National Policy on Public Private Partnership for Health in Nigeria

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List of Abbreviations

ARV	Anti-Retroviral Therapy
BOM	Build, Operate and maintain
BOT	Build, Operate and Transfer
BTO	Build, Transfer and Operate
CSO	Civil Society Organization
FEC	Federal Executive Council
FMOH	Federal Ministry of Health
HSR	Health Sector Reform
LGA	Local Government Area
MDG	Millennium Development Goal
NAFDAC	National Agency for Food, Drug Administration and Control
NCH	National Council on Health
NEEDS	National Economic Empowerment and Development Strategy
NGO	Non Governmental Organization
NHIS	National Health Insurance Scheme
NHMIS	National Health Management Information System
NPHCDA	National Primary Health Care Development Agency
NPI	National Programme on Immunization
OOP	Out of Pocket
OPS	Organized Private Sector
PMV	Patent Medicine Vendor
PPP	Public Private Partnership
TBA	Traditional Birth Attendant

Foreword

The present administration has embarked on fundamental reforms of the health sector with a view to attaining the Millennium Development Goals (MDGs) and other National Health Policy targets. A central aspect of these health sector reforms is to mobilize and harness all resources – across both public and private sectors – for the benefit of the population. Accordingly, it is desirable to develop a national public private partnership (PPP) policy in health.

Chapter 8 of the National Health Policy emphasizes the importance of partnerships and collaborations in health care provisioning. This policy document addresses the aspiration outlined in the National Health Policy and articulates the dimensions of public private partnerships and interactions, and how these should be strengthened in order to serve the people of Nigeria.

PPPs are not a new concept in Nigeria. Indeed, they are already practiced in different ways in every state. This policy therefore aims to build upon these current efforts, and to provide a framework for more sustained and effective action.

This PPP policy affords all the tiers of government, interest groups, including other stakeholders to identify with any or all sections of the recommendations that are outlined in it. The challenge and/or expectation are to harness all the abundant health care resources for the benefit for the people of Nigeria.

I wish to emphasize the need for all interest groups and actors in health to collaborate with FMOH and other health authorities at the State and Local government levels to ensure the successful implementation of this policy. This will result in more effective, affordable and efficient health services, improved performance of our health care system, and ultimately in the achievement of a better health status for Nigerian citizenry.

I commend this policy to all stakeholder sin the health sector in particular, and the Nigerian public and international health community in general.

Chapter 1

Introduction

1.1 The area of public-private mix in health care is a major issue of Health Sector Reform and policy analysis. Several factors are interacting to necessitate urgent development of public-private policy. Some of these factors are at a macro level, and beyond the health sector. (These include wider public sector reform, and the overall National Economic and Development strategy (NEEDS). At a sectoral level however, factors include on-going dynamic changes in the health system; the deplorable national health profile as evidenced by poor infant and maternal mortality rates, and low life expectancy. The declining resource allocation to health, and the breakdown of equipment in public health services, have worsened the situation. It has been acknowledged that government resources allocated to health have not been sufficient to: (i) maintain the existing health facilities; (ii) meet the increased demand due to population growth and rising public expectations; (iii) increase access to services; and (iv) improve the quality and level of care provided. Such key concerns about the ability of governments to finance health services adequately, the poor performance of public health service delivery systems, and the desire to expend the choices available to patients have prompted the federal Ministry of Health (FMOH) to search for solutions.

1.2 One of the key challenges to policy makers is how to form effective partnerships among different players in such a way that health care can be served efficiently, effectively, and equitably. It is vital to understand the operation of different players, their strengths and weaknesses, and based on such understandings, establish new relationships that will entail the act of learning, compromise, understanding and shared responsibilities. This collaboration will also allow for tolerance and the creation of an enabling environment and synergy that allows them to contribute more to the good of the general public than would have been achieved individually.

