low, you will be trying to achieve the impossible
 - If budgets are too high, you will deprive other departments of valuable resources.
- Do have a culture of continued review and revision
 - Revise budget in the light of what has actually happened
 - For example, reforecast every quarter
- Don't just add a percentage on last year's figures: Next year may not be the same! What will change?
- Don't build in slack: budget on a realistic basis.
- Don't spend 'up to' budget: Is an expense still necessary? Is there an alternative, cheaper method?

Issues in budgetary control

- Responsibility accounting
- Flexible budget
- Controllable and non-controllable items
- Significance of variance
- Setting control limit

Example of a skills station for this topic

Sources of revenue: There are various sources of revenue available to an organisation. You are required to itemise and discuss any other independent sources of revenue open to your organisation.

Analysis of financial information

Variable	2006 (million)	2007 (million)	2008 (million)	2009 (million)
No. of People immunised	45	75	100	130
No. of missed children	5	11	10	15
Outright rejection	1	2	2	3
Target Population	100	125	150	200

Requirement

1. Use the information in the table above to calculate:
 - a. Trend for all the variables
 - b. Ratio using target population as the denominator
2. Provide the likely reasons for your result in 1 above
3. Flexible budget

	BUDGET N	ACTUAL
Variable	3/unit	40,000
Fixed Cost	1/unit	9,000
OUTPUT	10,000 units	12,000 units

Required

- a. Prepare a flexible budget and obtain the variance based on the actual output.
- b. Give the likely reasons for the adverse variance obtained in the figure above.

4. Salary scale in public service

GRADE	STEP						
	1	2	3	4	5	10	17
1	150	200	250	300	350	600	900
2	250	350	450	550	650	750	850
3	400	600	800	1000	1200	2200	3600
4	550	800	1050				
5	700	1000	1300				
10	2000	2600	3200				
17	5000	6200	7400				

NB :

To compute a step in a salary grade level, one can use this formula

$$B + (n - 1) i$$

Where B is the basic or starting salary

n is the required step and

i is the incremental rate on the grade

Required: Fill in the missing figures

MODULE 3: LEADERSHIP AND MANAGEMENT

Subjects

Subject 3.1 Team Building

Subject 3.2 Effective Motivational Leadership

Subject 3.3 Human Resource Management.

Subject 3.4 Supportive Supervision in PHC

Subject 3.1: Team Building

Aim: To outline the skills required to build effective teams

Objectives: To help PHC managers become effective team leaders and team members

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the importance of team work in PHC programme and activities
- Be able to use teamwork in solving PHC problems within the scope of participants' responsibilities
- Be able to create effective teams
- Be able to function as an effective team leader and/or team member

Overview

- **Benefits of Team Building**
 - Successful team building will
 - improve the way team members interact,
 - improve their ability to solve problems,
 - increase efficiency, which tends to boost morale and productivity, and
 - decrease stress, turnover, and operating costs.

- **Characteristics of Team Building**
 - They operate with clearly defined goals and expectations.
 - Their leaders lead by example, not by virtue of job titles.
 - Their members are allowed a great deal of personal freedom to get the job done.
 - They make decisions in groups.
 - They share information.
 - They set high standards for themselves.
 - They are self-disciplined.
 - They acknowledge one another's contribution and support.

- **Team Building Requirements**
 - Before an effective team can be developed, the organisational environment itself must foster teamwork.
 - Accordingly, an effective organisation must:
 - Share a vision or sense of purpose that all its employees can articulate.
 - Develop a structure appropriate for the organisational environment (e.g., a structure that works for a bank may not work for a fire department).
 - Align employees so that everyone is going in the same direction.

Subject 3.2: Effective Motivational Performance Leadership

Aim: To help participants appreciate the critical role and importance of leadership in effective management and achievements of primary health objectives and goals, while providing knowledge and understanding of “what works” in leadership types and styles;

Objectives

- To facilitate an overview of leadership capabilities
- To encourage participants to redefine their leadership capabilities
- To enhance leadership for effective management of staff succession
- To enable participants to share practical experiences using case illustrations

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the basic principles and theories in motivational leadership
- Know how motivational performance leadership can inspire subordinates to work with sustained zeal and determination
- Be able to apply this principle to achieve effective human resource for PHC activities within the scope of their responsibilities
- Be able to work as both an effective leader and an effective follower in relevant contexts

Discussion points

- Overview and review of leadership concept, types, and styles
- The role of leadership initiative in crisis management
- Leading performance for productivity
- Strategic leadership in health planning and management
- Communicating as a leader
- Leadership and project management
- Leadership and motivational financial management

Motivation

- Welfare package allowances
- Training
- Conducive environment
- Good working relationship
- Empowerment
- Availability of good equipment and machines to use
- Productivity award

What is leadership?

- Leadership is a process by which you as a health professional influence others (medical staff, patients, community, and stakeholders) to accomplish the required activities and steps.
- Leading should be motivating, coherent, and cohesive.

The health professional as a leader



To effectively plan and manage work and resources

- Develop and share the vision
- Plan work
- Maximise resources
- Make decisions with the information you have
- Be flexible enough to change direction

To lead people

- Provide clear guidance
- Build a team
- Acknowledge your teammates
- Provide feedback
- Always set a good example

To guild future leaders

- Hold people accountable, including yourself
- Delegate to individuals and teams
- Coach individuals and teams
- Encourage development and publicly reward high performance in staff members

Leading is not about what you can achieve on your own, it is about inspiring your people to be the best they can be at what they do.

