PATHS

Nigeria Partnership for Transforming Health Systems

Technical Brief

Improved Management through Participatory Appraisal and Continuous Transformation (IMPACT)

DFID Department for International Development

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Staff celebrating QAR Award, Dr Gwamna Awan Hospital, Kaduna

Improved Management through Participatory Appraisal and Continuous Transformation (IMPACT)

Summary

IMPACT is an approach that systematically appraises health facilities, supports improved service delivery, encourages community participation and recognises and promotes service quality. This is achieved through the implementation of four iterative components which work in synergy to contribute to better health services for communities. The components[1] include:

Peer and Participatory Rapid Health Appraisal for Action (PPRHAA), a simple but comprehensive process for appraising and collecting information on all the major aspects of a health facility with a focus on service delivery and facility management, as well as the views of clients and other members of a health facility's catchment population.

Strengthening Systems and Capacity Building involves developing and implementing models for key systems (e.g. Financial Management and

1 Manuals and guides have been developed for all four components to describe the process and provide all the necessary tools. These are available on the CD that accompanies this Technical Brief series.

Health Management Information systems) and strengthening management capacity.

Integrated Supportive Supervision (ISS) is a unitary supervisory system which uses a common checklist and reporting format based on harmonised indicators from as many initiatives/ programmes as possible. It is driven by a common supervisory team.

Quality Assessment and Recognition (QAR) is an approach to assess, recognise and promote quality improvements within health facilities. It involves benchmarking facilities against agreed standards and publicly recognising and promoting the outstanding facilities.

IMPACT is a model that is based on a pro-active but firmly non-prescriptive step-by-step methodology that responds to where partners are and moves at a pace that keeps them involved. It increasingly empowers them to take leadership and assume ownership of reform activities. It requires a deep level of participation, shared vision, joint development of strategies and local determination of priorities from all participants.

PATHS used IMPACT throughout the six years (2002 to 2008) as its leading systems strengthening and capacity building initiative. IMPACT provided a framework and a platform on which significant other work was built. During this time, IMPACT resulted in many deliverables that were both locally appropriate and globally relevant. This brief provides an overview of the initiative and outlines the experiences, effective strategies, achievements and lessons learnt during the process. The brief also provides an opportunity to build on the successes of PATHS and sustain the notable momentum that IMPACT has generated.

Introduction

Nigeria is the most populous country in Africa with approximately 140 million inhabitants (Census, 2006). With a per capita GNI of US$640, about 57% of its population lives below $1 per day. Additional to the poverty factor, the performance of Nigeria's health system declined appreciably in the closing decade of the last century resulting in poor health outcomes. The health system faced major challenges such as inadequate funding, shortage and mal-distribution of human resources, general infrastructural decay, lack of harmonised and efficient logistics systems, a weak national health management information system as well as inefficient health programme management.

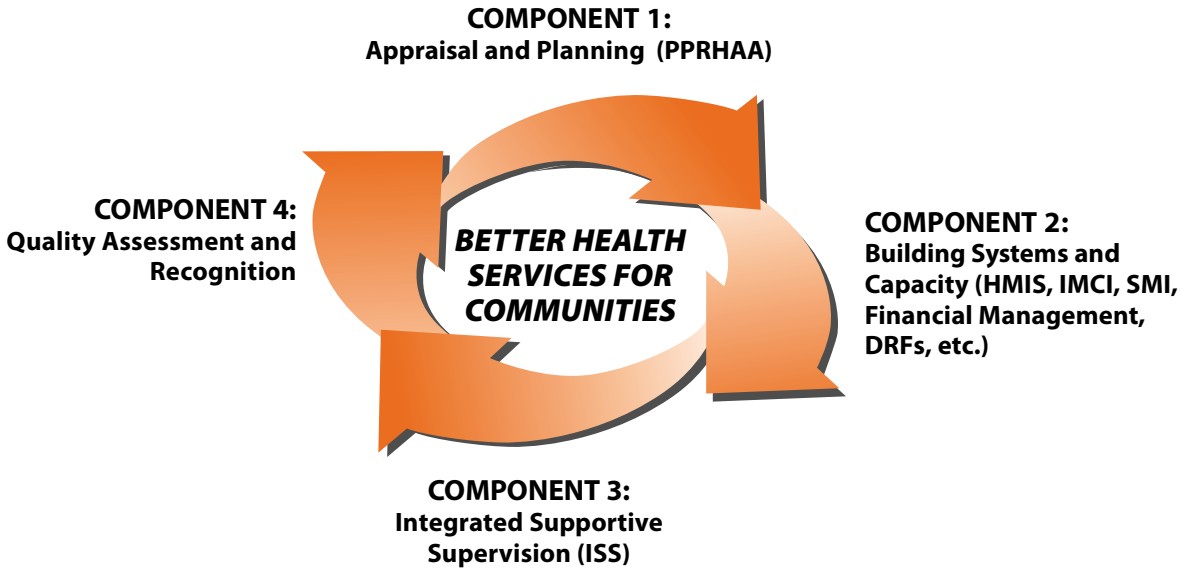
Through the Partnership for Transforming Health Systems (PATHS) programme (2002 – 2008), the UK Department for International Development (DfID) scaled up its work in selected states to address some of the issues that had led to the declining health situation in Nigeria. Improved Management through Participatory Appraisal and Continuous Transformation (IMPACT) was one of the strategies that the PATHS programme employed to tackle the health system at all three tiers of Government.