1.3 The public-private mix as already outlined in Chapter 8 of the National Health Policy strongly recommends and increased role for the private sector in service delivery. The policy permits the participation of the private for profit and not-for-profit including health providers, religious and other voluntary organizations, communal bodies, and individuals in the provision and financing of health care services. It has however been deduced that one of the key factors responsible for the unsatisfactory national health status is weak and ineffective coordination of the numerous stakeholders and active

participants in the health sector. Hence, "fostering effective collaboration and partnership among all the health actors" was articulated as one of the seven strategic objectives of the National Health Sector Reform (HSR) programme of Federal Ministry of Health.

1.4 An appropriate policy framework is required for this partnership and such policy should be crafted based on a consultative process. This approach guided the development of this policy document.

1.5 Consultation commenced in March 2005 when stakeholders were brought together; this was followed by expanded consultation nationwide, after which the draft policy document was prepared. The draft policy document was also presented for review to another group of stakeholders before being tabled at the National Council on Health. The process was to ensure that all stakeholders have had opportunities to offer inputs into the draft policy and to ensure that it captures the aspirations of all concerned.

1.6 The process is itself apart of a wider over-arching public sector reform effort within the overall Federal Government macro-economic framework: the National Economic Empowerment and Development Strategy, (NEEDS).

1.7 The essential policy and legal foundation underpinning the HSR processes include:

- The National Health Policy 2004
- The National Health Bill 2004
- The Health Sector Reform Program 2004-2007
- The Reviewed National Health Insurance Scheme (NHIS) 2003
- The Blue Print for Revitalization of the Primary Health care (PHC) 2004

1.8 The foregoing documents have also been reviewed and adopted by the highest health care decision making bodies; the National Council on Health (NCH0 and the Federal Executive Council (FEC). The Health Bill is in the process of enactment into law by the National Assembly.

1.9 The formulation of a National Public Private Partnership policy in health care provisioning is a vital step in the Health Sector Reform agenda and it is envisaged that the document will crate the basis to formalized, consolidate, and/or expand strands of partnerships and collaboration in their different contexts.

Chapter 2

Principles, Values, Concepts and Objectives

Principles, Values and Concepts

2.1 In addition to the principles already mapped out in the National Health Policy, the following key principles will underpin all PPP actions in the health sector.

- Governments (Federal, State and Local) share the obligation to ensure an enabling environment for the entire spectrum of (public and private) health provision. This obligation goes side by side with the parallel responsibility

for ensuring that all people are protected from harmful health practices, and have rights as consumers of health services.

- A "public private partnership" is a collaborative relationship between the public and private sectors aimed at harnessing (and optimizing the use of all available resources, knowledge, and facilities required to promote efficient, effective, affordable, accessible, equitable and sustainable health care for all people in Nigeria.

- Effective partnerships among private sector institutions, civil society organizations, and governments will allow fulfillment of their social expectations without compromising core missions.

- All formal (contractual) partnerships shall be based on written agreements specifying the purpose, duration, and exit arrangements.

- Partnership agreements shall clearly state the rights and obligations of all stakeholders. Such rights and obligations shall be enforceable.

- Best practices shall be encouraged/rewarded based on potential to improve upon the quality of care provided

- While for-profit institutions have a right (or an obligation) to make a profit, this has to be balanced against the equally important considerations of ensuring safety quality, and equity.

- PPP shall be recognized as a long-time process which requires perseverance, regular attention, and maintenance.

- There shall be ongoing communication/interaction on health issues by all stakeholders in the public and private sectors. As part of such interactions and consultation, private sector organizations shall have opportunities to contribute towards the planning and implementation of policy.

- There shall be decentralization of powers by government and acceptance of the expanded role of the private sector and the community.

- Part of the wider governmental obligations will include provision of basic amenities such as water supply, environmental sanitation, power supply.

2.2 In keeping with these principles, all compendia of regulations, codes of ethics, guidelines and other documentation pertaining to PPP shall be freely

available to those in the public and private sectors, and also to consumers of health care, through annual publication, websites, and other media.