- Nurses
- Doctors
- Pharmacists
- Physiotherapists

Qualities of a good leader

- Vision, courage, exemplary character, enthusiastic about their work and their people
- People skills, confident, knowledgeable, respect
- Functions in an orderly and purposeful manner in situations of uncertainty
- Focused in spite of challenges, committed to excellence, etc.

Leading your people to achieve the millennium development goals

- Leaders do not command excellence, they build excellence.
- Excellence is "being all you can be" within the bounds of doing what is right for your organisation.

- To reach excellence you must first be a leader of good character.
- You must do everything you are supposed to do.

What the outcomes of effective leadership?

- Excellent results
- Motivated staff
- Build future leaders

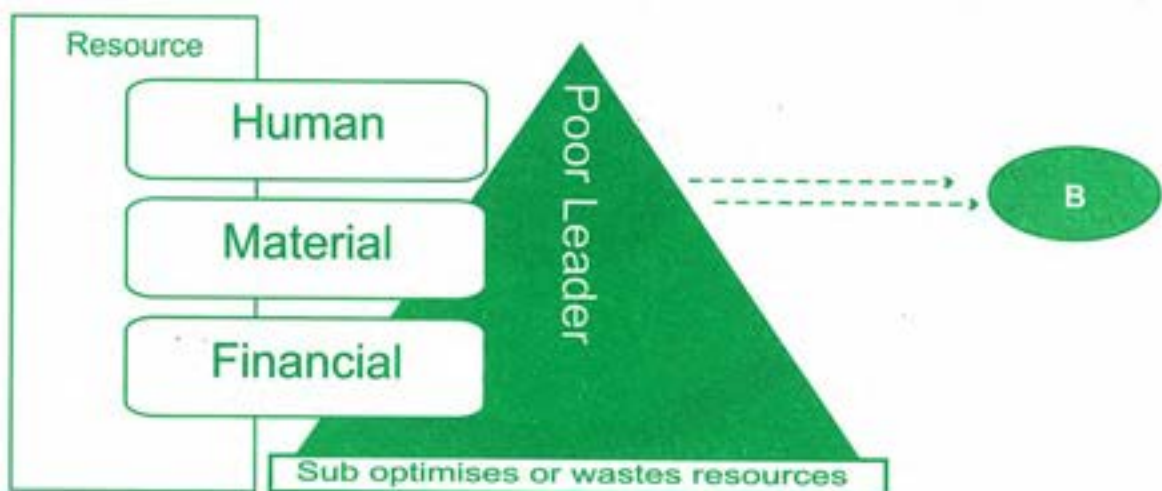
Resource Management (effective leadership)



What are the outcomes of ineffective leadership?

- Lack of vision, poor time management, limited resource management skills
- Inadequate communication skills, not developing leaders, poor delegation
- Poor coaching, limited supervision, bureaucratic bottlenecks

Resource Management (ineffective leadership)



Functional leader



Leadership Roles

Leader role	Manager role	Facilitator role
<ul style="list-style-type: none">• This is the best role if the task is setting direction for your members staff with the aim of helping them to see the bigger picture	<ul style="list-style-type: none">• This is best, when the task is setting limits on work, delegation, or defining deadlines.	<ul style="list-style-type: none">• This is best when the task is complex, requiring the assistance of a number of other people outside your staff base to complete

Performance Leadership

- Performance Leadership:
 - Performance leadership is a systematic result-oriented approach to management and leadership for high productivity.
 - This approach consolidates the fundamentals of management and leadership within the public sector and then builds on staff's existing abilities by increasing the effectiveness of their capabilities.
- Performance Leadership system
 - Organisational Capabilities (What is done?) – focused on the development of *core processes* that vital to the performing Civil Service
 - People Development (How are things done?) – focused on *core competences*, attitudes that are vital to the performing Civil Service
 - Knowledge Development (How are improvements sustained?) – focused on *core business intelligence*, e.g., knowledge sharing, innovations, and continuous learning.



Performance Leadership System

System Leader



- **Types of leadership**
 - Charismatic/transformational leadership.

- Contingency leadership.
- System leadership
 - Sustained improvement over time that moves an entire system, raising the average level of quality and performance while decreasing variation among units and engaging people.
- **The philosophy (Leadership by performance expectations)**
 - Leadership by PM is both a philosophy and a process
 - Setting clear objectives impacts on performance
 - Appropriate channeling of talent and effort for productivity
 - Effectiveness versus efficiency

Effectiveness vs. Efficiency

Effectiveness	Efficiency
Doing the right thing (DRT)	Doing things right (DTR)
Annual appraisal evaluation (APER)	Holding regular departmental/sectional meetings
Delegating tasks	Support task process

Performance Leadership Communication: Benefits versus Resistance

Benefits	Resistance
Maintain focus	Lack of time
Build relationships and nurture talents	Fear of causing morale problems
Gather information for effective evaluation and decision-making	Fear of not observing anything substantial to discuss
Measure gaps and allocate appropriate training	Unsure of how to approach and guide the discussion

Subject 3.3: Human Resource Management (HRM)

Aim: To provide a platform for healthcare managers to understand human resource issues in health care management while increasing participants' understanding of the strategic human resource management (SHRM) framework.