IMPACT is an approach that systematically assesses health facilities, supports improved service delivery, encourages community participation and recognises and promotes service quality. These are achieved through the implementation of four components that constitute the IMPACT initiative. Although the four components are usually presented in a sequence, in real life the process is iterative and must work in synergy to contribute to better health services for communities.

Apart from PATHS, other Nigerian national bodies and programmes have bought into the IMPACT methodology, including the National Primary Health Care Development Agency (NPHCDA), tertiary health facilities, Christian Health Association of Nigeria (CHAN), Evangelical Churches of West Africa (ECWA), the Partnership for Reviving Routine Immunisation in Northern Nigeria (PRRINN) and Save the Children UK (Nigeria). All these organisations were utilising one or more components of IMPACT by early 2008.

In discussing IMPACT, it is important to recognise that some states have developed the components further than others. Structures also vary from state to state, so flexibility was important as the IMPACT processes needed to be embedded within the systems of each state. Each of the four components of IMPACT is described in more detail below.

The four components of IMPACT



Component 1:
Appraisal and Planning through PPRHAA

Overview

Health service managers with minimum management training have often found traditional monitoring mechanisms intimidating and difficult to own. In addition, they are frequently time-consuming, expensive and therefore unsuitable for regular use in most African health services. The PPRHAA methodology borrows from several tools (e.g. Participatory Rapid Appraisal) and several models for assessment and accreditation.

PPRHAA is a relatively simple but fairly comprehensive process for appraising and collecting information on all the major aspects of a health facility with a focus on service delivery and facility management. Undertaken by peers from the health system, PPRHAA offers a supportive and safe environment for identifying practical priority issues for improvement, analysing the root causes of the challenges and initiating a 'systemic thinking' and planning culture in facilities and institutions. It encourages and empowers health managers, by focusing on what they "can do" themselves. In addition, by seeking client and community views on the health facilities' performance it provides an entry point for encouraging community participation in the development of health facilities and strengthening the accountability relationship between health provider and clients[2]. The appraisal also informs the second component of IMPACT by identifying system weaknesses. Thus, 'PPRHAA' facilities invariably become the focus of numerous systems strengthening initiatives.

The development of PPRHAA may be traced to the late 1990s, when a few African health managers were invited to Ghana's Upper West Region to appraise four hospitals and support them to improve their service delivery. At this formative stage of PPRHAA, the four hospitals were appraised in seven thematic areas. Subsequently, the tool was reviewed and streamlined to cover only four thematic areas which are: Patient Care Management, Internal Management and External Linkages, Finance and Equipment, and Facility Service Output. With the involvement of social development experts in the process the Client and Community Views thematic area was then introduced in 2003.

Methodology/process

The PPRHAA process consists of six distinct stages[3]. Each stage has various activities and the details of implementing each stage/activity are contained in two manuals developed for IMPACT component one. There is one manual for Secondary Health Care (SHC) facilities and one for Primary Health Care (PHC) facilities. There are also two field guides (one for PHC and one for SHC facilities) that serve as user-friendly documents for PPRHAA field workers.