Partners in Partnership

2.3 The public sector "players" potentially involved in PPPs include the Executive and Legislative bodies in all tiers of Government, as well as other public institutions (including the key health parastatals)

2.4 The private sector players are exceedingly diverse, and range across: the multiplicity of health providers, enterprises, economic institutions (e.g. banks), distribution companies, Chambers of Commerce, Labour Unions, Faith Based Organizations, Non-Governmental Organizations, Philanthropists, Clubs/Societies, other Civil Society Organizations and Cooperatives.

2.5 Other key partners include the Professional council, and Professional associations.

2.6 A final stakeholder group are the consumers of health care – as individuals, family and community members.

Types of Partnerships

2.7 One key form of PPPs will be specific contractual relationships – whereby the private sector performs certain functions, or deliver specific programmes, on behalf of government. Such PPPs may be employed by all tiers of government. In such partnerships, the responsibilities of both the private and public partners will be explicitly negotiated and documented at the outset in the form of a partnership agreement, contract or Memorandum of Understanding (MoU).

2.8 Other 'partnerships' will be based around governments (Federal, State and LGA) carrying out specific institutional functions in the public interest, and for the public good. These include the core governmental roles in regulating, and sustaining an enabling environment for, health markets.

2.9 Amongst the alternative types of partnership are:

Public Driven Partnerships:

a. Initiated by public administrations
b. Owned more than 50% shares

c. With a Board of directors, and decision making highly dependent on the public sector
d. More than 50 per cent involvement.

Private Driven Partnerships:
a. Mainly initiated by the private sector
b. Profit orientation may or may not be a primary goal (but would in any case need to be balanced along side the principles of ensuring safety, quality and equity)
c. More than 50% involvement in PPP
d. Public sector acts as a monitoring and standard setting body

Goal (Mission)

2.10. In pursuance of the National Health Policy goal to strengthen the national health system in order to provide effective, efficient, quality, accessible and affordable health service, the **goal** for public, private partnerships in health care provisioning is to promote and maintain all forms of partnership and collaboration between the public establishments and the private sector with a view to attaining and sustaining the desired level of health development in Nigeria, (as reflected in the MDGs, and other national policy targets).

Objectives

2.11 The primary objectives of the National Public Private Partnership Policy in Health shall be to:

i. Build confidence and trust in the public and private health sectors.
ii. Harness confidence and trust in the public and private sectors for the attainment of Millennium Development Goals, and other National Health Policy Targets.
iii. Promote and sustain equity, efficiency, accessibility and quality in health care provisioning through the collaborative relationships between the public and private sectors.

2.12 Other objectives are to:
a. Identify areas of need in which collaborations and partnerships are desired on long and short-term basis
b. Develop the regulatory framework for public and private interactions and collaborations in health care delivery in the country.
c. Facilitate universal access to a Minimum Health Package.

d. Support capacity building across the public and private sectors in health care provisioning
e. Contribute to the sustainability of the overall health system
f. Build the National Health Management Information System (NHMIS).
g. Underscore the contribution/roles of each of the sectors/partners in the partnership to health care delivery.

Chapter 3

Financing for different forms of Public Private Partnerships for Health

Current Situation

3.1 Annual public sector budgetary allocations to health are low, and often well below what is recommended by WHO. In addition, actual expenditures often do not even match approved allocations, as a result of bureaucratic and other barriers. This undermines the provision of good quality health care services. Many consumers have no option but to depend on private sector providers. Out-of-pocket expenditures are known the largest single element of financial resources for health care in Nigeria.

3.2 Some private providers are almost wholly profit-driven. Exceptions are the range of not-for-profit providers – although access to these varies considerably through-out the country.

Goal

3.3 The goal of financing under the rubric of PPP policy shall be to facilitate levels and patterns of funding which will generate improved provision of health care and services in both the public and private sector, and promote greater value for money across all health expenditures.