Objectives

- To identify the critical roles and responsibilities in human resource management
- To help participants understand the critical importance of performance management in human resource framework
- To enhance participants' understanding in the effective implementation of the new SHRM framework

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the basic strategies in HRM
- Be able to incorporate these strategies for effective management of HR for 'PHC activities within the scope of their responsibilities

Topics

- T1. Overview and implementation of strategies for HRM framework
- T2. Talent management and succession planning
- T3. Recruitment and career progression
- T4. Fundamentals and toolkits for strategic negotiations
- T5. Staff motivation reward systems and sanctions
- T6. Performance evaluation and staff appraisal
- T7. Overview of strategic human resources management concepts and principles

Overview

- Organisation is an entity that comprises human beings bounded by rules and aiming at the achievement of some goals.
- The most important element in an organisation is the human beings.
- 'Human resources' refers to the skills, knowledge, talents, and creative energy of people within an organisation.
- That the work force in an organisation has necessary skills and knowledge is not a guarantee for high performance.
- The resources must be managed to bring about desired level of performance.

Definition

- Human resource management could be defined as the coherent policies and practices that are put in place to manage people either individually or collectively in organisations.
- The overall aim is for the organisation to attain success through people.

Human resource function

- Employee sourcing
- Training and development
- Reward system

- Performance appraisal
- Manpower planning
- Discipline
- Developing productive and harmonising relationship

- **Employee sourcing**
 - This comprises of recruitment, selection, and placement.
 - Recruitment refers to attracting potentials candidates and sensitising them to apply.
 - Steps in recruitment
 - Establishment of vacancy(ies)
 - Job description
 - Man specification
 - Deciding on method of reaching out

- **Selection**
 - Screening or sifting of the best candidate for the job out of the pool of potential candidates.
 - Methods of selection are:
 - Interview
 - Test
 - Documentary evidence
 - Medical test

- **Placement:** This refers to assigning appropriate duty to the selected candidate and conducting induction to acquaint him with organisation.

- **Training and development**
 - Ensuring that the gap between expected and actual level of performance is closed
 - Finding out training needs and ensuring that appropriate programmes are attended to provide necessary skills and knowledge
 - Ensuring staff growth along career path
 - Making succession plans

- **Reward system**
 - Salary plans and administration starts from human resource section.
 - Determining the relative worth of each job and appropriate remuneration
 - Ensuring equal pay for equal work
 - Also determining necessary allowances and benefits to the staff

- **Performance appraisal**
 - Having a good system of evaluating individuals on team of workers
 - Ascertaining that the performance rather than the individual is being assessed
 - Set targets and benchmark with actual performance.
 - State standard to ensure objectivity.

- **Manpower planning**
 - Conduct staff audit from time to time to ensure no wastage and no shortage.
 - Check that the staff have the right skills and knowledge.
 - Conduct job analysis.

- Determine the skills required for each job.
- Ensure that the correct number of people are found in the appropriate job sections
- **Effective communication**
 - In the public service our product is service to the public.
 - Hence we need the skill for effective communication.
 - We produce ideas, information, policies, etc.
 - However, it is pertinent to note that the service has its style and language of communication.
- **Human Resource (HR) data management system using Information Communication Technology (ICT)**
 - The HR unit of every organisation generates a lot of data especially on personal records of staff.
 - HR practice is not left out of application of ICT to their work.
 - The computer serves as an instrument for processing and storing of records.
 - Some organisations are already practicing paperless office.
- **Discipline**
 - Having rules and regulation guiding work and its procedure and ensuring compliance
 - There should be attached punishment to the rules for non-compliance.
 - Discipline requires fairness to all. This is very important for every organisation.
- **Developing productive and harmonious relationship**
 - In any organisation these two groups must coexist harmoniously to excel. That is the employer or the management and employees or their union.
 - Prevent unfair labour practices.
 - Develop and promote effective communication to avert strikes and lockout.
- **Ensure judicious use of personnel:** The organisation should have human resource policies in these areas:
 - Performance management
 - Staff training and development
 - Staff welfare
 - Good conditions of service
 - Health and safety
 - Discipline
- **Importance of human resource management**
 - Effective and efficient use of resources
 - Ensuring that each person employed is qualified
 - The growth of organisation through the growth of individual
 - Compete effectively with others in the industry
 - Ensures job satisfaction
 - Leads to high performance
 - Reduce absenteeism and turnover
 - Human being the most dynamic asset of an organisation

- Promotes teamwork and team spirit among employees
- **Challenges of HR**
 - No two individuals behave alike.
 - Human beings cannot be treated like machines.
 - Human beings are insatiable, so difficult to please.
 - Even when some individuals want to perform on the job they are met with obstacles.
 - Every line manager or operational manager is a potential HRM; however, not everyone has that understanding, thus leading to lack of cooperation.
 - Improvement of organisation through the workforce.
- **Gender and HRM Practice**
 - Gender refers to male and female.
 - Statistics have demonstrated that one sex is usually more represented in organisation. Each sex should be given equal opportunity. There should be no discrimination on the basis of sex.
 - All vacancies should be made open for the two sexes. This will make for equal participation of all. Even in our policy formulation there should not be any form of discrimination. The policies must be strictly adhered to.
- **Conclusion**
 - Human resource management is a very important aspect of the administration of an organisation.
 - It deals with effective utilisation of human resource.
 - The human resource of an organisation is the most valuable asset.
 - If properly managed, human resources can take the organisation to greater height.

