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DECENTRALIZATION: FINANCE & MANAGEMENT PROJECT

Managed by
Associates in Rural Development, Inc.

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**USAID GOVERNANCE INITIATIVE IN NIGERIA
PHASE II REPORT:
DRAFT CURRICULUM MODULES AND MATERIALS
FOR LGA-PHC PARTICIPANT
TRAINING IN GOVERNANCE**

**Decentralization: Finance and Management Project
Associates in Rural Development, Inc.**

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Prepared for:

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PREFACE

This report is one of several prepared as a result of an ongoing program studying the issues of democratic governance as they relate to delivery of public health services in Nigeria. It was prepared through the Decentralization: Finance and Management (DFM) Project, with the support of USAID in Lagos, Nigeria. The DFM Project is managed by Associates in Rural Development, Inc.

The study team would like to extend its appreciation for the support provided by the USAID Affairs Office staff in Lagos.

I. INTRODUCTION

A. Background

This report summarizes the final phases of a project that conducted both research and preliminary program development and design for a program on governance and improved delivery of primary health care in Nigeria. The work was conducted by the Decentralization: Finance and Management (DFM) Project.

The initial phases consisted of a strategic assessment of the governance elements in the Nigerian primary health care (PHC) system, and two strategic issues workshops. At the workshops, over fifty participants involved in various aspects of the PHC delivery system reviewed the strategic assessment, and developed strategies for improving the effectiveness of the overall system. The assessment and workshops were described in the report "USAID Governance Initiative in Nigeria Phase I Report: Strategic Issues Workshops (Ife and Zaria)" (June, 1994).

Next the team designed prototype curriculum and trained the trainers who would deliver the program at a pilot session to be held at a later time. The final phase was to be the actual piloting of the curriculum modules. Due to a variety of circumstances, the planned pilot session has been delayed indefinitely. This Phase II report describes the modules that have been developed (section II) and what will need to occur in order to carry on the pilot session at some currently undetermined time (section III).

B. Objectives

One operational component of a USAID supported program to strengthen the governance aspects of PHC delivery is a targeted management and organizational training program. The DFM team's activities during the past 12 months have been concerned with development of that training program. This program would involve local practitioners who play critical roles in the PHC system, including LGA Council members, administrative heads (finance and personnel), and PHC managers. Perhaps other community members would also attend, such as health committee leaders and non-governmental representatives.

The training program would emphasize training in applied, real-world problem-solving as well as generic organizational skills. It would need to be highly practical and applied, consisting of:

- case studies relevant to the local PHC environment;
- group-team activities to work through problems and design innovative solutions that could be applied locally;

- sharing models of success, guidelines, protocols, between participating LGA PHCs; and
- tangible outputs (analytical studies, plans, budgets, supervision models, reports, etc.).

The style of the training would need to be highly participatory and interactive. While curriculum modules (drafts presented here) would outline the training objectives and suggested format, much of the content would be provided by the participants. They would analyze their own situations, review and comment upon recommended models of operation, and actually field-test some of the training program outcomes.

C. The Train the Trainer/Curriculum Design Session

The training and curriculum design session was conducted during one week in May, 1994 at the Administrative Staff College of Nigeria (ASCON) in Badagary. There were two overall purposes. First, to familiarize the training faculty with adult education and current training philosophies and techniques. Second, to draft an initial set of modular training formats that could be tested in a pilot session to be held later.

Curriculum for the training modules came from several sources.

1. The orientation report (contained in its entirety in the Phase I report); this is a synopsis of the earlier strategic assessment and contained vital baseline information, including identified shortcomings and issues within the current system.
2. A resource "library" of Nigerian-related articles, journals, government and private public health reports which provided general PHC information.
3. A thorough analysis of the reports from the strategic issues workshops (see the Phase I report) which gave critical insights on what strategies and models of success were most relevant to the PHC environment.
4. Several members of the training group have current involvement in local PHC programs. These include professors of local government and community health, as well as a medical doctor working in a "focus LGA", implementing PHC changes at the local level.

After initial "train the trainer" activities, the participants worked in four teams to develop the curriculum modules. Ten modules were developed, each including training objectives, presentation material, group learning activities, and time frames. The original drafts were completed at the one-week session at ASCON. Later, additional work including researching additional information and major re-editing, was done in Ile-Ife by an editing team. The training specialist then did some final editing and formatting of the draft modules, which are included in section II of this report.

Accomplishments

Accomplishments of the session include the following.

- Four hours were spent on adult learning theory and trainer skills and techniques.
- A three-hour module on "Governance as it Applies to the Nigerian PHC Delivery System at the LGA Level" was tested. The presentation was done by Dr. Dele Olowu based on a revision of the governance theory section from the Orientation Report. An interactive group activity was led by Gary Forbes.
- One full day was spent learning a participatory style of conducting group workshops. This included a practice session where all in attendance got an opportunity to facilitate a group discussion.
- There were sixteen in attendance at the session. By the end of the session an initial training faculty of nine individuals, representing both the university and public health sectors was identified and trained. The faculty includes (tentatively):
 - Dr. Lanre Nasser, Ile-Ife;
 - Dr. Kunle Awotokun, Ile-Ife;
 - Prof. David Adeyemo, Ile-Ife;
 - Dr. Anita Adetugbo, Ile-Ife;
 - Dr. Doyin Fagbule, NCCCCD;
 - Dr. Haruna Dlakwa, Maiduguri;
 - Dr. Omar Massoud, Zaria;
 - Prof. Festus Nze, Zaria; and,
 - Prof. Ebong Ikowiak, Zaria.

Dr. Dele Olowu, the Project Director, and Dr. John Erero, Project Coordinator, would also assist with curriculum delivery. Also it is possible that Mr. Ayo Ikotun from ASCON would be able to assist.

- **Drafts of ten training modules were completed:**

- **Governance;**
- **Inter-Governmental Relations;**
- **PHC Job Description;**
- **Community Participation;**
- **PHC Service Delivery Reporting;**
- **PHC Program Work Plan;**
- **PHC Budget Process;**
- **Revenue Mobilization;**
- **Effective Delegation in PHC; and**
- **Supervision Models.**

Each module is designed for a two to three hour pilot test with a group of LGA PHC practitioners, to be delivered by a two person training team. These ten draft training modules are presented in the next section of this report.

II. DRAFT TRAINING MODULES

A. Governance

Trainer Outline

Objectives:

Participants will be able to:

1. Understand the basic principles of the Governance Model;
2. Apply key concepts to the PHC environment;
3. Identify constraints and obstacles confronting the ongoing development of good governance; and,
4. Discuss and recommend potential relevant solutions for strengthening good governance in Nigeria's PHC.

Format:

1. Trainer provides an overview (see attached) of the governance model, presenting each element of the model with the group, and engaging them in discussion. The overview will be in two parts, first a walk-through of the basic elements, then a second time through discussing its application to Nigeria's PHC. Visual aids will be used to highlight key images and definitions. (75 minutes)
2. The group will be divided into five teams, each team representing an LGA. Each team will be given a worksheet (attached) to complete that has them identify major constraints and obstacles, and potential solutions for one of the governance elements. The team's key ideas will be written on a flipchart page for formal presentation to the group. (60 minutes)
3. Each team will present a five to 10 minute report on their findings. Note that there are five governance features thus five reports, one for each. Therefore each team has worked on only one of the features. The discussion that follows each report then is quickly to familiarize the rest of the group with that governance element and its application to PHC. (45 minutes)

Governance Overview

1. The Application of Governance Concepts to Strengthening LGA PHC

In recent years, the concept "governance" has come into use to help capture several major lessons learned over the last several decades:

1. There is no single or simple institutional "recipe" for good government;
2. There is no single characteristic or feature of government which, once achieved, will guarantee good performance; and,
3. Good governmental performance is associated with several operational features, all of which must be achieved to reach the goal of effective and efficient operations.

"Governance" is a newly created concept that is used to capture three basic ideas:

1. Governmental performance is the ultimate criteria of evaluation of any political-administrative arrangement. At the end of the day, can a particular government deliver those goods, services and social values which its citizens desire, and do so in a way which they believe to be legitimate?
2. Comparative analysis of government operations, including decision-making and administration, suggest that this effective performance and legitimacy require that any government embody five principles in its operation. These include:
 - accountability;
 - managerial and organizational efficiency;
 - transparency or openness in decision making;
 - responsiveness to the public; and,
 - pluralism in policy options.
3. Lastly, the concept of "governance" is intended to capture the importance of institutionalizing procedures that ensure officials and citizens alike operate consistently with the five organizational principles. Institutionalization requires that rules (laws, court decisions, constitutional provisions, generally accepted norms) govern and guide governmental operations.

At the heart of the "governance" concept are the five operational features which analysts believe are critically related to effective and efficient governmental performance. Each will be reviewed in some detail.

Accountability

Accountability is present when citizens and officials can hold one another to account for the discharge of their responsibilities to one another. Among other things, this means that persons have something close to symmetrical power relations with one another and that they know what their mutual responsibilities to one another are. One reason why elections and independent courts are often emphasized in discussions of sound administration is because they are ways by which governmental power is balanced by public means of accountability.

In complex organizations, accountability needs to run in three directions: top-down, bottom-up, and laterally. Each of these are worth reviewing:

Top-down: For accountability to exist from the top-downward, citizens and officials need to be able to ensure their superiors fulfill their responsibilities and obligations to them. These include the full and due enforcement of laws, honest and faithful handling of resources, fulfillment of obligations to deliver resources required by approved programs, and the like. Top-down accountability is usually exercised through elections, legal suits, administrative appeals and actions, provisions to discharge incompetent or faithless civil servants, and the like.

Lateral: Because most of a government's business, be it policy-making or administration of programs, occurs behind closed doors, and because of government's control of most of the information needed to assess performance, a second sort of accountability is needed to supplement "top-down." This is "lateral," the form of accountability where civil servants, political leaders and citizens observe one-another and demand ethical, efficient and effective performance. Do their peers follow professional norms? Are they discharging their duties fairly and honestly? Are they obeying law? Mechanisms to assure lateral accountability, among other things, include social pressure and high morale, procedures to protect "whistle-blowers" and provide for fair and impartial investigation of complaints, and professional norms articulated by professional associations and organizations.

Bottom-up: While it would seem fairly straight-forward that superiors must be able to hold their subordinates accountable for their performance, in fact it is not. The sheer size and scope of many organizations often make it difficult for superiors to keep track of service-delivery and middle-management personnel, while the ambiguity of measures of performance make evaluating organizational performance difficult. Information is lost going upward; authority "leaks" away going downward. Strong rules protecting civil service tenure, external pressure and the like also work to weaken chains of command. All these factors complicate the ability of superiors to demand good performance from subordinates, and hold them accountable when they fall short.

