



GHAIN HEALTH SYSTEM STRENGTHENING

END OF PROJECT MONOGRAPH

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GHAIN HEALTHCARE WASTE MANAGEMENT
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1

INTRODUCTION AND PROGRAM RATIONALE

Effective and sustainable Healthcare Waste Management (HCWM) systems in health-care facilities are critical components in the provision of high quality services. If not segregated and managed properly, healthcare waste (HCW) can pose serious risks to medical workers, waste handlers, and the general public. Infections and disease linked to healthcare waste accounts for a significant percentage of diseases and infections within healthcare facilities worldwide. The World Health Organization WHO (2004), estimates that approximately 16 billion injections are administered every year. Approximately 5% of HIV, 40% of Hepatitis C virus and 32% Hepatitis B virus infections are caused by unsafe and unnecessary injections worldwide.

The last two decades have seen an increase in funding to provide quality healthcare services especially within the public health sector in developing countries like Nigeria. The scale-up of health services, including HIV/AIDS services, has resulted in the increased production of hazardous and non-hazardous waste that requires proper handling, treatment and disposal. Although approximately 80% of the waste generated from health care services can be treated as household waste and pose a low risk, the remaining 20-25% is classified as hazardous waste and poses a significant risk to the public.

Program Rationale

A literature review undertaken by GHAIN identified lack of awareness about the health hazards of wastes, poor management practices, insufficient financial and human resources for waste management and poor control of waste disposal as the most common problems connected with general medical waste management in Nigeria. It also showed open burning as the commonest form of medical waste disposal in Nigeria. Though there was information from Nigeria and other developing countries on types and estimated quantities of wastes generated by general health services, there was none on effect of introduction of HIV/AIDS services. Information on wastes from HIV/AIDS services was limited to estimation of quantity of sharps generated and number of infections from such sharps. No information was found on other types of wastes generated from HIV/AIDS services, their quantities and implications. The GHAIN programme which also identified infection prevention and control as an important way of curtailing the AIDS pandemic took the way of proper waste management starting with injection safety to proper disposal of all HIV related waste as an option to explore.

2**DESCRIPTION OF SERVICE
DELIVERY PROCESS AND STRATEGY**

GHAIN's healthcare waste management program began in 2006. The objective of the program was to support training in injection safety practices, and the provision of safe injection equipment, waste-management systems, and promotion of universal safety precautions.

In 2010, GHAIN expanded its waste management focus to go beyond sharps to look at managing all medical wastes generated from HIV/AIDS services in its supported sites. GHAIN's integrated waste management approach goes beyond the traditional support for injection safety activities; it includes a comprehensive and detailed approach to managing all healthcare waste including sharps, from the point of generation to final disposal. It also includes proper sanitation. Activities include training on types of wastes and consequences of poor management, segregating waste, safe waste handling and disposal. It also included sensitization of decision makers on waste management and advocacy for incorporating waste management into health plans and budgets. The integrated strategy incorporated baseline studies of the existing situation regarding healthcare waste management in a typical GHAIN supported facility.

In terms of injection safety – a key component of HCWM systems - GHAIN aimed at making injection practices safer by creating an enabling environment for health care workers to provide clients with quality services without fear of medical accidents and infections; this is achieved through the introduction of proper waste segregation and disposal practices. From 2006, the program worked with John Snow Inc./Making Medical Injections Safer (JSI/MMIS), a USG implementing partner now called USAID/AIDSTAR-One, to support the Government of Nigeria (GoN) in addressing injection safety gaps through the training of health care workers and waste handlers, and the provision of safe injection equipment and waste management kits to supported facilities.

The approaches used were on-site refresher trainings and capacity building, behavior change communication (BCC) and advocacy to the health care workers, gate-keepers

and managers, procurement and supply of safe injection equipment, which in turn creates an assurance of proper health care waste management.

Support to the facilities included the provision of seed stock of safe injection equipment; training for the development of human resources and staff capacity; and the establishment of logistics management information system (LMIS). GHAIN provided technical assistance by monitoring the use of injection safety commodities provided to ensure their proper utilization. These commodities included safety boxes, color-coded bins and liners, waste handlers' personal protective equipment (PPE), auto-disable syringes, and universal safety precaution materials such as gloves and bleach.