Subject 3.4: Supportive Supervision in PHC

Aim: To develop the supervisory skills of middle-level managers in relation to PHC service delivery

Objectives

- To promote and inculcate the spirit of supportive supervision as part of human resource management in PHC
- To describe the various supervisory styles and tools used in PHC

Learning outcomes: After completing instruction in this subject (whether after a single classroom session or following a series of related classroom sessions), participants should be familiar with and able to use the following knowledge and skills.

- Know the techniques of supervision known as supportive supervision
- Appreciate the role of supportive supervision in motivating frontline PHC workers
- Be able to incorporate this technique in supervising PHC activities within the scope of their responsibilities

Topics:

- T1. Introduction
- T2. Supervisory styles/methods
- T3. Supportive supervision in primary health care

Supportive Supervision Topic 1: Introduction

What does supervision mean?

- Supervision is a process of keeping surveillance over the assigned.
- Thus, supervision is an aspect of implementation process of a programme or an activity. The implementation process itself entails appropriate organisational structure and staff mix, presence of an effective leadership with supervisory activities, and a set standard for evaluation and control.
- Supervision reinforces quality outcomes at all levels by focusing on provider motivation and improvement of efficiency of the whole organisation.
- It focuses on tasks performances while the duo of monitoring and evaluation on the other hand target activities and set objectives respectively.
- All three – supervision, monitoring, and evaluation – are interrelated as all are geared towards improving quality in the health care system.
- Careful and regular supervision is increasingly identified as a factor which impacts profoundly on quality of service delivery, while the supervisors play a vital role in keeping staff/health facility in touch with policy developments, treatment protocols, etc., field and service delivery realities are transferred back from the staff through the supervisors to help guide and inform on policies.
- Without supervision, staff easily feels unappreciated and insecure, which in turn leads to disenchantment with and resistance to the transformation process in the health sector.
- It has therefore been recognised that supervision is a critical part of human resource management for the delivery of basic health services and stands as one of the key approaches to improving the quality of health care and the performance of health care providers, especially given the labour-intensive nature of health service delivery.
- **Key functions and tasks of supervision**
Supervision in health professions consists of three (3) basic functions that include:
 - **Management**
 - **Education**
 - **Support**
- All three are geared towards provider and patient/client safety and the promotion of professional development of the health care worker.
- Further dissection of these broad functions is as shown below.
 - Plan and coordinate supervision activities.
 - Set performance objectives, manage conflict, deploy staff, develop work teams, and improve staff motivation.
 - Assess skills and provide guidance and training.
 - Interpret, use, and share data/information.
 - Manage supplies and equipment.
 - Identify and solve problems.
 - Communicate effectively and provide constructive feedback.
- The four (4) basic tasks of supervision are encompassed in the functions described above. The circular description of these tasks emphasises the ongoing nature of the process of supervision as seen in the figure below



The Process of Supervision



19-10

This slide presents a generic process for supervision, that can be used regardless of the programming framework or methodology that is being used overall.

- Set expectations – existence of clear expectations or standards against which performance and results can be measured
- Monitor and assess performance – once the guidelines/standards are set, the task of gauging the extent to which they are met becomes an ongoing activity
- Identify problems and opportunities – where there are gaps between expectation and results, the supervisor facilitates a team process for examining potential causes and possible solutions.
- Take action – supervisor helps marshal resources and motivates and supports providers to implement intervention and activities to address performance gaps or opportunities for improvement

Supportive Supervision Topic 2: Supervisory Styles/Methods

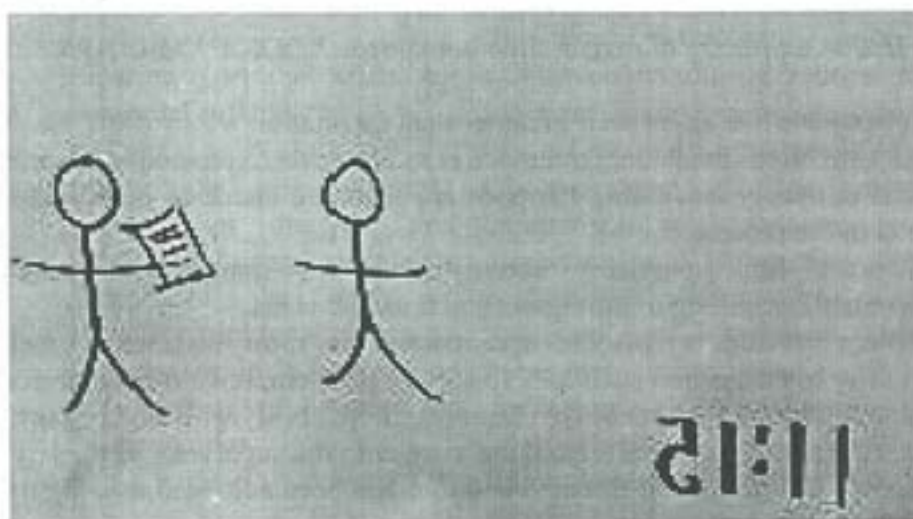
- Traditional/typical supervision
- Supportive supervision