Financing Options

3.4. Valuable *efficiency* gains will be sought through encouraging partnerships and collaborations in Non-clinical Support Services:

a. Mortuaries
b. Security
c. Laundry
d. Maintenance of clinical equipment
e. Amenity wards
f. Catering
g. Cleaning/Ground Maintenance (Domestic)
h. Ambulance
i. Engineering Maintenance including Power, water supply, Telephone/Intercom
j. Record Keeping
k. Revenue Collection (including the banking sector)
l. Administration
m. Information technology and technology transfer

3.5. Improvements in access and efficiency will be sought through exploring the use in Clinical settings of:
a. Intramural Practice
b. Locum for all cadres of health personnel
c. Restorative and Rehabilitation (e.g., Physiotherapy etc.)
d. Primary Health Care
e. Contracting not-for-profit organizations
f. Provision of services in under-served and rural areas
g. Prevention and treatment for certain priority diseases such as Tuberculosis, Malaria, HIV/AIDS

3.6 Other gains (in access and efficiency) will be sought through partnerships and collaborations in Supportive Clinical Services:
a. Diagnostics (Radiology, Laboratory)
b. Training – (for all professional cadres)
c. Franchising of Components of Services
d. Build Operate and Transfer (BOT) options

3.7 In health promotion and advocacy, PPP opportunities include:
a. Raising awareness about health consumer rights
b. Contracting NGOs for community mobilization and outreach
c. Using mass media – to disseminate essential health facts, and serve as a means of information exchange and dialogue
d. Promoting quality recognition (in line with the policy proposals outlined in Chapter 5).

3.8 Social marketing subsidies will continue to be provided under disease prevention programmes e.g. to promote the sales of bed-nets, and condoms.

3.9. Partnerships shall be encouraged in other areas that offer opportunities for improved accountability and efficiency:

a. Training – Continuing Professional education
b. Manufacturing of drugs e.g. contraceptives/ARV etc.
c. Research and Development

Promotion Equity

3.10 The PPP shall be implemented in a manner which will continue, or accelerate, current efforts to improve equity (in health provision and outcomes). Measures will be in place to ensure that current inequities are not exacerbated.

3.11 Non-profit providers (including faith based organizations) devote a substantial part of their annual budgets to the poor. Accordingly, all tiers of government shall provide annual grants to serve as financial buffers to these providers. Such grants will be conditional on: (a) grantee accounts will be available for annual auditing; (b) funds will be allocated according to either the numbers of people served and/or the packages of services provided; and (c) specific minimum service accreditation criteria will be met. Over time, such grants will include increasingly substantial performance (or output) based financing elements – where inputs are tied to attaining specific health outcomes.

3.12 There shall be increasing provision by all tiers of governments for exemptions, and/or deferred and discounted payments, for very poor and indigent patients. Such exemptions and deferrals should be available to those using specific and restricted private facilities and services.

3.13 Opportunities for 'profit sharing' shall be explored – as one means of cross-subsidization of services, and of buttressing the resources available for exemptions and deferrals.

3.14 Financial and technical support shall be available for traditional health practitioners and potentially other alternative – wherever these are the first 'point of call' for health care by the poorest and indigent.

3.15 Where necessary and appropriate, all tiers of government shall earmark special grants or incentives for health personnel (in either public and private sectors) working in under-served areas or infectious diseases centres.

Health Insurance

3.16 The present efforts to strengthen and reform the National Health Insurance Scheme (NHIS), and other insurance schemes will be continued.

Other PPP Financing Options

3.17. Other PPP financing options shall be explored; these include:

- Public private collaboration in the area of investment
- Tax relief/rebate for manufacturers of health products
- Credit options for private sector capacity building
- The promotion of private finance initiatives
- Establishing drug bulk stores
- Private sector distribution mechanisms

Budgetary and Financial Management Implications

3.18 The PPP policy will have important budgetary and financial management implication. In particular:

a. Increased allocations will be needed for most state and federal Exemption and Deferral Funds (or Emergency Preparedness and response Funds).
b. Allocations should be earmarked for grants to not-for-profit organizations (to provide essential services, operate in under-served areas, or undertake essential community mobilization).
c. Increased allocations shall be needed for key regulatory and quality recognition functions (set out in Chapter 5).