Overview: Accountability may be the most important of the five organizational requirements, because it is necessary to catch and correct shortfalls in the other four areas. Accountability requires multiple mechanisms: elections, independent courts of law, administrative tribunals, professional organizations, public knowledge, professional peers, inspectors-general, standard bureaucratic chains of command, and perhaps mechanisms by which citizens-consumers-clients can take their support/patronage elsewhere if all else fails. Together they can provide the multiple and diverse methods of holding office holders and officials to account. A general rule of thumb regarding accountability -- the more power anyone has the more essential there be multiple mechanisms of accountability.

Organizational and Managerial Efficiency

Organizations and their personnel need to be able to reliably, efficiently and effectively transform resources into good and services. To do this, among other things, they must be able systematically and accurately to determine needs, define problems, define solutions, plan programs, allocate resources, implement plans, evaluate performances, learn from their environments, and readjust programs.

Complex organizations attempting to achieve complex goals are particularly dependent on organizational and managerial efficiency. Their mission requires substantial division of responsibilities and labor; extensive technical specialization; geographic dispersion, coordination with other, independent organizations; adaptation to changing conditions; coordination over long periods of time; and efficient raising, allocation and management of costly and often perishable resources.

At least three dimensions must be considered in dealing with organizational and managerial effectiveness and efficiency: personnel skills; organizational procedures and routines; and basic organizational design. Personnel skills include standard management and executive skills as well as specific task-related skills. Personnel need those skills, judgement and intelligence necessary to do their jobs. Organizational procedures and routines refer to the standard operating procedures which characterize organizations and their routine functions: how budgets are made, performance is assessed, personnel are selected and promoted, resources are allocated, and the like. Procedures need to fit the organizational imperatives and constraints: resources, environment, task, goals, and the like.

Organizational design refers to the basic structure of the organization. For example, is it implementing a known technology, in a stable environment, with easily measurable results? If so, a traditional hierarchical structure may work well. However, if an organization is working with a problem which is incompletely understood, in a changing and unpredictable environment and with ambiguous results, than a more open, experimental structure may be optimal. Indeed, perhaps many, small, independent and quasi-competitive organizations would provide a better structure. Our understanding of the link between task and design needs to be further developed.

Organizational and managerial efficiency is far more complex than generic "management training" programs can hope to address. A comprehensive and custom-designed analysis must be performed to assess what any given organization must do to improve its operations.

Transparency or Openness in Decision-Making

Transparency refers to the extent to which citizens and officials have the information to critically appraise governmental action. It requires information be available on what decisions have been made, who made them, how they were made, what actions followed them, and what the outcomes of all these actions were. Transparency is important, among other reasons, because accountability and organizational and managerial efficiency depend on it. Unless citizens, peers and superiors can see what was done, etc., they can not know who to hold accountable; unless organizations and managers can assess what was done and with what consequences, they cannot determine how to improve organizational performance.

In local governments, a number of activities are critical to transparency:

- a clear budgetary process;
- accurate budgets;
- an open planning process;
- open discussion of priorities and their selection;
- reliable, accessible and comprehensible expenditure records;
- public criteria of, and announcement of managerial decisions;
- public measures of performance; and,
- openness as to when, how and by whom decisions were made.

Providing transparency is always challenging. Many decisions of government are technical; decision making itself is often confused; and decision makers often seek protection in secrecy. While perfect transparency is probably never achieved, without some level of transparency accountability is impossible; because no one (public or officials) can know who is responsible for governmental actions. Similarly, without some level of transparency, improving organizational and managerial efficiency is nearly impossible; no one can determine what caused sub-optimal performance.

Responsiveness to the Public

An efficient and effective governmental organization which is not responsive to the public will not provide good governance. For a time, under leadership exceptional both in knowledge and ethics, it may provide what the public wants and needs. But such leaders are unusual in any society, and when they pass from the scene the organization is likely to stray eventually from the public's agenda and pursue its own.

Responsiveness to the public can be achieved in a variety of ways: elections, a public role in planning and priority setting, dialogue with organizations representing the general public or specific communities within it, and the like. Responsiveness to citizens/clients/consumers is a key aspect of accountability. It is also necessary to alert organizations to shortfalls in their organizational and managerial effectiveness, and provide guidance for adjustment. In a world where democracy is the basic criteria of governmental legitimacy (even though it is at times more often invoked than observed), responsiveness is a necessary prerequisite for legitimacy.

Responsiveness does not necessarily imply a perfect correlation between public wants and governmental actions. Particularly in such technically complex areas as public and primary health care, mutual education and dialogue are essential to facilitate good policy choices. But there must be communication and, ultimately, convergence between public wants and governmental actions, or legitimacy and then performance will finally erode.

Policy Pluralism

Environments, technologies, public needs, and the resources available are always in flux. The problem of today differs from that of yesterday, and the tools at hand do as well. Organizations attempt to develop routines, procedures and policies to convert resources into solutions efficiently and effectively. But with so much change, organizations must be open to and presented with a constant flow of new strategies, options and tactics. This could be called "policy pluralism," and it is an essential ingredient to keep organizations responsive to public needs and wants and to maintain their organizational and managerial efficiency. Organizations cut-off from this are at best inefficient; often they become completely stagnant.

2. Governance and LGA PHC in Nigeria

Accountability

This is weak in all three directions: lateral, top-down, and bottom-up. Among professionals, morale is low, peer expectations appeared low, and operational standards were uneven. At the grass-roots there was little belief that they were able to influence PHC decisions or actions in any significant way. Similarly, PHC personnel appeared to accept with resignation poor support (funds, expertise, supplies, backing) from their superiors. The same applied to the professionals and the political leaders. From the top little administrative

control appeared operable. Zones and states had little authority over LGAs; PHC professionals were often more than out of touch with field personnel; and there rarely appeared any organizational coherence around any programs.

Transparency

This area was also in serious problems. Budgets were late, inaccurate, often ignored in practice, and rarely if ever followed by systematic work plans. Expenditures were unclear, with large amounts budgeted in ambiguous categories. Auditing was nearly absent. How budgetary decisions were made was obscure even to professionals in the LGA system. There were no measures of program achievements, no use of base-line studies to set goals, no systematic programs, no planning, and vacuous and vague work plans. The system was highly opaque in virtually every way.

In spite of directives in some states that a minimum proportion of an LGA budget should go to PHC, a much lower proportion is allocated in many LGAs. Unfortunately, even these low levels are never fully expended on PHC and several LGAs have not had an audited account for several years. As a result, the public lacks any clear information or indicator to hold the LG accountable for poor performance.

Organizational and Managerial Efficiency and Effectiveness

In the LGA PHC system, there are serious shortfalls in several areas. These include problem identification, planning, programme development, budgeting, monitoring, evaluation, supervision, quality control, efficient allocation of resources, maintenance of equipment and use of personnel.

The results of these deficiencies show up in the gradual erosion of the quality and reliability of PHC services throughout the LGA's. For instance, many health facilities are closed during normal business hours, have insufficient critical drugs, dilapidated equipment, poor to non-existent record keeping, absentee staff, dirty facilities, grounded supervisors because of broken transport, key monitoring and evaluation data often ungathered, some data suspect, no forms to record on and report data, broken cold-box chains, unavailable imprest funds for supervisory visits, critical equipment (generators, transport) misappropriated by other LGA personnel etc. Routine business does not go on as it should, and the more complex managerial activities such as performance evaluation, program appraisal and redesign, staff redeployment, capital planning and the like is rarely done.

Responsiveness

In general, there is little public input for PHC to respond to. What there was, because of the weakness of the LGA-PHC committee system, was often fragmented, not well informed, and not clearly representative of general public feeling. The LGAs as a whole, because of the underdevelopment of the election process, and PHC in particular, because of the incomplete development and utilization of the committee process, were not particularly responsive to public wants.

Policy Pluralism

In its youth, PHC is still attempting to implement effectively the national PHC policy and strategy. It has not begun to generate alternative strategies and tactics. This is partly understandable, but nonetheless a disadvantage in that the learning and refining process characteristic of all new programs is slowed.

3. Overview and Conclusions

Analytical frameworks such as the "governance" model are useful if they help people discover why operational shortfalls exist in particular organizations or programs. They should provide a "check list" of possible trouble areas to help inform and guide interventions to improve organizational performance.

In the case of the LGA-PHC system of Nigeria, numerous operational problems exist. "Governance" can be used to help determine the causes and suggest actions to remedy these problems. Nigeria's PHC program is a revolutionary effort to bring services to its rural population. It is hardly surprising there are numerous challenges to making this a success. It is to build on this start that this training module is designed.

Governance Worksheet

Accountability

Meeting in your team, discuss the Governance concept of Accountability, exploring the opportunities, constraints, and strategies for strengthening it within the LGA PHC. Designate someone to take notes of your discussion and appoint a reporter to represent the team's ideas to the group.

What major **Opportunities** exist for improving legitimacy and responsiveness to the public? List at least five below:

1.

2.

3.

4.

5.

What are the major **Constraints** that block legitimacy and responsiveness to the public? List three:

1.

2.

3.

What **Strategies** would you suggest for overcoming the identified constraints or obstacles? What are policy and procedures changes, and what changes are required in accepted practices? Please list three ideas.

1.

2.

3.

Governance Worksheet

Managerial and Organizational Efficiency

Meeting in your team, discuss the Governance concept of Managerial and Organizational Efficiency, exploring the opportunities, constraints, and strategies for strengthening it within the LGA PHC. Designate someone to take notes of your discussion and appoint a reporter to represent the team's ideas to the group.

What major **Opportunities** exist for improving legitimacy and responsiveness to the public? List at least five below:

- 1.
- 2.
- 3.
- 4.
- 5.

What are the major **Constraints** that block legitimacy and responsiveness to the public? List three:

- 1.
- 2.
- 3.

What **Strategies** would you suggest for overcoming the identified constraints or obstacles? What are policy and procedures changes, and what changes are required in accepted practices? Please list three ideas.

- 1.
- 2.
- 3.

Governance Worksheet

Transparency

Meeting in your team, discuss the Governance concept of Transparency, exploring the opportunities, constraints, and strategies for strengthening it within the LGA PHC. Designate someone to take notes of your discussion and appoint a reporter to represent the team's ideas to the group.

What major **Opportunities** exist for improving legitimacy and responsiveness to the public? List at least five below:

1.

2.

3.

4.

5.

What are the major **Constraints** that block legitimacy and responsiveness to the public? List three:

1.

2.

3.

What **Strategies** would you suggest for overcoming the identified constraints or obstacles? What are policy and procedures changes, and what changes are required in accepted practices? Please list three ideas.

1.

2.

3.

Governance Worksheet

Legitimacy and Responsiveness to the Public

Meeting in your team, discuss the Governance concept of Legitimacy and Responsiveness to the Public, exploring the opportunities, constraints, and strategies for strengthening it within the LGA PHC. Designate someone to take notes of your discussion and appoint a reporter to represent the team's ideas to the group.