Traditional/Typical Supervision

- This style of supervision is best illustrated as below:



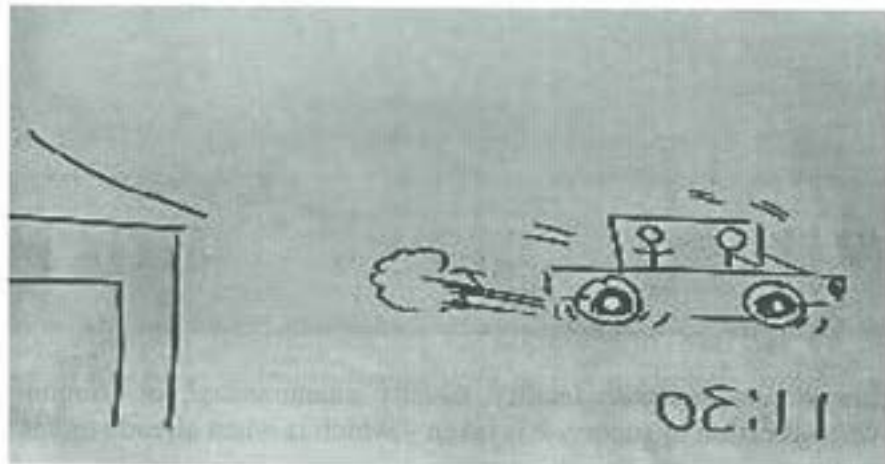
- Supervisor arrives at health facility, usually unannounced, or communicates with in-charge when decision to supervise is taken – which is when already on his way.



- A few minutes later, supervisor hurriedly walks through the health facility, sometimes may ask to see reports/ registers.



- May mention findings to in-charge, no solutions proffered, rather tells staff to take note or tells in-charge to prevent further recurrence; signs visitors' book.



- Zooms off with a promise of revisit, time not known. LOOK FAMILIAR?!!
 - It looks/feels like an inspection rather than facilitation.
 - Visits are often standalone; reference is rarely made to previous or future visits.
 - Focus is mostly on finding faults or apportioning blame to individuals rather than faults in the process.
 - Resources for supervisory activity, such as transportation, are frequently unavailable, resulting in infrequent and episodic visits.
 - Problem solving is episodic and reactive in most instances; supervisors lack authority to take action such as help solve a problem, reward good performance, and sanction poor performance. This limits their credibility with supervisees.
 - Supervision often centres around the visit, with the supervisor as the key actor.
 - It is not goal- and result-oriented and thus has been adjudged as a highly ineffective supervision style.

Supportive Supervision Topic 3: Supportive Supervision in PHC

What is supportive supervision?

- It refers to a range of measures to ensure that personnel carry out their activities effectively through direct, personal contact on a regular basis to guide, support, and assist designated staff to become competent and to meet expected standards in their work. It expands the scope of supervision methods by incorporating self-assessment and peer assessment as well as community input.
- It represents a major change from traditional approaches to supervision.
- It is not an inspection, rather a process of facilitating staff to become competent in their designated tasks.
- An approach that is non-punitive, sets out to identify gaps and competence to be corrected or used/praised
- It does not focus on specific area but a wide range of activities.
- Use of multidisciplinary teams to conduct supervision
- Use of tools and guidelines to conduct a structured visit
- Additional training for supervisor

Comparison between Traditional and Supportive supervision

Action	Traditional supervision	Supportive supervision
Who performs supervision	External supervisors designated by the service delivery organisation	External supervisors designated by the service delivery organisation; staff from other facilities; colleagues from the same facility (internal supervision); community health committees; staff themselves through self-assessment
When supervision happens	During periodic visits by external supervisors	Continuously: during routine work; team meetings; visits by external supervisors
What happens during supervision encounters	Inspection of facility; review of records and supplies; supervisor makes most of the decisions; reactive problem-solving by supervisor; little feedback or discussion of supervisor observations	Observation of performance and comparison to standards; provision of corrective and supportive feedback on performance; discussion with clients; provision of technical updates or guidelines; onsite training; use of data and client input to identify opportunities for improvement; joint problem-solving; follow-up on previously identified problems
Activity after supervision encounters	No or irregular follow-up	Actions and decisions recorded; ongoing monitoring of weak areas and improvements; follow-up on prior visits and problems

The purpose of supportive supervision

- Many approaches have been proposed to improve the quality of health services (for example, quality assurance). The supportive supervision approach improves services by focusing on meeting staff needs for management support, logistics and training, and continuing education. Using short checklists enables supervisors to provide guidance on