3.19 In order to maximize potential efficiency gains, current efforts to facilitate autonomous management of resources and finances by secondary, tertiary, and teaching hospitals shall be accelerated.

3.20. The financing of services, and programmes under PPP shall be determined by partners on mutually agreed terms, taking into account public interest and transparency. The public sector shall fulfil its obligation to ensure financial releases in accordance with agreed prior payment schedules. The private sector will report on the use of any resources (as per agreed schedule), and will make their accounts available for annual auditing.

Chapter 4

Provisioning of Care in Public Private Partnership for Health

Current Situation

4.1 Health care delivery in the public sector is currently highly bureaucratized, Undermining effective delivery of services, professional ethos, job performance, and morale. In the private sector, the cost of care is unaffordable to a large percentage of the people, and very high for those who could even afford such services. As a result, the populace is unsatisfied with services provided in both public and private facilities..

4.2 Referral should be a two way affair (viz, referral from lower to higher level facilities and vice versa and between the public and private health providers). There is evidence that referrals from the non-governmental to higher level public facilities are viewed with disdain.

4.3 As a consequence, national health indices are abysmally poor. Finding better
ways of provisioning health care is therefore essential.

Goal

4.4 Provisioning will be restructured through health sector reform to ensure that every

Nigerian has access to quality and affordable health care services (in both public and private sectors) for the attainment of optimal health status.

Primary (Preventive/Promotive/Curative) Care

4.5 The public sector, private-not-for-profit/for-profit providers, communities, civil
society organizations, media, and households shall share the responsibilities for primary preventive, promotive and curative health care. All will command the support of all tiers of government in this regard.

4.6 Traditional health practitioners, as well as other alternative health providers, whose practices are of proven value, shall be encouraged and supported as the 'front line' of health care provision for many people. Such providers will however be brought under regulations, to ensure adherence to rules and health care guidelines

4.7 Patent medicine vendors should likewise be afforded opportunities to iprove the quality of their services, whilst being brought under the same regulations (in line with current policy on PMVs).

4.8 Local Governments should encourage and support health care providers (of all forms) in under-served rural areas.

4.9 Provision of, and access to, a Minimum PHC package (with defined quality standards) shall be encouraged.

Clinical Services at the Secondary and Tertiary Levels

4.10 Clinical services at the secondary and tertiary levels may be provided by public sector facilities, private hospitals (for-profit and/or not-for profit), or under a partnership arrangement involving both public and private players. Such partnership and contracting arrangements should be encouraged by State and Federal Governments.

4.11 Two way referrals shall be formalized and enforced.

4.12 Intramural practice shall be encouraged, promoted, and sustained.

4.13 Provision and access to Minimum Health Care Package shall be encouraged. Priority will be given in State strategic plans to ensure the provision of such a Minimum Package in all currently under-served areas

4.14 Group practices so as to improve access and specialization shall be promoted and encouraged.

Non-Clinical Services at all Levels

4.15 Non-clinical services may be provided by either or both of public and the private not-for-profit/for-profit organizations.

4.16 The Federal Government (in consultation with other tiers of government, and other stakeholders) will issue updated guidelines for the effective and efficient delivery of non-clinical health services.

Evidence Base and Health Management Information System

4.17 The Federal Government shall establish and maintain an evidence base documenting essential data pertaining to both public and private sectors. State and LGA governments may want to maintain their own evidence base. Technical support from the federal government shall be available for this evidence base.

4.18 Current efforts to map all public and private facilities will be the foundation for this evidence base.

4.19 A comprehensive Health Management Information System shall be an integral element of such an evidence base. The private sector will collaborate in developing the framework for such a comprehensive HMIS – including data collection, collation, processing, and report preparation.

4.20 Data on utilization, diseases, entities, and bed capacity/occupancy across both the public and private sectors shall be disseminated nationwide annually through publications and a web site dedicated for this purpose.

4.21 The national PPP evidence base shall also systematically document “due process” and ‘good (or best) practice’. (Failures will also be recorded!)