In order to predict future healthcare management waste trends and to better design waste minimization and management strategies, an assessment to determine type and quantity of waste generated by HIV/AIDS services, was conducted in October 2010. The assessment was conducted in Maitama District Hospital (MDH) Abuja, a GHAIN supported secondary healthcare facility that offers comprehensive HIV/AIDS treatment and care services. The assessment was conducted in two phases; the pre-assessment exercise and the quantification exercise.

3

PROGRAM ACHIEVEMENTS/ RESULTS

The original target for GHAIN's injection safety program was to support 48 facilities. By the end of the project, it had scaled up to 69 facilities in the 36 states and the FCT. The injection safety program helped to ensure the development of capacity for safe injection practices and healthcare waste management in supported facilities. The program trained 2,713 HCWs as against the target of 780 healthcare workers (GHAIN bulletin, April 2011 Edition). These facilities were provided injection safety and healthcare waste management commodities such as auto disable syringes, safety boxes, color-coded bins and liners and bleach. They were also provided with waste-handlers kits (boot, apron, face-mask), personal protective equipment (PPE) such as hand gloves and laboratory coats, for universal safety precaution and in compliance with safe injection and healthcare waste management practices.

Pilot assessment in Maitama District Hospital (October 2010)

The one day pre-assessment exercise evaluated service processes per patient at the Maitama District Hospital. All seven ART service delivery areas were reviewed. The team took note of all the commodities utilized in each service delivery area for each patient encounter and the corresponding waste category and waste type generated. The healthcare workers were also interviewed on their activities, the type of waste they generate and how the waste is managed within their units. The pre-assessment found that:

- There are four main waste categories generated within the HIV/AIDS service delivery areas: highly infectious waste, infectious waste, sharps and general waste
- Wastes were not properly segregated into highly infectious, infectious and general waste stream
- The waste handlers did not wear their personal protective equipment
- There were no disposal system for sharps and other hazardous waste
- There were a high attrition of waste handlers in the facility
- Awareness and knowledge of HCWM was lacking
- There were inadequate waste segregation and disposal materials

- Waste segregation and disposal materials were not enough in HIV-AIDS service delivery points

Pre-Assessment Findings

- There are four main waste categories generated within the HIV/AIDS service delivery areas: highly infectious waste, infectious waste, sharps and general waste
- Three service delivery areas were identified for the pilot study: HT&C; ART laboratory and ART pharmacy
- Wastes were not properly segregated into various streams
- The waste handlers were not with their personal protective equipment
- There is no disposal system for sharps and other hazardous waste
- High attrition of waste handlers in the facility
- Inadequate awareness and knowledge of HCWM
- Inadequate waste segregation and disposal materials
- Waste segregation and disposal materials were not enough in HIV-AIDS service delivery points

The second part of the assessment, the quantification, took twelve days over a four week period targeting three HIV/AIDS service delivery areas: HTC; ART laboratory and the ART pharmacy. The methodology involved 1) collecting actual waste generated per day per service area; 2) recording the number of patients encountered per clinic day; and 3) analyzing service processes per patient encounter by enlisting all waste generating points and commodities going into one patient flow encounter and calculating waste that should be generated per patient encounter.

The quantification exercise found that:

- 34% of all the total waste collected from the 3 HIV/AIDS service delivery points was hazardous as against 10-25% from general health services (WHO 2004)
- ART Lab generates the most highly hazardous waste

- Over 60% of highly infectious waste generated is from CD4 count test
- Latex gloves constitute a large portion of the infectious waste in HCT and ART lab
- Pharmacy generates only general waste consisting mainly of package waste

Results from the quantification exercise

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4 DISCUSSION

Healthcare waste management in most facilities is geared mainly towards injection safety. As majority of the hazardous waste generated were highly infectious and infectious waste and latex gloves constituted a significant proportion, healthcare waste management for HIV/AIDS programs should go beyond management of sharps to include all other wastes. Integrated healthcare waste management should go all the way from separation through transportation to actual disposal of wastes.

The pilot assessment has created awareness not only on the various streams of waste from HIV/AIDS activities but also on gaps in waste management. An immediate result is the improvement in waste segregation practices in Maitama General Hospital.

5 CONCLUSIONS & RECOMMENDATIONS

The assessment result has shown the high level of infectious waste associated with HIV/AIDS services which was expected, considering the human-immune-virus resident in the infected patients. In summary, planning for healthcare waste management within HIV/AIDS service delivery programs is a necessity in providing quality and sustainable health-care services. It is an aspect of public health that should not be ignored but advocated for within public health and development programs.