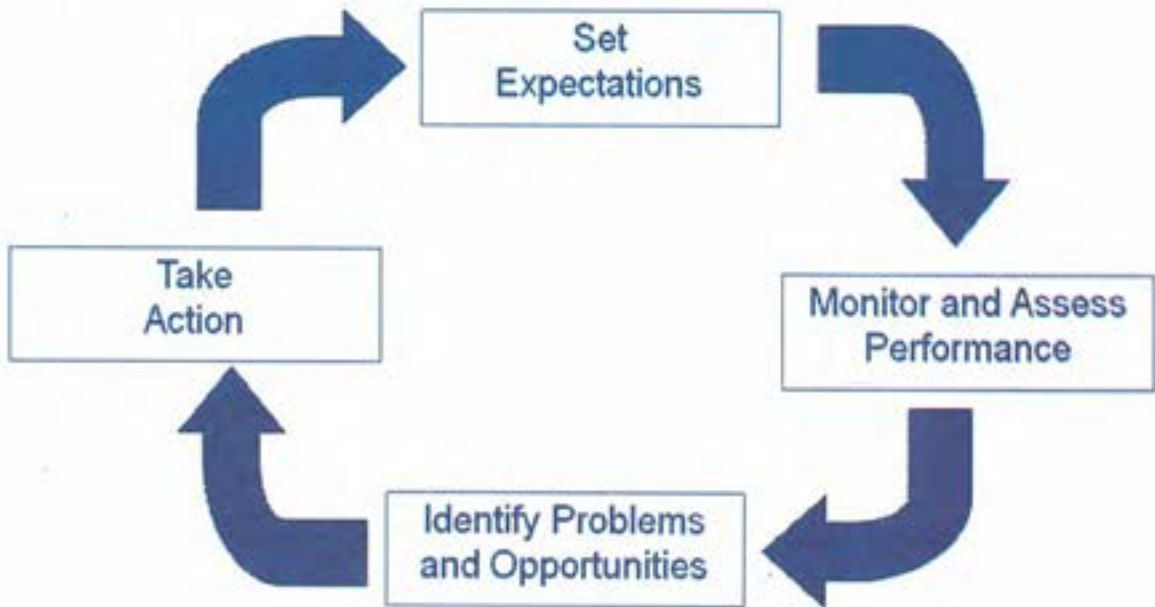
the technical aspect of the services, which, combined with a client-centred outlook, results in high-quality primary health care.

- Overall, supportive supervision sets out to do the following:
 - Make sure set objectives are appropriate
 - Make sure staff adjust to difficulties encountered on the job
 - Help develop staff motivation
 - Help staff to improve performance
 - Promote efficient, effective, and equitable health care

Components of Supportive Supervision

- The approach of supportive supervision requires the following to allow for success:
- Documented and well-known standards of expected performance which help to serve as baseline against which actual performance is measured.
- The standard for core determinants for performance such as knowledge, attitude, and skills of providers and other mostly neglected ones such as work environment, support system, and necessary tools to carry out tasks need to be clearly stated.
- New thinking about who does supervision and how and when it occurs. A key concept in supportive supervision is that it is implemented by multiple parties and at different levels including officially designated supervisors, informal supervisors, peers, and health care providers.
- Expanding the notion of who supervises has directly impacted on when and where supervision occurs.
- Motivation on the part of supervisors and staff alike to adopt new behaviours. This includes mutual respect during meetings to promote cooperation and treating problems as 'our problem' rather than supervisors assuming an accusing stand.
- Use of locally appropriate and tested tools. These help to ensure all key areas are covered and findings are documented. It also helps to confirm that standards are met.
- Supportive supervision requires time and investment to establish and take root.
- The commitment of top management and some decentralised decision-making authority
- Integration into existing human resource management systems rather than creation of a parallel system to 'work around' problems

The process of Supportive Supervision



- It encompasses the key functions/ tasks of supervision as stated above. It is an ongoing, continuously occurring performance which involves:
 - Stating objectives
 - Preparing guidelines and tools
 - Conducting frequent and regular planned visits
 - Carrying out a performance appraisal and reviewing against stated objectives
 - Recognising gaps and opportunities
 - Solving problems using systemically analysed performance issues and providing on-the-job training when required
 - Giving two-way and timely feedback in clear and specific areas

The three levels of supportive supervision

- External supervision – the supervisor is designated from outside the health facility/office, usually from a higher level in the system, and carries out site visits at scheduled periods

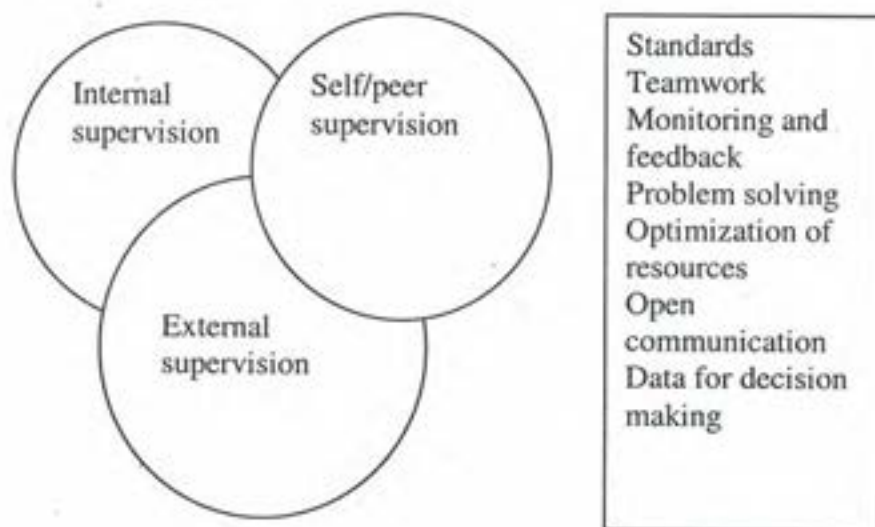
Stages of Supervision

s/no	Stages	Activities	Objectives
1	Stage one	Preparation for supervision	Study available documented standards Identify priorities Prepare supervision schedule
2	Stage two	Supervision proper	Establish contacts Review objectives and targets Observe workers as they perform tasks Identify gaps Report to health team/committee
3	Stage three	Follow up on supervision	Clarify objectives and targets Joint organisation of training programmes if needed Effect changes where necessary Prepare and circulate supervision report