Research and Development

4.22 The Federal Government shall collaborate with the private pharmaceutical sector to encourage local development and production of raw materials for drug manufacturing, consumables and other health products of strategic importance to health care delivery system (e.g., development of petrochemical industries, ban on importation of certain manufactured drugs.)

4.23 Federal and State government shall also

- Encourage research into, and the conservation of, local medicinal plants.
- Encourage/support development of vaccines.
- Promote/collaborate in clinical and drug trials.

Chapter 5

Regulatory Framework for Health

Current Situation

5.1 The regulatory mechanisms for health service delivery, quality assurance management and distribution of commodities such as drugs, vaccines, and equipment are largely ineffective. Services in public and private sectors frequently all below acceptable standards. In some cases, the lack of effective regulation is resulting in people receiving (and paying for) treatment of little or no therapeutic value; even worse, some are exposed to dangerous products and practices, and are thereby suffering harm.

Goal

5.2 The goal is to revitalize a standardized regulatory framework spanning both the
public and private sector, improve, assure, and sustain the quality of health care provisioning.

Facilities/Services

5.3 A uniform accreditation regimen shall be established for both public and private

facilities and enforced for quality care – so as to have a level playing field for all health facilities.

5.4 A minimum standard of operation for registration and accreditation shall be established and sustained.

5.5 Registration and accreditation of public and private facilities shall be on a two yearly basis (in accordance with the provision of the National Health Bill).

Personnel

5.6 Extant Codes of professional ethics shall be compiled and made available to all health practitioners across the public and private sectors.

5.7 Continuing education on current issues such as ethics, drug prescription, management of services, diagnosis of emerging infections/diseases etc shall be enforced for all health care providers yearly/regularly.

5.8 Such continuing education and training will be an immediate priority for patent medicine sellers, traditional birth attendants, traditional health practitioners and other alternative providers – as a foundation for more effective and rigorous registration and regulation of these health providers.

Responsibilities for Regulation and Accreditation

5.9 The primary responsibilities for registration and accreditation will continue to be shared between:

- All tiers of Government
- Professional Councils
- Professional Associations
- National Hospital Service Agency (once established and operationalised)

5.10 Further strengthening shall be sought through:

- Capacity building and increased resources for all of the above to enable the bodies to fulfill their duties.
- Franchising specific inspection and accreditation functions to qualified private agency(ies).
- Encouraging self-regulation and accreditation efforts.

5.11 Health promotion shall be undertaken to ensure national awareness of such quality recognition processes.

Chapter 6

Human Resources for Health

Current Situation

6.1 The numbers of health personnel are insufficient to meet the needs of the country (with the possible exception of certain categories e.g. nurses/midwives). At the same time, there is serious under-utilization of personnel (at certain levels and in specific facilities). Uneven distribution of health personnel persists nationwide: between the public and private sectors; between rural and urban localities; and in terms of the location of specialists vis-à-vis non specialists. The capacity of health human resource across the various cadres remains weak due to inadequate curricula, poor teaching, poor funding and conditions of service. Finally, there is lack of human resource planning including data.

6.2 As a consequence, the performance of most health professionals fall below desired levels, morale is poor, and job satisfaction is low.

6.3 Other factors are also emerging-one of which is the growing international market for certain cadres of health personnel.

Goal

6.4 The goal is to enhance capacity, harness, and redistribute health human resources for improve health care delivery and system performance.

Capacity Building and Enhancement

6.5 Patent medicine vendors shall be afforded opportunities (training and other)to improve their performance-in line with PMV policy.

6.6 Training of house Officers in accredited private sector health facilities shall be facilitated.

6.7 The capacities and competencies of traditional healers/TBAs (hygiene, referral, record keeping) will be enhanced – within the confines of regulations etc.

6.8 Training curricula will be reviewed – in the light of current and prospective HR needs.

6.9 Subsidies will be explored for accredited private sector training institutions.

6.10 Continuing professional education (at accredited public and private training centres) shall be institutionalized for all cadres of health personnel as- pre-requisite for re-registration/renewal.