What major **Opportunities** exist for improving legitimacy and responsiveness to the public? List at least five below:

1.

2.

3.

4.

5.

What are the major **Constraints** that block legitimacy and responsiveness to the public? List three:

1.

2.

3.

What **Strategies** would you suggest for overcoming the identified constraints or obstacles? What are policy and procedures changes, and what changes are required in accepted practices? Please list three ideas.

1.

2.

3.

Governance Worksheet

Pluralism in Policy Options

Meeting in your team, discuss the Governance concept of Pluralism in Policy Options, exploring the opportunities, constraints, and strategies for strengthening it within the LGA PHC. Designate someone to take notes of your discussion and appoint a reporter to represent the team's ideas to the group.

What major **Opportunities** exist for improving legitimacy and responsiveness to the public? List at least five below:

1.

2.

3.

4.

5.

What are the major **Constraints** that block legitimacy and responsiveness to the public? List three:

1.

2.

3.

What **Strategies** would you suggest for overcoming the identified constraints or obstacles? What are policy and procedures changes, and what changes are required in accepted practices? Please list three ideas.

1.

2.

3.

B. Inter-Governmental Relations

Trainer Outline

Objectives:

Participants will be able to:

1. Understand the critical significance of strong and effective relations between the LGA PHC and other governmental entities;
2. Analyze the strengths and weaknesses of the LGA PHC relationship to the FMOH, SMOH, CDAs/NGOs, and other LGAs (lateral relations); and,
3. Strategize on what could be done to strengthen specific inter-governmental relations.

Format:

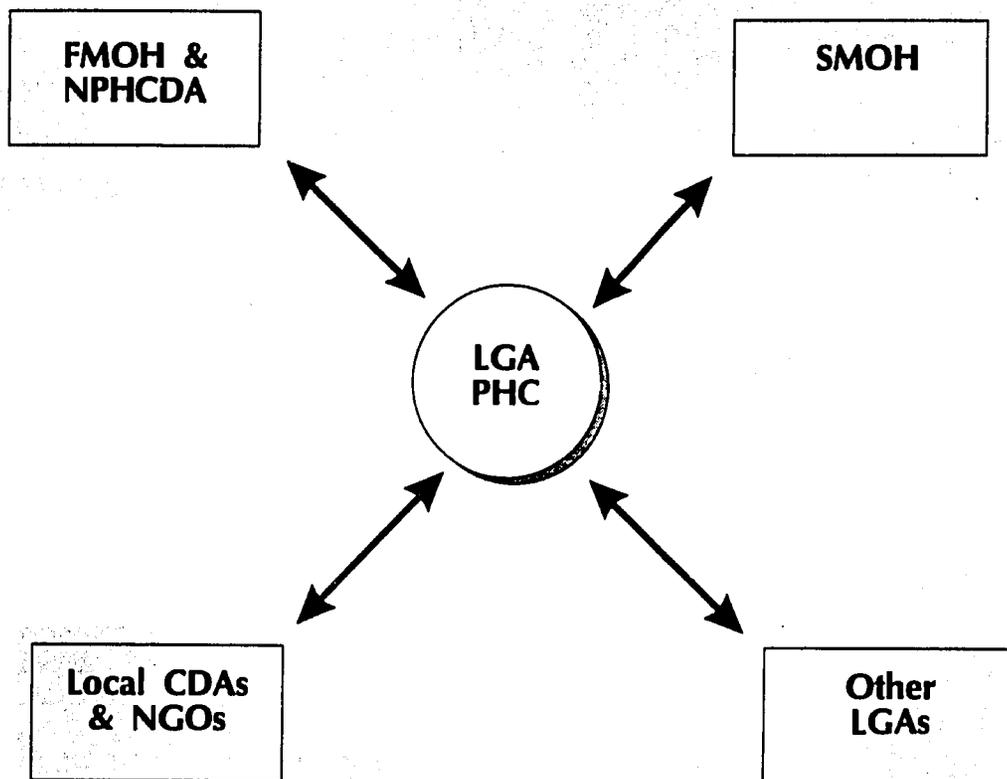
1. Trainer reviews the hand out (attached) that describes inter-governmental relations, engaging group discussion. Invites group to add, delete, or clarify items listed in the checklists. (15 minutes)
2. Trainer introduces group activity, gives instructions, and divides group into four teams to complete the worksheets (attached). (45 minutes)
3. Each team reports their findings and ideas on large flipchart page. Trainer leads whole group in discussing and adding to list of opportunities and strategies. (60 minutes)

Description of Inter-Governmental Relations

Definition: Inter-governmental relations is simply the relationship among the levels of government, namely, federal, state, and local governments.

With respect to PHC this relationship can be further broken down to levels of responsibilities which are intended to be performed by the various levels of government.

The pattern of the inter-relationship is illustrated in the model below. Note: because significant PHC activity takes place outside of strictly "governmental" agencies, a fourth relationship called CDAs/NGOs (community development associations/non-governmental organizations) is added to the model.



Inter-Governmental Relations

In the Nigerian National Health Policy, certain roles and responsibilities related to inter-governmental relations have been specifically identified. The checklists below attempt to categorize the most important ones. The purpose of these checklists is to educate individuals and PHC entities as to their mandated responsibilities, and to strengthen the collaborative working relationship between the various governmental agencies.

Please participate in the group discussion by adding your comments that might clarify or elaborate the key statements.

Responsibilities of Federal Ministry of Health:

1. Formulation of Primary Health Care policy
2. Designing of national health strategies, programs and intervention
3. Provision of management guidelines for PHC program implementation
4. Formulation of PHC training programs and inspection of PHC training institutions
5. Provision of financial support for the implementation of PHC programs
6. Integration of data on PHC in the National Health Information System

Responsibilities of National Primary Health Care Development Agency

1. Promote monitoring of PHC plan implementation at various levels
2. Review existing health policies particularly as to their relevance to the development of PHC and to the integrated development of health services and health manpower, and suggest changes when necessary
3. Prepare alternatives or options for decision-makers at all levels deriving from scientific analysis including proposals for health legislation

4. Conduct studies on health planning for PHC at various levels, with emphasis on relevance to national health policy, feasibility, and multi-sectoral effectiveness
5. Stimulate technical development of PHC on an equitable basis in all LGAs

Responsibilities of State Ministry of Health:

1. Audit LGA finances
2. Promote inter-sectoral coordination
3. Train health personnel
4. Provide monitoring and evaluation forms
5. Advocacy role for the PHC
6. Assist in the improvement of LGA management capacity
7. Improve health technology
8. Maintain technical assistance standards among the LGAs
9. Coordinate and plan state-wide PHC programs

Responsibilities of State Council on Health:

1. Facilitate the coordination of plans, programs and activities at the State level
2. SMOH PHC Director is member of Council and represents interests of PHC at State level
3. Approve SMOH PHC budget
4. Encourage better LGA PHC performance in general

Roles and Responsibilities of LGA PHC Towards SMOH:

1. **Collection and submission of timely monitoring and evaluation (M&E) forms**
2. **Promptly reporting cases of epidemics**
3. **Provide monthly report to SMOH PHC Director through LGA Director of Personnel Management**

Worksheet on Inter-Governmental Relations

Examine the patterns of inter-governmental relations between an LGA PHC and the Federal Ministry of Health (including the NPHCDA). Record your reflections and insights in this chart and be prepared to discuss your findings with the other teams.

STRENGTHS	OPPORTUNITIES
WEAKNESSES	FUTURE STRATEGIES

Worksheet on Inter-Governmental Relations

Examine the patterns of inter-governmental relations between an LGA PHC and the State Ministry of Health. Record your reflections and insights in this chart and be prepared to discuss your findings with the other teams.

STRENGTHS	OPPORTUNITIES
WEAKNESSES	FUTURE STRATEGIES

Worksheet on Inter-Governmental Relations

Examine the patterns of inter-governmental relations between an LGA and the neighboring community development associations and non-governmental organizations. Record your reflections and insights in this chart and be prepared to discuss your findings with the other teams.

STRENGTHS	OPPORTUNITIES
WEAKNESSES	FUTURE STRATEGIES

Worksheet on Inter-Governmental Relations

Examine the patterns of inter-governmental relations between one LGA and other LGAs. Record your reflections and insights in this chart and be prepared to discuss your findings with the other teams.

STRENGTHS	OPPORTUNITIES
WEAKNESSES	FUTURE STRATEGIES

C. PHC Job Descriptions

Trainer Outline

Objectives:

Participants will be able to:

1. Define what job descriptions are and why they are important in the PHC;
2. Know how to write a comprehensive and clear description of duties, skills and qualifications; and,
3. Design a job description for a PHC position reporting to them.

Format:

1. Trainer discusses key concepts of job descriptions, highlighting the handouts on elements of a job description (attached) and the illustration of a well done job description (attached). (15 minutes)
2. The group is divided into teams of 2 - 3 individuals who share similar positions. They pick a PHC job title of one of their members and fill out the model job description (attached). (45 minutes)
3. Each individual chooses one key position reporting to them and designs a job description, filling out the model form (attached). (45 minutes)
4. Trainer hands out the Barkin Ladi example of a job description for an assistant coordinator and briefly discusses it with the group (attached). (15 minutes)

Why Job Descriptions are Useful

A job description serves several purposes:

- Hiring:** To ensure that the person who is hired has the necessary qualifications.
- Training:** To identify the training needs by noting the discrepancies between trainee capabilities and qualifications needed for the job.
- Orientation:** To help the new employee understand what is expected in the job.
- Supervision:** To help the employee's supervisor monitor his/her performance on a regular basis.
- Performance Evaluation:** To help the supervisor systematically and objectively review the employee's performance on all assigned tasks.
- Workplace Coordination:** To ensure that all the necessary tasks are being assigned to the right employee and that no two employees are inadvertently assigned the same task.

Overview of Job Descriptions

A job description outlines an employee's tasks and responsibilities, what his/her authority is, and what skills and qualifications are necessary to do the work. Without a written job description, neither the supervisor or the employee will have a clear idea of what the employee is expected to do.

Job descriptions must be clearly written before you select new staff members. These planning documents should be written for each staff position reporting to you. They should describe thoroughly the duties and responsibilities assigned to each position. This provides the basis for orienting and training new staff.

Elements of a Job Description	
Job Title	Standard title for the person doing the work or job.
Date	Should be dated and then revised over time as the nature of the job changes.
Job Summary	Summary of the main job function(s); should be brief - one or two sentences
Duties	A detailed description of the major activities for which the employee is responsible. For complex jobs, it helps to divide this section into categories.
Relationships	Who does this person report to and who are staff he/she supervises?
Qualifications	A description of skills and qualifications required for the job.
Review and Appraisal	Criteria to be used in assessing the employee's performance.

JOB TITLE: Nursing Sister for Ajara PHC

DATE: 27-4-94

JOB SUMMARY: To provide effective supervision on the activities of Staff Nurse and Midwife working in the PHC system.