Expected competence of a supervisor

- **Leadership:** A competent supervisor is trained (including people and technical competence) and able to develop a leadership style that will allow staff to grow and develop while getting things done. Able to delegate authority. The supervisor facilitates decision making and problem solving.
- **Communication:** He seeks to understand and be understood, understands the goals, objectives, and mission of the system/organisation, and communicates same to staff. He creates a welcoming environment where two-way communication exists.
- **Coaching and empowerment:** Shares knowledge with staff, gives honest recognition of good work, and gives credit for ideas/contributions in front of others. Capable of identifying training needs and promotional potential as well as disciplinary needs in staff.
- **Motivating and interpersonal skills:** Treats staff with respect and promotes participative work environment. Welcomes ideas/suggestions and put them to practice.
- **Internal supervision:** a process in a particular facility or department to oversee performance of individuals and the quality of service delivery. An internal structure for on-going supervision is created and should encompass, broadly:
 - Clinical services:
 - Guidelines and protocols should be put in place
 - Periodic checks to be sure these are being observed
 - Often done through peer discussion groups
 - Management activities:
 - Assessing resource management
 - Monitoring particular services through the information system
- **Self- and/or peer supervision** – a process by which individuals monitor and improve their own skills and performances and those of their colleagues. Clear performance expectations are set.
- **Post-consultation self-assessment forms** are valuable. Monitoring and quality improvement becomes a routine part of health workers' jobs.

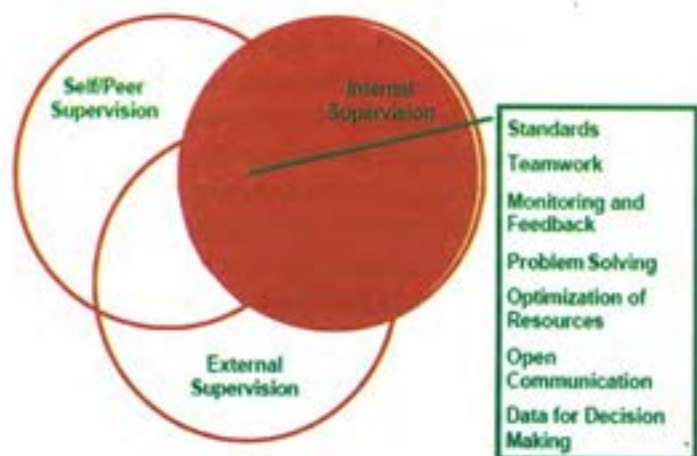
- It is not a standalone process as external supervisors serve as facilitators by leading planning and problem solving.
- These are usually organised by in-charge or other health workers themselves.



These three levels/mechanisms of supervision are simultaneous, complementary, and overlapping.



Aspects of Supportive Supervision



19-15

Supervision can and should occur in several ways. Individuals and teams should supervise themselves and each other, as peers. The most experienced individual within a team or facility should provide continuous technical support, shown here as internal supervision.

The 'Ten Commandments of Supportive Supervision'

- Thou shalt involve all team members in planning the process.
- Thou shalt communicate plans with all concerned.
- Thou shalt allocate roles/assign responsibilities.
- Thou shalt always link supervision with work.
- Thou shalt provide feedback.
- Thou shalt play a supportive supervisory role, not a punitive role.
- Thou shalt make on-the-job training an integral part of your supervisory role.
- Thou shalt be in touch with programme focal persons on regular basis.
- Thou shalt listen.
- Thou shalt be firm and fair and share mutual respect with supervisees.

Tools used in supportive supervision

• Structured Checklist

- A checklist is a tool applied during supportive supervision.
- It is a succinct choice of essential elements drawn from each programme or function.
- The list contains key observable features signifying that the most important resources and activities are in place.
- Examples include: Is the vaccine refrigerator operating? Are the vaccines appropriately stored in it? Are HIV rapid tests kits adequate in stock? Is service statistics report completed on time?
- Why do you need a checklist?
 - Checklists help organise the work of supervisors to make it regular and reliable.
 - Supervisees find this objective process motivating, because it helps them identify and address the highest priority problems by focusing on the critical inputs and processes required to deliver the essential PHC services.
 - They know what is expected of them and when they have met those expectations.
 - By jointly reviewing a checklist, a supervisor and staff member follow a systematic process that structures supervision.
 - Both can feel assured that if all features of a checklist are in place, the function or programme is performing up to expected standards.
 - Alternatively, missing elements require attention and serve to highlight gaps.
 - Thus, supportive supervision using checklists allows both supervisor and staff to see the full, integrated set of services that happen at the facility.
 - This approach is more reflective of client needs and of the way providers must work in the many situations where specialisation is not an option.
- How do you develop a supervisory checklist?
 - Create a series of indicators processes (providing a given service), to outputs (how many people access or use the service), to outcomes (the benefits of the service provided), to impact (the overall effect on well-being).
 - The supervisory checklist should evolve from measuring inputs (things you need to do the activity) to measuring outputs (things you have accomplished)