6.11 Statutory National Professional Councils shall partner professional associations and multinational firms in organizing courses recognized for the award of credit approved for re-registration/renewal.

6.12 All accredited providers should employ formally trained and registered nurses/midwives.

6.13 Private sector staff shall be eligible for training opportunities and access to technical support and equipment.

Needs Assessment

6.14 Enhance capacity on negotiating skills/contracting of the health human resource across the sectors.

6.15 Determine the size of health human resource in the private sectors.

6.16 Encourage/support the development of strategic plan on health human resource in each state.

6.17 Base PPP on needs assessment of health human resource across the public and private sectors.

Chapter 7

Roles and Responsibilities

Current Situation

7.1 Health is a concurrent issue in the 1999 and previous Nigerian Constitutions. Nonetheless, it is widely agreed that the roles and responsibilities of the various tiers of government are not well defined. Nor have these Constitutions defined the roles and responsibilities of the private sector in health care provisioning.

7.2 The management of health services is centralized and bureaucratized, allowing different actors and players in the health sector to absolve themselves from various role and responsibilities. This lacuna is being addressed in the proposed National Health Bill which is before the Federal Legislature.

Goal

7.3 The goal is to specify, and clarify the role and responsibilities of the various actors and stakeholders in health care provisioning.

Roles and Responsibilities of the Public Sector

7.4 **The Federal Government (including national health paratstatals) shall:**

a. Set national/public health goals (the MDGs and other Health Policy Target**s)**
b. Establish relevant service norms and standards
c. Be committed to, and ensure Federal resources are available for, the implementation of the health sector reform
d. Raise awareness of consumers' rights (including within a PPP context)
e. Formulate, review and implement a national policy on PPP
f. Create an enabling environment for PPP actions to be formulated and sustained.
g. Implement the PPP policy:
    - within Federally financed tertiary and teaching institutions
    - through national and zonal social marketing campaigns
    - within the framework of national programmes (NPI), Roll Back Malaria, TB DOTS, etc.)
h. Liaise with Professional Councils and Professional Associations in discharging the shared responsibilities for regulation and accreditation (quality recognition).
i. Fulfill HR responsibilities.
j. Ensure harmonization of all health policies .
k. Provide (as requested) guidance and assistance to other levels of government in developing and implementing PPP policies in health.
l. Be committed to the devolution of powers as required for PPP.
m. Co-ordinate Monitoring and Evaluation of this policy.
n. Encourage/support Research and Development in PPP.
o. Establish and Maintain a PPP evidence base – and implement the HMIS.

7.5 **The State Governments shall:**

a. Develop and implement state health policy.
b. Set state health goals and targets.
c. Ensure norms and standards (in line with national standards).
d. Be committed to the devolution of powers.
e. Be committed to the implementation of the health sector reform.
f. Raise awareness of consumers' rights.
g. Undertake comprehensive state strategic planning – covering both public and private sectors.
h. Formulate a state policy on PPP
i. Implement any state PPP policy, including
    - within State financed Secondary health care institutions.
    - though strengthening registration, regulation and accreditation across both public and private sectors.
    - through the grants to not-for-profit and faith based organizations.

j. Fulfill state HR responsibilities.
k. Make the necessary budgetary changes for effective PPP implementation (including ensuring adequate resourcing for any State Deferrals or Emergency Fund).
l. Create an enabling environment for PPP to succeed, including ensuring harmonization of all state health polices.
m. Undertake capacity building and training in PPP.
n. Co-ordinate Monitoring and Evaluation of PPP policies.
o. Raise awareness of consumers' rights and obligations on PPP.
p. Encourage/support Research and Development.

7.6 **The LGA shall:**

a. Enact LGA by-laws on PPP.
b. Set LGA goals.
c. Establish and ensure norms and standards (in line with national and state standards).
d. Be committed to the implementation of the health sector reform.
e. Be committed to the devolution of powers.
f. Formulate a LGA strategy on PPP.
g. Create an enabling environment for PPP to succeed.
h. Implement any LGA PPP strategy, specifically with regard to underserved areas for PHC.
i. Undertake capacity building and training in PPP.
j. Co-ordinate Monitoring and Evaluation of policy as required for PPP.
k. Raise awareness of consumers' rights and obligations on PPP.
l. Encourage/support Research and Development.
m. Ensure accounting for transparency.