Future assessments should consider the entire waste generated from the facility to be able to calculate the additional effects of HIV/AIDS services in quantity and type of waste and also help plan a comprehensive waste management strategy for the entire facility.

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GHAIN WORKLOAD ANALYSIS
END OF PROJECT MONOGRAPH

1

INTRODUCTION AND PROGRAM RATIONALE

Human resources management and development pose a major challenge to the implementation of health sector reforms and achievement of the health related Millennium Development Goals in many resource-limited settings, including Nigeria [1]. In an attempt to confront the human resources for health (HRH) challenges, the Nigerian Federal Ministry of Health in consultation with stakeholders drafted a comprehensive National Human Resources for Health Policy and Strategic Plan in 2007[2]. Though the policy recognizes the role of workload analysis in providing information for proper human resource management, little has been done in gathering information and analyzing the relationship between staff availability and workload.

Traditionally human resource estimates have been determined using the population approach, which defines ratios of health workers to population based on expected needs, such as numbers of doctors, nurses, and community health extension workers (CHEWs) per 1,000 population. The strength of this approach is that it takes needs into account and assists long-term planning to ensure the appropriate mapping and resourcing of facilities. However, because this approach does not distinguish between needs and expressed demand, it tends to overestimate the actual utilization of services. Actual demand is influenced by factors such as beliefs, financial constraints, infrastructure and geographical access [3, 4].

Workload analysis, on the other hand, uses a utilization based approach and aims at quantifying staffing needs for each category of staff per health facility, and ensuring optimal allocation of the right quantities and skills mix. It considers actual work done or expected to be done by the health workers in determining numbers of a particular staff category required to satisfy the level of service demand in the community/catchment population. The utilization based approach is best adapted to short-term planning and management to ensure equity, quality and efficiency. It is also highly sensitive to changes in population, burden of disease, and the removal of barriers to access. The two methods, population approach and utilization based approach, complement each other. Medium-term planning requires that the difference between needs and actual demand be analyzed and addressed.

As part of GHAIN's health systems strengthening effort, the project worked in collaboration with the Federal Government of Nigeria and Cross River State Government in 2008, to adapt and utilize a tool for workload analysis at primary health care level public health facilities, which included primary health centres, health clinics, and health posts. This tool was adapted from the modified World Health Organization (WHO) Workforce Indicator for Staffing Needs (WISN) model which was piloted earlier in South Africa. [5]

GHAIN introduced this tool to help determine human resource needs and financial implications for sustaining existing services, scaling up services, introducing new services and task shifting. The tool seeks to answer the following questions:

1. How many staff per category of staff is required given the current or projected levels of utilization and what are the recruitment and financial implications of the target versus existing staff profile?
2. Should health staff deployment be reassessed within facilities and across a Local Government Area (LGA) or state to increase equity in staff allocation?
3. What will be the staff implications of increasing attendances?
4. What will be the staff implications of introducing new services?
5. Will task shifting allow for more efficient use of available staff?

2

DESCRIPTION OF SERVICE DELIVERY PROCESS AND STRATEGY

The workload analysis (WLA) tool was developed in Microsoft Excel, and is formula-driven, but all assumptions and calculations are made clear in order to increase understanding and transparency. The model auto-calculates staffing needs based on staff and utilization data; it requires the following inputs: utilization data (attendance for different services), staff per facility, facility operating hours, salary for different staff categories, and assumptions on categories of staff that provide each service, and how each category of staff use their time in the health facility (proportion of time each staff category devotes to tasks in health facility). Because staffing norms do not apply universally across all states, assumptions varied across states.

Ideally, accurate measure of time allocation for each clinical act should be done using time-motion studies, but this could not be accommodated by limitations in resources and time. An alternative was to use assumptions established elsewhere and adapt them through consultation with experts and local stakeholders. The model takes into consideration the number of staff needed for level of observed utilization as well as minimum staff complement needed to keep the facility open. The minimum staff complement needed to keep a facility open is an important consideration because there must be staff in the facility once it is open, since attendance is not scheduled and so unpredictable. The model also allows for modeling staff implications for increased utilization, introducing new services and task shifting.