- **Self-assessment guidelines**
 - Self-assessment guidelines encourage staff to review how they perform daily tasks and serve as a catalyst for analysing the problems they identify.
 - The guides contain key questions based on international clinical and service standards.
 - They also highlight client-provider interactions and other client concerns.
- **Written report of the supervision encounter**
 - This is a written summary of the supervisory encounter, based on an agreed-upon format; it extracts the key findings both of progress and of problems for the attention of higher-level management.
 - The written report serves as an assured mechanism of information sharing with higher-level functionaries.
- **Feedback**
 - This refers to the act of giving information to a person about his or her performance, related to a task or a behaviour. It is best done as a **SPECIFIC, TIMELY COMMUNICATION** of information about performance following a supervision encounter.
 - The feedback message/information should:
 - Describe **BEHAVIOUR**, i.e., what the person did. Clear and specific statements, non-judgmental, based on positive intent and directed towards behaviour that the receiver can do something about
 - Describe **IMPACT**, i.e., how the supervisor and/or others reacted to the action/behaviour
 - **CONSEQUENCES**: describes what may happen in the future as a result of the action/behaviour
- **Forms of feedback**
 - On-going feedback: done on an on-going basis, this refers to agreements made in work plan conversations and on data collected during monitoring.
 - Corrective feedback: provided when performance does not meet expectations, this focuses on gaps between expected and observed performance
 - Positive feedback: when performance meets or even exceeds expectations. Most effective and motivating when it is not combined with corrective feedback

Challenges to the supportive supervision approach

- Lack of a comprehensive and clear policy on supervision.
- The conduct of supervision is often left to the initiative of different programme managers who often relegate tasks to spare moments.
- Resistance to change
- Requires time and investment to establish
- Lack of locally appropriate and tested tools
- Lack of commitment from top management

Conclusion

- Supportive supervision using a checklist or workers' performance guidelines that can easily be modified/updated is a real contribution to realising the Primary Health Care principles embodied in the Alma Ata Declaration.

- Reports as well as a two-way feedback guides management of resources as well as service provision and quality care.
- Full participation at all levels is central to the philosophy of supportive supervision.
- Ultimately, the result will be a more competent and satisfied staff providing improved health care for all.

Recommendations

- There is need to have a written policy on supervision so as to guarantee an improvement in the PHC.
- Key elements of a supervision policy include:
 - Appointment of a generalist supervisor to oversee each facility.
 - Facility staff should know the person to whom they are accountable to and who carries their concerns to higher levels.
 - Adequate time must be formally allocated for preparation, travel, visits, report writing, and follow-up activities.
 - Regular scheduled visits, reliably fixed to enable staff to plan and interact with supervisor during visits. This allows for full discussion and educational activities.
 - Reliable transport, either dedicated or through allocation of other vehicles in accordance with supervisory schedule.
 - A written report of supervisor's findings and actions taken, both for progress and problems to inform higher-level management.
 - Clear authority and responsibility given to designated supervisor by the policy as well as resources to carry out the supervision role, which includes making decisions to implement changes in management and design of services.
 - Authority also given to mobilise support to address high-priority problems; this enables rapid response to problem and avoids bureaucratic delays.
 - Change can be daunting and threatening, but it is an important ingredient in improving PHC.
- Supportive supervision requires motivation and behaviour change on the part of supervisors and staff alike.
- Supervisors themselves must be convinced of the need for and value of the supportive supervision approach. They are the catalysts and models for a sustained change.
- Supervisors need to use strategies to overcome resistance to change and in turn adapt the work environment to reinforce the change. They in turn need support and positive reinforcement from various angles, such as community organisations and professional associations, to sustain supportive supervision.
- Supportive supervision should receive resources (both time and investment) to develop staff capacity to implement it.
- External supervisors should engage in more facilitative and team-based activities, while health providers themselves regularly perform self- and peer supervision. This aims to develop supervisor's skills, orient staff to its tools and methods upgrade the technical/clinical skills a supervisor.
- Locally appropriate and tested tools should be provided for the supervision encounter. Preparing it may involve stakeholders, and it is based on defined standards of practice.
- Top management must be committed to sustain the approach of supportive supervision.
- Senior managers must be visibly involved and support the approach of supportive supervision.

- Supportive supervision should be integrated into existing human resource management system rather than as an isolated intervention/parallel system; it should work with the current system for sustainability.
- Documentation of impact of supportive supervision and its cost will help to provide a stronger case for advocacy for the expansion of the approach.

Example of a skills station for this topic

- Is there any link between supervision and programme performance? Ask participants to break into 3 groups. Following a brief discussion, let them generate ideas and present in plenary.
- Give participants pieces of cards. Each should itemise:
 - In a logical sequence, various steps involved in supportive supervision. Select about 6 persons to read what they have written.
 - Merits and demerits of the different styles of supervision
 - Importance of feedback and report in supervision process
 - Qualities of a good supervisor
 - Describe clearly the relationship between supervision, monitoring, and evaluation
 - Ask participants to compare traditional and supportive supervision based on the following headings: who does supervision, when does supervision occur, what happens during supervision encounter, and what happens after the supervision encounter.