DUTIES:	FREQUENCY OF DUTY	% OF TIME
1. To plan, organize and oversee the following Health Services: *maternal and child health *family planning *immunization, *home care, *school care, *health education	Daily	40%
2. To supervise the ordering and distribution of equipment, drugs and supplies	Daily	15%
3. To arrange and facilitate contacts within Community Groups and actively promote community participation in health programs	Daily	35%
4. To supervise the work of district midwives, community health aids, and supporting staff	Daily	10%

RELATIONSHIPS:

Report to the Chief Nursing Officer, and supervise Nurses and Auxiliary Nurses and supporting staff.

QUALIFICATIONS:

Registered Staff Nurse/Midwife with 6 years experience.

REVIEW AND APPRAISAL:

Annual increment and promotion will be dependent on a work and performance appraisal, it will be based on clinic reports, personnel visits and interviews with the Community Health Committee made by the Senior Nursing Officer and M/E unit.

JOB TITLE:		
DATE:		
JOB SUMMARY:		
DUTIES:	FREQUENCY OF DUTY	% OF TIME
RELATIONSHIPS:		
QUALIFICATIONS:		
REVIEW AND APPRAISAL:		

JOB TITLE:

DATE:

JOB SUMMARY:

DUTIES:	FREQUENCY OF DUTY	% OF TIME

RELATIONSHIPS:

QUALIFICATIONS:

REVIEW AND APPRAISAL:

Job Description Example

Job Description for Assistant Primary Health Care Coordinators, Barkin Ladi Local Government Area

The Assistant Primary Health Care Coordinators of Barkin Ladi LGA are senior health members of the Primary Health Care Department. Each Coordinator is expected to develop his/her responsibilities in the LGA Health Districts based on the specific functions of the unit.

Qualities of Assistant Coordinators:

1. He/she should be knowledgeable in Primary Health Care activities.
2. Should be very dedicated to duties.
3. Should be honest, reliable and live by example.
4. Should be able to make decisions independently.
5. Must have initiatives and be tolerant of others.
6. Be able to develop others.

Assistant Coordinator: Disease Control/Immunization/Environmental Health

The functions of the Assistant Coordinator for Disease Control/Immunization/Environmental Health are as follows:

1. Develop a one year work plan for the unit in all the Districts.
2. Set up the District health system which includes:
 - selection of district health supervisor;
 - mobilization of the District health supervisor for health action;
 - training of the District supervisor on the techniques of immunization, investigation of outbreaks and the construction of VIP latrines.
3. Supply immunization equipment to all health facilities for efficient immunization coverage.
4. Investigate any reported outbreak of disease in any District of the LGA.
5. Submit report of outbreak of any disease to the Deputy Coordinator of PHC and the State Epidemiological Unit.
6. Maintain the potency of vaccines at all levels which includes:
 - vaccine storage at the appropriate temperature;
 - vaccines to be transported at the appropriate temperature in containers and vehicles;
 - vaccines are administered at the appropriate temperature and sterile procedures are maintained.
7. Notify the Deputy PHC Coordinator on outbreak of any communicable disease in the LGA.

8. Develop health education programs and posters for all Districts on the dangers of communicable diseases and the need to immunize children and women of childbearing age against the six killer diseases.
9. Set up supervisory mechanisms for the control of communicable diseases, maintenance of potency of vaccines at all levels, and maintenance of community wells and boreholes in all Districts.
10. Set up logistical support for distribution of vaccines and equipment.
11. Liaise with DIFRRI in the construction of wells and boreholes in any of the Districts.
12. Ensure that all reports of immunization activities, communicable diseases, and WATSAN are sent by the District supervisors.

D. Community Participation

Trainer Outline

Objectives:

Participants will be able to:

1. Grasp a heightened awareness of the importance of community participation/mobilization in PHC.
2. Understand the composition, responsibilities, and operating guidelines of the official three tier committee structure within PHC.
3. Initiate discussion of actual effectiveness of this structure and develop strategies and procedures to improve it.

Format:

1. Trainer presents concepts of PHC and community participation using material in the handout (attached). (15 minutes)
2. Trainer assigns PHC teams to complete handout on composition, responsibilities, actual operating guidelines for, and challenges facing, committees in their LGA (see attached). Each team briefly reports to the group on their committee operations. Trainer leads group discussion on what seems to be working well, problems the PHCs are having in getting community involvement, and models of success that might be happening. (30 minutes)
3. Trainer hands out official committee structure materials (see attached) and reviews the main points with the group. (15 minutes)
4. Trainer challenges participants with such questions as; are the committees in your area effective in mobilizing grassroots participation? Why or why not? Trainer then facilitates a mini workshop on the focus question, "How to Initiate and Strengthen Village Health Committees." This workshop is fast-moving, interactive, and results in 5 - 10 priorities of action for PHC officials to use to utilize community participation in their PHC programs.

Community Participation and Mobilization

Primary health care is essential health care based on practical, scientifically sound and socially accepted methods and technology. It is to be made universally accessible to individuals and families in the community and through their full participation and at a cost that the community and country can afford. At every stage of their development the spirit of self-reliance and self-determination is needed to keep it strong. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and community with the national health system. It tries to bring health care as close as possible to where people live and work, and is the first element of a continuing health care process.

The national health policy and strategy is based on the primary health care philosophy. Primary health care is the key to attaining the goal of health for all people in Nigeria, and is promotive, preventive and rehabilitative. The ten components of primary health care are:

1. Health Education
2. Food and Nutrition
3. Environmental Services
4. Immunization
5. Maternal and Child Health (including family planning)
6. Treatment of Minor Ailments
7. Essential Drugs
8. Control of Endemic Diseases
9. Mental Health
10. Dental Health

Community mobilization is a means of encouraging, influencing, and arousing interest of people to make them actively involved in recognizing and finding solutions to some of their own problems. Community mobilization is important to facilitate:

- resource mobilization;
- self-help activities;
- communication of local needs and priorities to PHC personnel;
- reporting on the performance of the PHC service delivery personnel to PHC management;
- spreading information from PHC to the community;
- rapid action in health emergencies; and
- assert community health priorities to LGA leadership in the budget and planning process.

It is the key mechanism to bring to the grassroots a sense of ownership of the PHC program, and thereby lead the community itself to apply their skills and resources to the ongoing improvement of individual health and well-being.

PHC COMMITTEE STRUCTURE WORKSHEET

Identify the composition, major responsibilities, operating guidelines, and challenges in your PHC Committees.

PHC Committee	Composition	Major Responsibilities	Operating Guidelines	Challenges
Village Health Committees				
District Health Committees				
PHC Management Committee				

PHC Committee Structure

The official Nigerian PHC participation structure (i.e. committee structure) is as follows.

I. Village Health Committee

A. Composition

- village head or other respectable person appointed by committee members as chairman
- primary school headmaster
- representatives of religious groups
- representatives of women's associations
- representatives of occupational groups
- representatives of NGO's
- representatives of youth groups
- any others who may be deemed fit for membership

A trusted member of the committee will serve as treasurer; a literate member of the committee will serve as secretary.

B. Responsibilities

1. identify health problems in the community;
2. plan for the health and welfare of the community;
3. set achievable local health targets, e.g. construction of pit latrines, and wells;
4. identify available resources within the community;
5. select appropriate persons from the community for training as Village Health Workers/Traditional Birth Attendants;
6. establish and maintain a village health post;
7. provide necessary support for the VHW for the provision of PHC services;
8. accountable for DRF monies;
9. decides who is exempted from paying for drugs and pays for those services;
10. to alert PHC coordinator directly in cases of emergencies, epidemics, etc.;
11. mobilize community in PHC activities and community outreach programs;
12. mobilize communities for effective participation in PHC;
13. supervise the activities of the LGA PHC coordinator;
14. designate persons to run the Drug Revolving Funds and monitor progress;

15. receive monthly reports from the PHC Coordinator;
16. collaborate with government agencies, NGOs and international agencies in their health and health related activities; and,
17. monitor health activities at district, facility and village levels.

C. Operational Guidelines

The committee shall:

1. Meet at least once every month;
2. Record minutes of meetings; and,
3. Recommend that minutes of meeting be signed by the Committee chairman and secretary after adoption at next meeting.

The treasurer should record and keep all monies, spend money only after approval by committee, and record all expenditures. Where there is a bank account signatories will be the committee chairman, treasurer and secretary.

II. District Health Committee

At the district level a PHC committee will be set up. Where a district committee already exists, PHC will be added to the work of such a committee.

A. Composition of the committee

- district head (chairman)
- district health team leader
- all village heads within the district or their representatives
- secondary and primary school headmasters
- most senior agricultural extension worker in the district
- district community development officer
- representative of international organizations and NGO's in the district
- representative of religious groups
- representative of women's groups

B. Terms of Reference

Responsibilities:

1. identify local human and material resources to meet these needs;
2. mobilize and coordinate planning and implementation and evaluation of health projects;
3. raise funds for community projects at village or district levels;

4. provide feedback to rest of community on how funds raised were disbursed;
5. provide input on health needs and prioritizing for PHC budgeting at LGA level;
6. monitor PHC activities at both health facilities and village levels;
7. liaise with government and voluntary agencies in responding to health-related problems; and,
8. forward health plans to LGA PHC.

C. **Operational Guidelines**

In following the above the committee shall:

1. Meet at least once every month;
2. Record minutes of meetings; and
3. Recommend that minutes of meetings shall be signed by the chairman and secretary after adoption at the next meeting.

The treasurer should record and keep all monies, spend money only after approval by the committee, and should record all expenditures. Where there is a bank account signatories will be the committee chairman, treasurer and secretary.

III. **PHC Management Committee**

A. **Composition**

- chairman of LGA (chairman)
- supervisory councillor for health (members)
- the LGA secretary
- LGA PHC coordinator (secretary)
- representative of CHO training institutes
- representative of health-related occupational associations
- senior Community Health Officer in the LGA
- community development officer for LGA
- district heads or their representatives; representatives of International agencies having PHC programmes in the LGA
- heads of other health related departments in the LGA (education, agriculture, etc.)
- representative of NGO's
- representative of women's groups
- representative of religious groups

B. Responsibilities

Terms of reference of the LGA PHC Management Committee shall be to:

- 1. plan, approve work;**
- 2. approve PHC training proposals;**
- 3. consider and offer feedback on PHC budget proposals;**
- 4. provide critical and relevant data and input into PHC programme plans;**
- 5. provision of policy and overall direction for PHC and the LGA; and,**
- 6. approve, modify and reject if necessary, proposals brought to it from PHC technical committee.**

C. Operational Guidelines

The committee shall:

- 1. Meet at least monthly;**
- 2. Record minutes of meetings;**
- 3. Recommend that minutes of meetings be signed by the Committee chairman and secretary after adoption at the next meeting;**
- 4. Comply with the number of persons set for starting meetings in order to maintain a quorum;**
- 5. Forward copies of monthly meetings to the State Ministry of Health, PHC Department/Agency; and,**
- 6. Feedback to District and Village Health Committee.**

E. PHC Service Delivery Measurement and Reporting

Trainer Outline:

Objectives:

Participants will be able to:

1. Appreciate the need for and benefits of a detailed service delivery report;
2. Develop appropriate formats for gathering and disseminating key service delivery results.