Execution of the workload analysis tool took place in a step-wise manner:

1. Sensitization workshop on the workload analysis concept and exposure to the workload analysis tool (typically a one-day event). Participants included staff from Cross River State ministry of health and Yakurr LGA.
2. Collection of data to run the model. This included data on scope of activities within health facilities for a defined period (preferably a 12-month period), different staff

cadres in the facilities, opening hours of health facilities and cost to employer for the different staff cadres. Data was collection was led by GHAIN staff.

3. A collaborative session with officials for the state and LGA health departments to define assumptions for adapting the model.
4. Dissemination of preliminary findings from the workload analysis project to stakeholders (typically a one-day event).
5. Introduction of workforce discussions into the agenda of the LGA health management committee meetings

3

PROGRAM ACHIEVEMENTS/ RESULTS

The workforce analysis tool was initially piloted in Yakurr LGA, Cross River State in 2008. The results demonstrated that the LGA had adequate staff to handle the current level of utilization and more if utilization alone is considered as basis for staff determination. When utilization and minimum staff required for opening hours are considered, the results change to show shortages across all cadres except midwives and community health officers (CHOs).

Staff category	Yakurr LGA		
	Actual facility based staff	Staff required for utilization	Target staffing (staff required for utilization + opening hours)
Doctor	1.4	2.2	35.9
Nurse/Midwife	11.2	0.0	0.0
Community Health Officer	43.8	3.2	3.2
Community Health Extension Worker	15.6	9.4	49.9
Junior Community Health Extension Worker	1.0	0.3	9.0
Pharmacy Technician	0	0	9.0

The pilot showed the need to review some of the built-in assumptions such as the categorization of CHOs to remove those that are also nurses, and modification of the assumptions regarding pharmacy and lab staff.

Between 2008 and 2010, the workload analysis tool was subsequently scaled out to seven additional LGAs: Kachia LGA in Kaduna state (see below table), Nasarawa LGA in Kano state, Ajeromi LGA in Lagos state, AMAC in the Federal Capital Territory, Orhionmwon LGA in Edo state, Udi LGA in Enugu state and Bauchi LGA in Bauchi state. Representatives of the human resource unit of the Federal Ministry of Health (FMOH) and National Primary Health Care Development Agency (NPHCDA) were trained in the use of the workload analysis tool and also participated in workload analysis in Ajeromi and Kachia LGAs.

Staff category	Yakurr LGA		
	Actual facility based staff	Staff required for utilization	Target staffing (staff required for utilization + opening hours)
Doctor	11.7	2.7	21.9
Nurse/Midwife	3.2	3.4	3.4
Community Health Officer	40.8	13.2	13.2
Community Health Extension Worker	10.8	16.1	65.9
Junior Community Health Extension Worker	0	1.4	6.0
Pharmacy Technician	17	0	6.0

The findings of workload analyzes were disseminated in each LGA and also shared with the FMOH. The summary reports have been presented at two international scientific conferences and at regional NPHCDA meetings. Following GHAIN's scale up of the workload analysis approach, several other LGAs have requested assistance to conduct workload analysis. The NPHCDA has also required further capacity building on using the adapted WLA tool.

4 DISCUSSION

GHAIN's workload analysis activities provided eight LGAs with information on the workload of their current health care workers and have also helped them identify areas where efficiency can be improved by redeploying staff from low load to high load facilities. As demonstrated by the results from Yakurr and Kachia LGAs, workload analysis revealed that most of facilities do not have enough staff to effectively handle the current level of utilization. When considering the number of hours these facilities are expected to be open and the number of health care workers that are required to staff the facility during those hours, it becomes clear that the required number of staff in most cases exceeds available staff. This implies that most of facilities are understaffed for the hours they are open.

Options for increasing the efficient use of health care workers include reducing opening hours for lower level facilities and provision of staff housing within the facilities so they can be contacted from home when needed, actively identifying and addressing barriers to utilization. The above results indicated that CHEWS are generally in excess while the JCHEWS are inadequate. Options to address this situation would be to introduce task shifting; to move duties from JCHEWS to CHEWS or to limit the number of CHEWS employed and increase the number of JCHEWS hired.

One must note that even though the model analyzed only workload at the health facilities some of the staff cadres also carry out community health activities. This was accounted for by taking into consideration only the amount of time they spent in the facilities. Further modifications to the model may wish to explore the actual amount of work carried out in the communities.

Most of the assumptions on category of staff providing specific services, time spent per consultation, time spent between clinical and non-clinical activities and time spent between the facilities and communities, were obtained from expert consultation workshops. Standardized staffing norms will make the assumptions more objective and time motion studies to benchmark average time spent on different services will make the results more accurate.