Roles and Responsibilities of the Private Sector

7.7 **Private for Profit Partners shall:**

a. Ensure and sustain professional and technical standards of health services in line with national or state standards (i.e. be accredited).
b. Submit reports (financial, HMIS, etc) in line with agreed reporting requirements.
c. Establish and maintain the requisite capacities (management and administrative expertise and systems)to negotiate, and participate in, PPPs.
d. Fulfill reporting requirements (including HMIS reporting)
e. Ensure and provide training
f. Participate in the transfer of technology
g. BOT

h. BOM
i. Undertake research
j. Create financial concessions- to promote equity in service provision
k. Ensure transparency in accounting
l. Provide quick emergency relief

7.8 **Private Not-for-Profit shall:**

a. Ensure and sustain professional and technical standards of health services in line with national or state standards (i.e. be accredited)
b. Submit reports (financial, HMIS, etc) in line with agreed reporting requirements
c. Establish and maintain the requisite capacities (management and administrative expertise and systems) to negotiate, and participate in PPPs (including having they systems to facilitate the receipt of grants from state authorities)
d. Provide quick emergency relief
e. Encourage community participation in service delivery
f. Undertake capacity building and training
g. Be part of the network of the referral system
h. Monitor the community in order to identify eligible beneficiaries for government supported programmes and services
i. Provide advocacy to promote and sustain PPP
j. Facilitate data collection from rural communities
k. Be involved in, and promote, operational research
l. Participate in planning, administration, and ownership of health and other social programmes
m. Ensure transparency in accounting
n. Provide quick emergency relief

7.9 **Clients/Consumers/Households shall:**

a. Comply with referral
b. Demand rights
c. Be aware of the responsibilities and duties in safeguarding their own health, and that of others
d. Understand the reasons for paying for services
e. Appreciate the cost effectiveness of the services provided

Chapter 8

Monitoring and Evaluation

Current Situation

8.1 Rigorous monitoring and evaluation of health policy implementation remains more the exception than the rule in most contexts in the country. Where it is carried out, M&E is often not undertaken in an objective and transparent way. These weaknesses are associated with inadequate record keeping and data management, as well as shallow understanding of the relationships between data and planning.

Goal

8.2 The goal of M&E is to promote transparency and efficiency; tract progress towards equity; and assess compliance with standards in order to sustain quality care and services.

Structure and Process

8.3 A comprehensive and user friendly data management and monitoring framework (containing a check list for assessment) shall be developed for the entire health system (public and private).

8.4 An independent team with representation drawn from the stakeholders shall be constituted to undertake M&E. This is without prejudice to other internal M&E exercises within each of the organizations concerned.

8.5 M&E shall be embarked upon regularly

8.6 Reports of M&E shall be submitted annually

8.7 M & E reports shall be disseminated widely

Indicators for Services

8.8 Indicators for monitoring and evaluating the performance and impact of services (public and private) shall be developed and may include:

- Number of clients;
- Ratio of health providers to clients;
- Provider attitudes;
- Client satisfaction;
- Waiting times;
- Availability of drugs;
- Rational drug use;
- Existence of therapeutic drug committees;
- State of equipment; and
- Maintenance and appropriate use of equipment etc.

Indicators for Facilities

8.9 Indicators for monitoring and evaluating facilities shall be developed and may include;

- cleanliness;
- esthetics of the environment;
- security;
- location of sign posts;
- lighting, and other electrical equipment;
- availability of a functioning water supply;
- clean drains;
- record keeping;
- state of beddings etc.

M & E for Equity

8.10 An equity monitoring system shall be developed – based around a range of indicators and measures to assess; use of deferral and exemption

arrangements; differentials in access to care; the risks of falling into poverty (as a result of health); differentials in expenditures, etc.