Format:

1. Trainer presents an overview of service delivery measurement and reporting concepts and benefits (attached). (15 minutes)
2. PHC teams discuss their program organizational chart, their major functional units and the programs within each. Trainer asks each PHC to report on how they are organized programmatically. For the purposes of this seminar, the group agrees on a general PHC program chart of six units, e.g. Maternal Health Care and Health Education, Essential Drugs, etc. (15 minutes)
3. Trainer divides group arbitrarily into three teams. Each team takes two units and writes 2 - 4 service indicators for each unit (see attached form). Each team reports to whole group. (45 minutes)
4. In PHC teams again, and using the indicators just developed by the group, summarize 1994 service results (estimating will probably be necessary). Then, set 1995 service delivery targets. Trainer calls for brief reports and leads discussion on how to use these methods. (45 minutes)
5. Trainer reviews handout on Facility Assessment Survey (attached) with the group.

PHC Service Delivery Measurement and Reporting

Service delivery measurement and reports are a means of analyzing the results or outcomes of PHC programs. These reports are also a way to communicate to policy-makers, both locally and in the PHC system, and the general public, of the overall effectiveness and advancement of PHC services and programs.

Benefits

To PHC Staff:

- Provides sense of accomplishment and fulfillment.
- Provides basis for setting new goals.
- Holds staff accountable to established targets.
- Elicits support and commitment from the community -- the more they know about PHC, the more they support PHC.

To Policy-Makers:

- Provides a means of monitoring PHC activities and progress.
- Provides objective accountability to recognized policy makers.

To the Community:

- Informs public of PHC progress.
- Provides basis for recognizing accomplishments and/or shortcomings so that the community can be involved in a more knowledgeable manner.
- Creates a sense of responsibility and ownership of PHC programs among community members.

Characteristics of Effective Measurements

1. Must relate to direct client services.
2. Must measure and report significant PHC results and deliverables.
3. Must be visible, understandable indicators.
4. Must have some quantifiable measures included, e.g. numbers, percentages, units, hours, events, etc.

SERVICE DELIVERY TRACKING AND TARGET SETTING

Program Unit	Service Indicators	1994 Results	1995 Targets

FACILITY ASSESSMENT SURVEY

LGA: _____ Facility: _____ Obs #: _____ Date: ___/___/91]

Health Worker Observed (Title): _____ Interviewer: _____

OBSERVATION CHECKLIST #1 ***SICK CHILDREN***

DOES THE HEALTH WORKER DETERMINE THE CHILD'S:

- | | | | |
|----|---|---|---|
| 1. | Age..... | Y | N |
| 2. | Weight..... | Y | N |
| 3. | Temperature with a thermometer..... | Y | N |
| | Temperature by touching the skin..... | Y | N |
| 4. | Respiration rate..... | Y | N |
| 5. | Does the child have a health (immunization) Card..... | Y | N |
| | If Yes, does the health worker: | | |
| | Check the child's immunization status..... | Y | N |
| | Refer for immunization (when needed)..... | Y | N |
| 6. | Does the mother have a health (TT) card..... | Y | N |
| | If Yes, does the health worker: | | |
| | Check the mother's TT status..... | Y | N |
| | Refer for TT immunization (when needed)..... | Y | N |

DOES THE HEALTH WORKER ASK QUESTIONS ABOUT:

- | | | | |
|-----|-------------------------------------|---|---|
| 7. | General condition of the child..... | Y | N |
| 8. | Duration of the illness..... | Y | N |
| 9. | History of fever..... | Y | N |
| 10. | Vomiting..... | Y | N |
| 11. | Diarrhea..... | Y | N |
| 12. | Duration of diarrhea..... | Y | N |
| 13. | Number of stools/past 24 hrs..... | Y | N |
| 14. | Blood in the stool..... | Y | N |
| 15. | Coughing..... | Y | N |
| 16. | Difficulties with breathing..... | Y | N |
| 17. | Problem with swallowing..... | Y | N |
| 18. | History of home treatment with: | | |
| | Traditional medicine/practice..... | Y | N |
| | Western medicine..... | Y | N |

DOES THE HEALTH WORKER EXAMINE THE CHILD'S:

- 19. Eyes.....Y
- 20. Ears.....Y
- 21. Throat.....Y
- 22. Breathing.....Y
- 23. Abdomen.....Y
- 24. Skin fold.....Y

*** DIAGNOSIS***

DOES THE HEALTH WORKER DIAGNOSE THE CHILD AS HAVING:

- 25. Diarrhoea.....Y
- 26. Dehydration.....Y

If Yes: _____ Slight
 _____ Moderate
 _____ Severe

- 27. Cough.....Y
- 28. Cold.....Y
- 29. Pneumonia/Bronchitis.....Y
- 30. Fever.....Y
- 31. Malaria.....Y
- 32. Other: _____

*** EDUCATION OF THE MOTHER***

DOES THE HEALTH WORKER EXPLAIN TO THE MOTHER:

- 33. How to administer medications.....Y
- 34. The importance of completing the treatment.....Y
- 35. The need to:
 - * give more fluids than usual.....Y
 - * give fluids after each diarrhoea episode.....Y
 - * give fluids after each vomiting episode.....Y
 - * continue breastfeeding the child.....Y
 - * continue feeding the child.....Y
 - * give an antipyretic.....Y
 - * give a tepid bath.....Y
- 36. That she should return to the health center
 if the child's condition gets worse.....Y

DOES THE HEALTH WORKER:

- 37. Explain how to prepare SSS.....Y
- 38. Demonstrate how to prepare SSS.....Y
- 39. Ask the mother to demonstrate how to prepare SSS.....Y

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- How many times do you give it to the child each day?
- for how many days will you give the medicine to the child?

MEDICINE		How much each time?	How many times each day	For how many days?
Chloroquine	(Tab)	___ Tap	_____	_____
Chloroquine	(Syr)	___ Tap	_____	_____
Antibiotic	(Tab)	___ Tabs	_____	_____
Antibiotic	(Syr)	___ Tabs	_____	_____
Paracetamol	(Tab)	___ Tabs	_____	_____
Paracetamol	(Syr)	___ Tap	_____	_____

5. Did the health worker tell you what to do for the child when you return home Y N

What did he tell you? (Check all that apply)

- Give more fluids than usual
- Give fluids after each diarrhoea episode
- Give fluids after each vomiting episode
- Continue breastfeeding the child
- Continue feeding the child
- Give an antipyretic (medicine against fever)
- Give a tepid bath
- Other: _____

6. Did the health worker tell you when to bring the child back..... Y N

What did he say? (Check all that apply)

There is no need to return
(Child is in good health and has received all necessary immunizations)

When? _____ Knows
 _____ Doesn't know

Return if the child's condition becomes worse

How will you know if the child's condition becomes worse?

- if he has fever
- if he refuses to eat
- if diarrhoea gets worse
- if he has chest indrawing
- Other: _____

7. Did the health worker greet you..... Y N

State: _____ LGA: / _____

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Facility: _____ Type of Facility: _____

Interviewer: _____ Date: ____/____/9____

*****EQUIPMENT/SUPPLIES*****

- 1. Thermometer..... Y N
- 2. Weighing scale..... Y N
In working order?..... Y N
- 3. Immunization register..... Y N
- 4. child health (immunization) cards..... Y N
- 5. Adult health cards..... Y N
- 6. TT cards..... Y N
- 7. Timer (60 second)..... Y N
- 8. Watch (with second hand)..... Y N
- 9. Oxygen cylinder..... Y N
If Yes: Empty
 Full

AMOUNT

- 10. Needles (Disposable)..... Y N _____
- 11. Needles (Reusable)..... Y N _____
- 12. Syringes..... Y N _____
- 13. Sterilization method: _____ Steam
_____ Boiling
_____ Other: _____

- 14. Steam Sterilizer..... Y N
In working order?..... Y N
- 15. kerosine stove..... Y N
In working order?..... Y N
- 16. Electric Cooker..... Y N
In working order?..... Y N
- 17. Refrigerator..... Y N
In working order?..... Y N

Type: _____ Electronic Condition: _____ Good
_____ Kerosine _____ Fair
_____ Gas _____ Poor

- Thermometer inside..... Y N
- Temperature today: _____
- Temperature chart..... Y N
- Since start of month, number of days

BEST AVAILABLE DOCUMENT

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When temperature was: 0-8 _____
 <0 _____
 >8 _____

- N
 18. Spare cylinder for refrigerator..... Y
 Cold box..... Y
 Condition: _____ Good
 _____ Fair
 _____ Poor
- Thermometer inside..... Y
 Temperature today:
- Temperature chart..... Y
 Since start of month, number of days.
 When temperature was: 0-8 _____
 <0 _____
 >8 _____
19. Expired vaccines in refrigerator/cold box..... Y
 20. Frozen DPT or TT in refrigerator/cold box..... Y
 21. Frozen cold blocks available..... Y
 22. Bowls to prepare ORS..... Y
 23. Containers to measure ORS..... Y
 24. Spoons to give ORS..... Y
 25. Sugar for SSS..... Y
 26. Salt for SSS..... Y
 27. Potable water at health center..... Y

*** MEDICINE***

				AMOUNT IN STOCK
28.	Chloroquine (Tablets).....	Y	N	_____ Tabs
	Chloroquine (Syrup).....	Y	N	_____ ml
29.	Cotrimoxazole (Tablets).....	Y	N	_____ Tabs
	Cotrimoxazole (Syrup).....	Y	N	_____ ml
30.	ORS Packets:			
	600 ml.....	Y	N	_____ Pkts
	1 Liter.....	Y	N	_____ Pkts
	6 Liters.....	Y	N	_____ Pkts
31.	Vaccines:			
	Measles.....	Y	N	_____ Doses
	DPT.....	Y	N	_____ Doses
	OPV.....	Y	N	_____ Doses
	BCTG.....	Y	N	_____ Doses
	TT.....	Y	N	_____ Doses
32.	Notifiable Disease Report Forms.....	Y	N	_____ Forms

BEST AVAILABLE DOCUMENT

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F. PHC Program Work Plan

Trainer Outline:

Objectives:

Participants will be able to:

1. Understand the purpose and benefits of program work plans;
2. Be able to identify the basic elements of a work plan; and,
3. Be able to design work plans for their own units.