5 CONCLUSIONS & RECOMMENDATIONS

Results of workload analysis highlight the location and magnitude of shortages /surpluses by staff category and identify the additional cost or savings from addressing the shortages or surpluses respectively. The adapted tool's modeling function allows for assessment of health workforce needs of new policies such as decentralization of services and task shifting.

By showing staffing needs based on current utilization as well as being able to model future scenarios, the WLA tool provides useful information for short and medium term human resource planning at the management and service delivery levels. This approach can complement the more long term population based human resource for health projections and is recommended for adoption nation wide as one part of the human resource for health planning and management strategies.

A key lesson learned is that even though the LGAs are in charge of the primary level health facilities, key decisions about staffing are made at the state level by the Local Government Service Commission; this has been major cause of slow change. The excesses and shortages of different staff cadres within the LGAs show that state wide application of workload analysis will be more beneficial to allow for re-deployments across LGAs, to achieve better staff mix. The scale up revealed that the extent of devolution of financial and management authority to the LGAs varied from state to state. With this scenario, workforce solutions at the primary care level might have to be specific for each state.

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**GHAIN LGA BUDGET SUPPORT
END OF PROJECT MONOGRAPH**

1

INTRODUCTION AND PROGRAM RATIONALE

The way a health system is financed is a key determinant of population health and well being [1]. The 2003 – 2005 National Health Accounts reported that 68% of total health expenditure was made up out of pocket payments [2]. This system of financing health replicated at the 3 tiers of government in Nigeria creates huge financial barriers to accessing health care [3] particularly given the large proportion living under the poverty line [4].

Before 2002, HIV/AIDS services were only provided by some Federal Government owned tertiary facilities and private facilities in urban areas such as Lagos and Abuja. Clients mostly paid out of pocket for HIV services. ART was very expensive and remained out of reach for the majority of the population. In January 2002, the Government of Nigeria (GON) started a program to provide antiretroviral (ARV) drugs at a subsidized rate to 10,000 adults and 5,000 children living with HIV/AIDS in 25 tertiary health facilities across the country. A joint federal ministry of health and WHO situation analysis of anti-retroviral (ARV) drug use in 2003 showed that only 3 centers provided free ARVs. It is against this background that the PEPFAR funded GHAIN project was designed to provide care to 1.75 million people living with HIV/AIDS, and to prevent over 1 million new infections in Nigeria. The GHAIN project worked in partnership with the Nigerian government to rapidly scale up access to free, comprehensive HIV/AIDS services across the country. Since 2008, GHAIN has been decentralizing integrated HIV/AIDS, TB and sexual reproductive services to the primary health care (PHC) level to take services closer to the people.

The Local Government Areas (LGAs) are responsible for the primary health care facilities in which these services are provided. Planning for health at the LGA level often does not take into account the reality of available resources and budgets are seldom derived from any process of analysis or mechanism for prioritizing health needs at the LGA level. The ensuing result is that there is often a gap between the budget approved for health and

what is actually required; there is a further gap between what is approved and what is eventually released for health. Furthermore, there is lack of appropriate mechanisms for tracking budget implementation leading to lack of accountability in use of resources that have been approved.

To improve chances of sustainability of these services so they don't eventually end up as additional out of pocket expenditures, GHAIN started providing technical assistance to LGAs to build their capacity to better plan and budget for health. The technical assistance also included capacity building in budget advocacy and budget implementation monitoring.

2

DESCRIPTION OF SERVICE DELIVERY PROCESS AND STRATEGY

The GHAIN budget support aimed at strengthening LGAs' capacity to plan, advocate for and manage resources. To engender sustainability, activities and programs supported by GHAIN were gradually introduced into the LGA work plans and budgets. The strategy included providing technical assistance to LGA Primary Health Care (PHC) departments on development of annual work-plans and performance-linked budgets; advocacy to LGA authorities for ownership of the process; and budget release and well as budget monitoring. The key steps in the process were:

- **Advocacy** - The process was initiated by a half day sensitization workshop for the LGA council, members of the health management committee and from the departments of administration and finance. The objective of the sensitization was to enlighten the stakeholders on the anticipated benefits and process. A plan for continuous advocacy for ownership and timely budget release was then developed.
- **Constitution of the budget sub-committee** - This was set up as an expanded sub-committee of the LGA health management committee. Its members were drawn from the LGA PHC department and LGA department of administration and finance. The PHC coordinator served as the chairman of the committee. The role of the committee was to coordinate the development of the work plan and performance based budget with support from GHAIN. The committee's mandate also included leading advocacy for fund release, monitoring the implementation of the budget, and providing quarterly and end of year budget implementation reports to the LGA health management committee.
- **Work plan and budget development** – The LGA PHC department was supported by the GHAIN health financing team to develop a user friendly, Microsoft Excel-based work plan and budget with the following elements:
 - broad goals and objectives
 - activities for actualizing these goals and objectives
 - output and outcome indicators

-
- timelines for delivery
 - cost of activities
 - persons or agencies responsible for implementation
- **Budget monitoring** – The budget sub-committee was to meet on a quarterly basis to analyze budget release and implementation. The outputs of these meetings were reviewed at the LGA health management committee meetings where appropriate action could be decided and carried out.

3

PROGRAM ACHIEVEMENTS/ RESULTS

This process was first piloted in one LGA (Yakurr LGA in Cross River State) in 2008.

Subsequently, the process was repeated in the same LGA (Yakurr) and rolled out in five other GHAIN supported LGAs (AMAC LGA, FCT; Kachia LGA, Kaduna State; Nasarawa LGA, Kano State; Orhionmwon LGA, Edo State; and Udi LGA, Anambra State).

In 2010, a training of trainers on the process was conducted for 24 GHAIN zonal staff. This created a pool of master trainers that have since cascaded down the training at the LGA level.

As a result, to date, 13 LGAs are being provided with ongoing support for annual work planning and budget development and monitoring. All 13 LGAs now have some of the activities funded by GHAIN in their budgets. Additionally, some of the LGAs have taken over funding of some activities previously funded by GHAIN. Two LGAs (AMAC and Nasarawa) now pay monthly stipends to community volunteers who support the provision of community based services and assist health facilities with contact tracking and referrals.

One LGA (Yakurr) now funds the monthly LGA health management committee meetings. Two LGAs, Orhionmwon and Nasarawa had an increase in their approved health budget from 2009-2010. Furthermore, as part of the build-in for a sustainable system, the LGAs now have budget sub committees comprising key representatives from the health and finance departments as well as from the local government council.

The budget for health is now on the agenda of the monthly LG health management committee meetings this is because it provides a forum for implementation monitoring and sustained advocacy.

Nevertheless, there are still some challenges. Although the budgeting process has improved, there was poor release of funds across all the LGAs. Also, budget expenditure could not be assessed as none of the LGAs provided expenditure records.

4 DISCUSSION

GHAIN's support on work plan development and budgeting is a strategy that has been well received by the PHC departments in GHAIN supported LGAs. Work-planning helps the LGAs prioritize and the developed performance indicators constitute an easy mechanism for PHC departments to monitor implementation of their budgets and track performance against their set objectives. The steps in the process ensure that the stakeholders at the LG level buy into the strategy and that there is LG ownership.

There were key lessons learnt during implementation. The PHC department is one unit in the wider LGA administrative structure; therefore a wider LGA strategy may yield better results. The lack of an accountability and transparency culture is endemic in most LGAs and necessitates increased and targeted advocacy as well as support for establishment of financial management systems. There is often significant discrepancy between what is needed for health and what is approved for health, and a further discrepancy with what is eventually expended. This is partly due to the already mentioned issue of accountability but is largely due to diversion of fund on the part of the LG authorities. A key feature in GHAIN's strategy has been to strengthen the budget sub-committee to conduct advocacy in order to ensure timely and adequate release of funds to ensure service delivery. This is a continuous effort and process.

5 CONCLUSIONS & RECOMMENDATIONS

GHAIN developed a strategy aimed at strengthening LGA's capacity to plan, advocate and manage resources and increase their fiscal responsibility for health. This includes building the capacity of local stakeholders to develop performance based budgets which among others incorporate the services delivered as part of the GHAIN project. The strategy yielded successes including increased allocation for health in some LGAs and transfer of fiscal responsibility for some interventions previously funded by GHAIN. Poor budget release and lack of budget tracking mechanisms remain a big challenge.

Recommendation:

Future support should target LGA wide planning and budgeting and establishment of financial management systems. Implementation of the strategy highlighted that the process of improving planning and budgeting for health at the LGA level is an ongoing process requiring continuous mentoring and advocacy.

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