Format:

1. Trainer presents an overview of program work plans, using the handouts on definitions and qualities of a good work plan (attached). (15 minutes)
2. Trainer distributes blank work plans (attached) to participants and discusses how to use the basic model. Talks through each of the six components -- objectives, activities, location, time, responsible parties, and budget. Ensures that group clearly understands how to write good objectives, using the SMART model (see attached). (30 minutes)
3. Group divides into PHC teams. Each team will choose one of its program units (Maternal and Child Health Essential Drugs, etc.) and design a one-year work plan for that arena, based on local health issues, needs, and constraints (see attached). Trainer will facilitate each team to ensure they are doing it correctly. Some of the data may be in draft form, e.g. the budget line, but they are encouraged to fill out the entire work plan to gain the experience. (45 minutes)
4. Each team will report on their program unit work plan, and answer questions from the group and trainer. The trainer will lead a discussion on the mechanics of writing a good plan and answer questions from the group. Examples of successful work plans will be shared with the group as well. (30 minutes)
5. A possible field project is for the PHC teams to return to their LGA site and complete program work plans for the other major units. These could be sent to the project for review and comment, or discussed at a later follow-up meeting.

Work Plan Overview and Definitions

Planning deals with the identification of problems, the setting of priorities, the allocation of resources, and the evaluation of results. It is one of the foundations of management in any effective organization. In the LGA-PHC, annual work planning or programming provides a guide to the staff for achieving their comprehensive objectives.

- WHY:** To have a clear and detailed picture of what needs to be done, and to make decisions about resources, responsibilities, and time frames.
- WHO:** PHC coordinator and Assistant Coordinators.
- WHEN:** Annually, before fiscal year begins (October-December).
- HOW:** The one-year work plan format.

Definitions:

Management: An organizational process of planning, organizing, directing, and controlling of resources (human, material, and financial) to achieve a set of stated goals and objectives. The goals are the National Health targets for the year 2000. Objectives are shorter term and more specific targets for the LGA PHC or PHC activity areas.

Planning: Determining what work has to be done and how to do it. Requires establishing PHC goals and objectives and determining ways of achieving them. Requires an understanding of local health problems and needs. The PHC technical committee is charged with comprehensive PHC planning.

Action/Implementation Plan: A carefully designed and specific scheme of activities, with responsibilities assigned, and dates for beginning and completing each activity specified. Also includes budget forecasts. Often done at the PHC Program level (e.g. Maternal and Child Health).

Qualities of a Good Plan:

1. **Supports and facilitates** accomplishments of PHC purpose, goals, and objectives. Should make results easier to achieve.
2. Is the **first step** in carrying out the overall PHC management responsibility; precedes all other management functions. In other words, without **good planning**, it is impossible to achieve **good results**.

3. Is comprehensive; includes all components of an organization and builds on the past.
4. Is realistic in terms of cost effectiveness and time frames. If plans are idealistic, it only leads to frustration and unmotivated staff.
5. Is participatory by involving both those charged with implementing the plan and also other significant parties (committees, users).
6. Is written and shared with all those who are involved in implementing the plan.

PHC ANNUAL WORK PLAN

s/no	OBJECTIVES	ACTIVITIES	LOC	TIME	RESP	BUDG

The Annual Work Plan Form

An effective PHC work plan has six key components.

1. **OBJECTIVES**

Once the PHC Program area (or Special Project that needs a work plan developed) has been identified, a short list of key objectives are written out. These spell out the current PHC priorities. They are derived by identifying local problems, analyzing recent "baseline surveys," and gathering community input. A planning tool to use in determining objectives is SMART; every good objective should be specific, measurable, attainable, results oriented, and time limited.

Specific:

- practical, serving as guides to action
- positive statements of what is to be accomplished
- written clearly and concisely

Measurable:

- expressed so that you know when you have accomplished the objective
- defined, when possible, with a unit of measure

Attainable:

- feasible in terms of staffing, financial, and other resources
- targeted at incremental growth and improvement

Results-Oriented:

- defined in terms of results, outcomes, deliverables
- meaningful steps toward meeting long term goals

Time Limited:

- expressed with time limits
- often includes start time, end time, or ongoing
- may include deadlines

2. ACTIVITIES

These are the multiple specific tasks that will be required to accomplish the stated objectives. They are stated in very precise terms, often describing jobs to be performed. There may be only one activity for each objective, but most often there are several.

3. LOCATION

Specify the unit or units where each task will be carried out.

4. TIME

The plan provides estimated time needed for tasks; sometimes states start or end date; or it may indicate a deadline.

5. RESPONSIBILITY

Identifies the officer or staff responsible for each activity. This is the individual or individuals who will be held to account for the activity. They are also responsible for evaluating and reporting progress at designated intervals during the year.

6. BUDGET

Translates the activities into estimated but realistic financial costs. If possible they are itemized. They must fall within the overall budget guidelines, i.e. budgetary ceilings. They must also demonstrate a prudent use of the limited PHC resources and avoid wasteful expenditure.

GROUP ACTIVITY

1. Meet in your PHC team
2. Identify the composition, major responsibilities, and operating guidelines for each of the committee levels within the PHC in your LGA.
3. Prepare a brief report to make to the whole group and appoint a reporter.

LGA PHC			
COMMITTEE	VILLAGE	DISTRICT	MANAGEMENT
TOPIC			
COMPOSITION			
RESPONSIBILITIES			
OPERATING GUIDELINES			

G. PHC Budget Process

Trainer Outline

Objectives:

Participants will be able to:

1. Understand what a budget is and the importance of the budgeting process;
2. Comprehend the seven-step process of preparing a realistic budget;
3. Appreciate the importance of community understanding of the PHC budget; and,
4. Identify the programs and priorities of their PHC budget.

Format:

1. Trainer presents a simple definition of a budget, the importance of budgets in public agencies, and different types of budgets (see attached). (15 minutes)
2. Trainer leads group through the seven-step official PHC budget process (see attached):
 1. response to call circular;
 2. pre-draft budget hearing by district committees;
 3. complete unit/program work plans showing budget estimates;
 4. draft overall PHC budget;
 5. budget defense with Council;
 6. budget ratification; and,
 7. dissemination of budget to the community.(30 minutes)
3. Trainer leads discussion on where the official budget process breaks down, listing the insights and comments on a flip chart for later reference.

Trainer then breaks group into three or four teams, giving each the assignment to discuss and submit five suggestions or recommendations that might improve the process. Some of these may require official changes in policy, but some should be procedural changes that could be implemented in the LGA. Each group reports out their recommendations in a written format, and the trainer retains the results for continuing policy analysis by the project. (1 hour)

4. Group activity:

- **Trainer instructs LGA PHC teams to complete PHC budget summary form (attached), including program budget estimates, and percentage of total PHC budget.**
- **Trainer leads group in filling in flipchart of percent budget allocation for each program in each LGA PHC.**
- **Trainer leads discussion with PHC teams on budget priorities. (45 minutes)**

PHC Budgetary Process

Annual Budget:

A plan of expenditures and revenues over one year (a fiscal year).

Importance of Budgets in PHC:

- forces officials to think each activity through in detail and commit their projections, expectations, and decisions to paper;
- provides for communication to public, and possibly input from the public;
- allows for holding both administrators and officials accountable for cost-effective operations;
- provides essential information needed for projecting costs of intended activities; and,
- helps programs to conform to schedules and workplans in carrying out activities.

Types of Budgets:

Line-Item (traditional) Budget

- emphasizes specific items of expenditures, i.e. stationary, travel, supplies, etc.
- the base is always kept as given
- it is incremental in nature (previous allocations used as the starting point)
- time-specific

Program Budget

- programs are the main guides of expenditure
- broad in orientation, i.e. it can extend beyond one year
- it eliminates unnecessary activities from the previous budget period
- it has strong performance review process

Zero-Based Budgets

- disregards previous year's budget commitments as the starting point
- considers each budget year afresh
- it requires thorough annual assessment of activities

Official PHC Budget Process

Step 1 - Response to Call Circular:

- call circulars are normally sent out to LGA in October
- early preparation in anticipation of budget call circulars; organize essential information that may be needed on quarterly basis
- meet deadlines by starting early; initiate action as soon as call circular arrives
- derive additional information from rolling plan

Step 2 - Pre-Draft Budget Hearing by District Committees:

- involve communities in identifying and prioritizing local health needs
- hold meetings with each District Committee
- PHC Coordinator and/or assistant coordinators attend District Committee meetings

Step 3 - Complete Unit Workplans Showing Budget Categories:

- each program or unit has a workplan
- workplan has objectives, activities, time frame, location, responsible officers, and budget estimates
- budget estimates are derived from previous year's estimates, present cost trends, and information on last year's actual expenditures
- each assistant PHC coordinator is responsible for his or her unit's workplan and budget estimates

Step 4 - Draft Overall PHC Budget:

- collate all unit budget proposals
- PHC coordinator meets with assistant coordinators to analyze and prioritize budget line items, including adding or deleting specific line items
- PHC coordinator submits written draft budget to Treasurer, who insures that it conforms to standard guidelines

Step 5 - Budget Defense With Council:

- PHC coordinator verbally defends budget, answering questions, clarifying issues and recommended changes in line items

Step 6 - Budget Ratification:

- Council ratified LGA budget and notifies various departments of their approved budget
- Ratification should be completed 30 days before beginning of fiscal year to ensure proper authorization
- Late budgets mean delays in execution of critical health services

Step 7 - Dissemination of Budget to Community:

- LGA chairman announces budget at press conference
- PHC coordinators should also disseminate budget highlights to District Committees
- Consider alternative ways to inform community, e.g., using local languages, bulletins, PHC fact sheet, etc.

PHC BUDGET SUMMARY

PROPOSED EXPENDITURES: Total Naira _____

<u>Program Units</u>	<u>Budgeted Naira</u>	<u>% of PHC</u>
Mother & Child Health Care	_____	_____
Health Education	_____	_____
Monitoring & Evaluation	_____	_____
Immunization/Disease Control	_____	_____
Essential Drugs	_____	_____
_____	_____	_____

* * * * *

EXPECTED REVENUE: Total Naira _____

<u>Sources</u>	<u>Naira Revenues</u>	<u>% of Total</u>
Statutory	_____	_____
User Fees	_____	_____
Grants/Donors		
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
• _____	_____	_____
Cost Recovery	_____	_____
_____	_____	_____

H. Revenue Mobilization

Trainer Outline

Objectives:

Participants should be able to:

1. Develop strategies for revenue mobilization at the local level;
2. Inculcate the value of self sustenance (cost recovery) at the LGA level; and,
3. Identify critical success factors in maintaining a drug revolving fund.

Format:

1. Trainer gives a brief lecture, using handout on "Approaches to Revenue Mobilization at PHC Level" (attached) as a guide. (15 minutes)
2. Group discussion (30 minutes)
 - Trainer introduces group activities on user fees, making sure the concept is understood. Participants will be divided into five groups.
 - Worksheet (attached) will be distributed to all the groups.
 - Each group to discuss at least five different user fees, with their advantages and disadvantages making use of the worksheet.
 - Groups to reconvene and each group to present their best two ideas.
 - Trainer to moderate and synthesize the various ideas.
3. Trainer will facilitate a mini-workshop on "What are Alternative PHC Revenue Opportunities to Strengthen the PHC Services?" (60 minutes)
4. Trainer leads a brief lecture with group discussion on critical success factors for the drug revolving fund (DRF). Group is encouraged to add additional Critical Success Factors to the list (attached). (15 minutes)

Approaches to Revenue Mobilization at PHC Level

Revenue mobilization at the PHC means raising funds and in-kind contributions to support the ongoing services provided in the health facilities.

There are basically four different approaches that can be utilized to support the PHC. The most important one is the annual statutory grants from the federal government. This source essentially funds almost all of the LGA services, but is not the only way to support critical PHC programs and services. We also want to consider user fees, cost recovery fund (CRF) and special funding schemes.

Statutory Grant

The revenue of the Federal Republic of Nigeria is divided among the three levels of government namely, Federal, State and Local Governments.

It has been suggested by many concerned with effective PHC delivery of services that two percent of the federal government allocation to local governments should be directed to the PHC. This becomes necessary because of the inflationary trend in our economy, and the need to get adequate drugs all the time for the mass of people in the rural areas.

The reason for taking two percent of the local government revenue for drugs is to enable the PHC department to keep adequate services, particularly drugs.

User Fees

This is another way of mobilizing revenue for PHC activities. User fees simply means that local users are asked to pay minimal fees for some of the PHC services provided. Health registration cards, dressings, and drugs are the easiest to ask users to pay for. The money collected is directly applied to the local health facility to replenish its supplies.

The question which may be asked at this stage is that of what happens to those who are unable to pay? The community could identify such people and pay on their behalf through the Village Development Committees.

Cost Recovery Fund

Cost Recovery Fund (CRF) simply means that the money spent on the purchase of drugs should be recovered through a minimum charge to users. The Bamako Initiative (BI) used in many LGA's is a type of cost recovery fund.

Drugs should be distributed to health facilities through district supervisors, who in turn take stock of drugs distributed to VHWs. The District Supervisor should settle his/her account forthrightly. On no account must s/he give drugs to VHW if the previous ones have not been settled.

Special Funding Scheme

The local government can be of assistance in this direction. Here the LGA or PHC coordinator plans different activities that would generate money for PHC. This can include fund raising, lotteries (where applicable) and even donations from public spirited individuals. Special fund-raising activities might be held to help raise funds for designated projects, for example the purchase of needed equipment or supplies.

WORKSHEET FOR USER FEE ACTIVITY

USER FEES	ADVANTAGES	DISADVANTAGES
1.		
2.		
3.		
4.		
5.		
6.		
7.		

Critical Success Factors for the Drug Revolving Fund

1. Availability of funds at all times at the facility level; e.g., through user fees (health cards, registration cards, bandages, syringes and needles, etc.).
2. The pharmacies at the local government should always be replenished. A current inventory at all times is very important.
3. Pharmacies should be established at the district level.
4. Village Health Workers should always have on hand the basic drugs available.
5. A separate bank account should be opened for the DRF and deposits made on a daily basis. Where this is impractical, a cash box should be provided specifically for drug sales.
6. Expenditures must be accounted for within two weeks by the district supervisor. Distribution of drugs and other essential materials must be on a cash and carry basis.
7. Village Health Committee must be involved in monitoring the performance of Village Health Workers.
8. The Village Health Committee should be responsible for identifying those people who cannot pay for services (orphans, disabled, elderly, etc.) and exempt them.
9. The Village Health Committee will be responsible to make cash provisions for all exemptions.

Others:

- _____
- _____
- _____

I. Effective Delegation In PHC

Trainer Outline

Objectives:

Participants will be able to:

1. Identify the organizational benefits of delegating responsibilities;
2. Identify difficulties in delegation; and,
3. Apply rules of effective delegations through analyzing case study and role play.

Format:

1. Trainer discusses effective delegations (15 min.)
2. Group exercise on advantages and disadvantages of delegating tasks to subordinates (see attached) (30 min.)
3. Case study: "Mrs. Eziashi's busy schedule" (attached) (30 min.)
4. Practice role play (attached) (45 min.)

Delegating

Definition:

Delegation is the assignment of responsibilities. Delegation gives appropriate authority to others to ensure the effective functioning of an organization.

Significance:

Delegation is important not only for the supervisor assigning the tasks (because one person cannot do everything) but also for the individual employee (because it provides an opportunity to learn new skills and contribute to the organization).

What are some additional advantages of delegation, and what are some difficulties or disadvantages in effective delegation? Write down some of your group's ideas below.

ADVANTAGES:

- 1.
- 2.
- 3.
- 4.
- 5.

DIFFICULTIES/DISADVANTAGES:

- 1.
- 2.
- 3.
- 4.
- 5.

Rules for Effective Delegation:

1. Have a clear-cut description of what is to be delegated.
2. Select the appropriate person and make sure s/he has the necessary skills. (Delegate to the lowest level possible).
3. Explain to others that you have delegated work and to whom.
4. Do not interfere unless you have been asked for assistance.

5. Be prepared for some mistakes.
6. Give support and continue to monitor work progress.
7. Recognize a job well done. If the employee had a problem accomplishing the task and you know that s/he worked hard, find a way to help the employee do the job better the next time.

Critical Points in Delegation:

- Establish an atmosphere conducive to mutual understanding.
- Use an affirming and positive style relating to subordinates.
- Clearly define the responsibility of the delegated task and what the supervisor expects of the subordinate.
- Be aware of the consequences of unsatisfactory delegation: subordinates not sufficiently challenged; unpredictable work environment (i.e. "what's expected?"); absence of clear instructions; performance standards not clearly understood.

Case Study: Mrs. Eziashi's Busy Schedule

Mrs. Eziashi is director for family planning and MCH services in Abakaliki LGA. She supervises 24 maternity centers and family planning clinics. One of her many responsibilities is to collect and verify the statistical data that comes to her from the various centers and combine these into one comprehensive report which is sent each last Friday of the month to the department of Population Affairs in the capital city. As the information sometimes comes in late and incomplete, Mrs. Eziashi finds herself spending many hours on this task.

When a rumor touches off a crisis in the Abakaliki family planning programme, Mrs. Eziashi realizes that her many routine administrative tasks, such as the monthly reporting, keeps her from giving her full attention to events that can significantly affect the programme.

Mrs. Eziashi has decided to delegate the monthly reporting, and after much thinking and a review of performance reports, she chooses a bright, young nurse who has been with the programme for two years and who has done very well. She calls in Mrs. Ekenna and asks her how she would feel about taking on an additional responsibility. When Mrs. Ekenna expresses some fears, Mrs. Eziashi assures her that she is going to explain exactly what is expected of her and that she will be available to help in the beginning, but that she is also confident that Mrs. Ekenna can handle this new assignment.

When Mrs. Ekenna's first report comes in, there are quite a few mistakes, and Mrs. Eziashi finds herself working nearly as much as when she would have done the whole report by herself, since she had to check all the calculations. When she calls in Mrs. Ekenna, the next day, she pulls up a chair for her and tells her to sit down, and explains where the mistakes were and how to correct them. However, she also encourages her to try again next month, emphasizing the things she did right.

Three months later, Mrs. Ekenna's reports need few corrections, and Mrs. Eziashi has more time to study the numbers in the reports and use them to better manage her programme.

Study Questions:

1. What does Mrs. Eziashi say she wants Mrs. Ekenna to do, and why?
2. If you were Mrs. Eziashi, how would you explain to Mrs. Ekenna her new task?
3. If you were Mrs. Ekenna, what would some of your fears and worries be?
4. What did Mrs. Eziashi do to insure effective delegating of the monthly reporting task to Mrs. Ekenna?

Role Play: Mrs. Eziashi and Mrs. Ekenna

You are Mrs. Ekenna, a junior nurse/midwife who works in the Abakaliki family planning programme, under the supervision of the programme director, Mrs. Eziashi. After a serious crisis, one that might ruin the programme, has been averted and life has returned to normal, Mrs. Eziashi calls you into her office.

When you enter, she asks you to sit down and explains that the crisis taught her how little time she has to deal with such events. She tells you that she would like to delegate some of her routine administrative tasks and proposes you take on this new assignment. Your duty will be to routinely collect and verify the data of the 24 maternity centres and FP clinics run by the programme, and to write the monthly report on these data to the Directorate for Population Affairs in the capital city.

You are awed by the tasks and not quite sure that you can handle this. You are also worried about the amount of time this will involve. You really feel you need some time to think about this. You have a lot of questions, such as, What would happen if you mess up? How do you know if the data is correct? How does one write a report to the Ministry? What about your regular responsibilities (are they reduced or unchanged?) Will you be able to return to your previous job if this works poorly or if you tire of it? Having never done this before, it makes you very nervous.

Role Play Questions:

1. Get into groups of three people.
2. One person plays Mrs. Ekenna, the subordinate; another plays Mrs. Eziashi, the supervisor, and the third is the observer.
3. Read the information to provide background for the role play.
4. Do a five to 10 minute role play, discussing the questions listed.
5. Observer gives feedback to the others, covering what went well, what seemed difficult, commenting on the use of the rules for effective delegation and the critical points.

J. Supervision Models Of PHC

Trainer Outline

Objectives:

Participants will be able to:

1. Assess different methods of PHC supervision;
2. Effectively supervise PHC activities in their LGAs;
3. Effectively use the supervisory checklist.

Format:

1. Trainer introduces participants to methods and models of PHC supervision (attached). (15 minutes)
2. Group activity: Trainer leads group discussion on advantages and disadvantages of district and functional models of supervision (see attached). Each group will use the worksheet provided. (30 minutes)
3. Trainer reviews handouts on supervisory checklist (see attached). (15 minutes)
4. Trainer hands out the draft supervisory checklist (attached) for discussion and critique. For each section, trainers elicits comments on additions, deletions, and/or modifications.

Models of PHC Supervision

In PHC, supervision activities normally consist of:

- physically going to the site of activity (health center);
- specifically and visually assessing facility, infrastructure, equipment, materials, and supplies; and,
- assessing performance of PHC staff in delivering services.

Supervision deals with the one-on-one appraisal of facility and personnel performance. Monitoring and evaluation, on the other hand, deals with overall PHC performance on certain key health indicators.

The defined method of PHC supervision consists of visits to VHW's and facilities by designated supervisors. They are required to visit at regular intervals (once a month) and make direct observations as personnel carry out their tasks.

Supervision is designed along one of two lines: district areas and PHC functional areas. In the area or District approach, a district health supervisor is given responsibility for an area and required to supervise the volunteer health workers, PHC personnel, and PHC facilities in that geographical area.

The supervision visits are sometimes anchored by a supervisory checklist, which provides for a detailed report that is used for follow-up discussion and corrective action. This model is used by several focus LGAs and found to have significant advantages. It provides for a clear channel of responsibility and a written documentation for making performance improvements.

Where supervision is carried out along functional lines, the assistant PHC coordinator for monitoring and evaluation plays a key role. However, he or she rarely has any contact with health personnel beyond their statistics, and also almost never has any clinical training. The other assistant coordinators are required to visit health facilities and personnel across the LGA territory and supervise the PHC services for which they are responsible. Reports of their supervision activities are to be submitted to the PHC coordinator. This has generally led to fragmentation of effort, little attention to facility performance, and little documentation upon which to make decisions and solve problems.

Supervision Models

Discuss and write down some of the advantages and disadvantages of each model of supervision.

	<u>ADVANTAGES</u>	<u>DISADVANTAGES</u>
DISTRICT MODEL	1.	1.
	2.	2.
	3.	3.
	4.	4.
	5.	5.
	6.	6.
<hr/>		
FUNCTIONAL MODEL	1.	1.
	2.	2.
	3.	3.
	4.	4.
	5.	5.
	6.	6.

The Supervisory Checklist

The **SUPERVISORY CHECKLIST** is a written list of critical activities you need to review routinely on your supervisory visits.

The main emphasis should be on personal and supportive interaction and dialogue with the staff you are visiting. The kinds of checklists you will use during these visits will probably vary according to the specific purpose of the visit and the frequency of your visits to that particular site. Other variables might be whether this is the first visit and if the staff is new. You may even develop your own checklists for different types of visits.

It is essential that the checklist be practical, appropriate and consistent. A more detailed checklist is useful for first-time visits. The version we will be discussing with you is a shortened, modified version that can be used for a frequent visit.

A supervisory checklist is one of the most effective tools available to assist supervisors in carrying out their duties. It helps ensure that a supervisor reviews all important activities on each visit to a facility.

Advantages:

1. Guides the supervisor in knowing what to assess.
2. Provides for a comprehensive and focused overview of all activities.
3. Allows for uniform and consistent observation.
4. Documents problems, needs, comments, improvements needed, and recommendations for follow-up action.
5. Clarifies responsibility and authority directly from PHC coordinator to supervisor to the health worker.

Disadvantages:

1. Can be time consuming.
2. If not monitored by PHC coordinator, it will lose value.
3. If follow-up is not demanded and achieved, it will also cease to be an effective tool.
4. Checklist forms may not be available.

Elements of Supervisory Checklist

1. General description: who is being supervised where and by whom.
2. Task to be done by the health workers being supervised in order to solve the given health problem.
3. Standard of performance according to program guidelines.
4. Relationship with supervisor, peers, subordinates, community.
5. Progress of performance toward the stated objectives.
6. Logistics and support system.
7. How service recipients feel about services provided.
8. Reporting and recording data.
9. General findings.
10. Actions taken during the visit.
11. Comments.
12. Recommendations.

Reminders for Supervisors

1. Review the job description of the person you are visiting.
2. Review the last monthly MIS report and any other reports.
3. Review the checklist from the previous supervisory visit.
4. Check to see if there are materials, supplies, commodities that you could take for the visit.
5. Perhaps schedule a health education class or other training event, or committee meeting to coincide with your visit.

PHC SUPERVISORY CHECKLIST

Clinic: _____ **LGA:** _____

Date: _____

Service Provider in Charge: _____

Title: _____

**Other Providers
on Site:** _____

Supervisor Conducting Visit: _____

First visit to this clinic: **Yes** **No**

If no, date of last visit: _____

ASSESSMENT KEY:

GOOD: Meeting quality standards

ADEQUATE: Minor improvements necessary

FAIR: Major improvements necessary

POOR: Total reorganization required

N/A: Not available/not applicable

Area Observed	Good	Adequate	Fair	Poor	N/A	Comments/ Recommendations
I. ASSESSMENT OF FACILITY AND INFRASTRUCTURE						
1. Appearance of facility (clean, orderly, free of litter, painted, educational materials posted) - client reception area - client registration area - client interview area - client examination area - dispensing area						
2. Toilet/latrine properly maintained						
3. Refuse is properly and regularly disposed of						
4. Source of water supply						
5. Electricity supply						
6. Clear signs/ directions to facilities and exam rooms						
7. Physical layout for smooth client flows and privacy						
8. Dust Bin						
9. Wash bowl and stand						
10. Hand towels						
11. Storage facilities						

Area Observed	Good	Adequate	Fair	Poor	N/A	Comments/ Recommendations
II. ASSESSMENT OF EQUIPMENT AND MATERIALS						
1. Availability of standard equipment and materials						
2. Equipment functioning correctly (note any equipment requiring repair)						
3. Equipment and materials are clean and properly maintained						
4. Materials needed for aseptic techniques area sterilized						
5. Materials are stored according to National Standards of Practice						

Area Observed	Good	Adequate	Fair	Poor	N/A	Comments/ Recommendations
III. ASSESSMENT OF COMMODITIES						
1. Commodity stock levels for: (list commodities dispensed) - - - - - -						
2. Requisition and balancing of commodities						
3. Commodity register reflects current inventory						
4. Commodities are properly stored and secure						
5. First-in/first-out system of commodity dispensation used						
6. Forecasting of commodity needs is done systematically						

Area Observed	Good	Adequate	Fair	Poor	N/A	Comments/ Recommendations
IV. ASSESSMENT OF CLIENT ATTENTION						
Reception:						
1. Service provider is courteous and puts clients at ease						
2. Client seating is available						
3. Client flow is efficient and systematic						
4. Client waiting time is reasonable (from both client and provider points of view)						
Client Education:						
1. Service provider gives correct and relevant information, using language and visual aids appropriate to clients						
2. Service provider encourages and responds to all clients' requests						
3. Privacy is maintained as much as possible						
4. Provider ensures client understanding of need for history taking						
5. Provider uses existing forms to obtain and record all necessary information concerning client's health						
6. Provider makes client comfortable and gives feedback						
7. Provider follows prescribed protocol for follow-up and referrals						

Area Observed	Good	Adequate	Fair	Poor	N/A	Comments/ Recommendations
V. ASSESSMENT OF PROVIDER SKILLS						
1. Jobs are assigned according to current job description, capacity, interest and clinic need						
2. Staff supervision is carried out in the form of guidance and assistance						
3. Staff meetings are held regularly for the purpose of planning and problem-solving						
4. Service provider shows recognition for good work done by staff						
5. Measurable service objectives are established for the month and year						
6. Service objectives are understood by staff						
7. Activities are planned by clinic staff according to service objectives						
8. Monitoring & Evaluation forms are completed in a timely and appropriate manner						
9. Activities (immunizations, visits, etc.) are tracked and posted to show progress						

VI PERSONNEL ASSESSMENT

- 1. Overall clinic management
- 2. Staff readiness and willingness to serve clients
- 3. Responsiveness to new techniques
- 4. Communication and coordination with PHC administrators
- 5. Involves community in planning, coordinating, and problem solving of health care issues

6. General remarks: _____

7. Recommendations: _____

8. Actions taken on problems or areas of improvement noted during last site visit:

Areas for Improvement	Actions Taken

Name of Service Provider/Signature

Date

Name of Supervisor Conducting
Visit/Signature

Date

III. CONCLUSION

The original plan for this project was to design initial curriculum modules with the assistance of professors of local government and then pilot test them with a group of local PHC practitioners. Although the pilot session has been indefinitely postponed, that remains the best strategy for eventually preparing a full training program. The modules are still tentative and incomplete, and lack a real-world focus that would make them more appropriate to the Nigerian PHC context. A pilot testing followed by evaluation and re-editing would help prepare them for future use in a management and organization training program.

Piloting the modules in a shortened version -- two to three hours -- helps to highlight the most important training objectives and most helpful group activities. This was the objective of the cancelled pilot session and should be the goal if the pilot can be rescheduled. After a pilot training session some of the modules would be lengthened by adding additional training materials and exercises. The long-range intent would be to keep the curriculum in a modular format; trainers could expand, subtract, or focus the materials to fit the exact needs or requirements of the training program.

It has not been pre-determined to only use a single-site, extended schedule (e.g. two weeks, or two months), or a residential approach to the PHC management training program. There are other possible ways to deliver targeted training to local practitioners. One would be to offer regional short-term courses of several days. Another would be to offer stand-alone modules as part of other training programs. Still another would be to offer some of the modules, or practical variations of them, on-site in a particular PHC, in order to better initiate direct changes in local PHC practices and procedures.

In summary, the current PHC training modules need to be offered to a group of local PHC staff. This needs to be followed by an intensive critique and re-write of the modules in preparation for launching a PHC training program.

It is important to have some trainers with PHC experience on the training faculty to bring additional real-world expertise to the team effort. As an example, Dr. Fagbule from NCCCCD was an excellent addition to the faculty because of her experience in the focus LGAs in the NCCCCD program, as was Dr. Adetugbo who spends most of her time in PHC clinics.

Generally, the training faculty has considerable experience in academic-based teaching modes, i.e. stand-up lectures with minimal group involvement. Therefore, enabling them to become acquainted with the current training styles of group activities, feedback learning techniques, and action-based exercises (as was done at the training of trainers session) was critical. The faculty was very willing to learn new trainer skills, and adapted very quickly to their training role. However, they still need considerable practice and feedback from others (including training participants) to further develop their skill base.

After drafting the training modules, the Project Team discussed ways to make the pilot session even more targeted to the local PHCs, with even greater immediate impact. Provision of "take home" exercises within the pilot session was suggested. That is, during a scheduled break within the five day pilot session schedule, participants from the LGA's represented would be asked to research and

develop certain pertinent charts, analyses, etc. and report back when the training session reconvenes the next week. This provides a component in the training event of "action learning," and should be considered in any further development of the training program.

Another strategic idea is to schedule a collaborative planning session with State Ministry of Health officials and local PHC coordinators. The director of Osun State PHC attended an earlier workshop and was very supportive of the training concept. Piloting this concept in Osun State has been considered. The plan was to invite ten PHC coordinators from Osun LGAs to an all-day planning session, along with ten staff from the SMOH. It would be a facilitated event, focused on how to strengthen the inter-governmental relations within the PHC system. This concept should also be considered should the pilot session be rescheduled.

The monitoring and evaluation component within the PHC system continues to be problematic. There is a need to develop appropriate and simple measurement tools that primarily serve the local PHC staff's needs. These would include activity tracking charts, graphing local indicators, etc. Of course, this needs to be done in consultation with the current health information systems approach (HIS) being promulgated by the Federal and State Ministries of Health, in concert with donor agencies. There seems to be significant systemic breakdowns in that approach. These monitoring and evaluation issues require resolution through both a sharper methodological focus and strategic intent before the project pushes ahead with a training curriculum in the monitoring and evaluation area.