STAGE I
Preparing for the PPRHAA exercise

Preparations for a PPRHAA exercise usually commence a couple of weeks before the actual event. It involves working with a small group of senior staff from supervisory bodies such as Local Government Councils, Local Government Service Commissions, Hospital/Health Boards and State Ministries of Health to prepare for the various tasks related to each stage of the PPRHAA process. Key decisions taken during the preparatory stage include the dates for the various activities, the number of Districts/LGAs/Boards, health facilities and communities to be covered and the composition of the PPRHAA team. Field experience has shown that many of these factors were determined by the amount of funds available. PPRHAA team members are chosen from all cadres and categories of staff in the health sector to foster a sense of ownership and as a first step towards institutionalising the process. Once in place, team members undergo training to strengthen their capacity in skills such as facilitation, problem analysis, report writing and team work that are needed for the process and for improved service delivery at their work place.

2 For more information see the Technical Brief on Strengthening Voice and Accountability in the Health Sector

3 Note that a short summary of the process is presented. For obvious reasons some of the complexity is not mentioned.

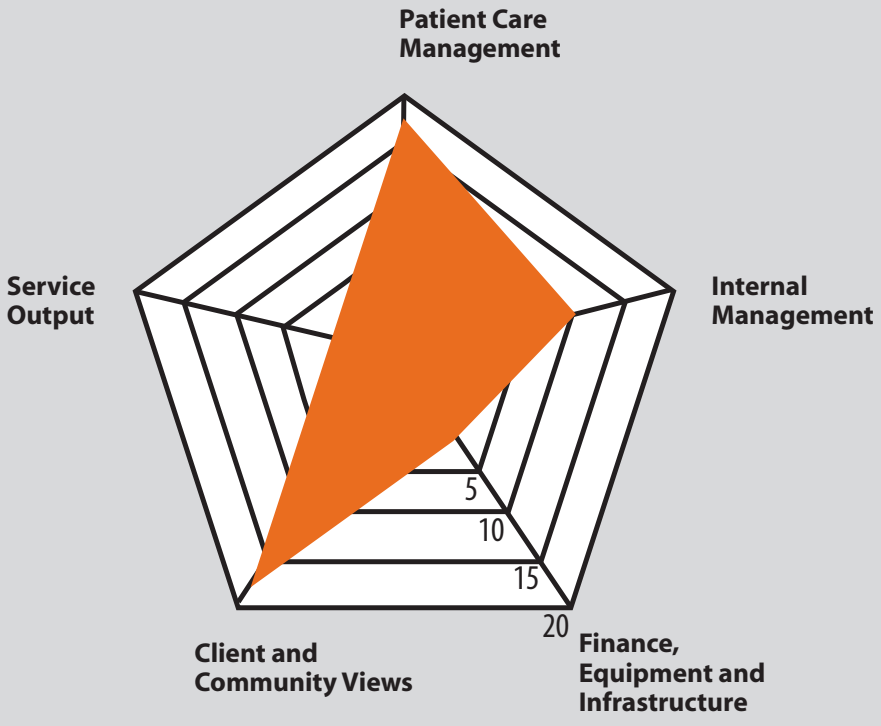
If a team or state is conducting a PPRHAA appraisal for the first time, it may consider appraising only a small number of facilities and scale up over time. In the same vein, they may need some national or international consultancy support to get to grips with the methodology. It is recommended that a team of at least two consultants, one PPRHAA clinical consultant and one social development consultant, be contracted. Appraisal teams are likely to need intensive technical support at the start of the appraisal – until they become conversant with the appraisal tools and processes. Initially, the PPRHAA process was implemented with the support of external facilitators. As the process has become more understood, stakeholders have assumed more responsibility for the process.

STAGE 2
The PPRHAA Appraisal Visit

Districts/LGAs/Boards, health facilities and communities need to be sufficiently notified and their consent obtained before a PPRHAA appraisal visit. During the visit, information is collected, reviewed and documented. A preliminary analysis of the information collected takes place at the facility on the same day. This includes a feedback meeting. The length of an appraisal visit to a health facility is dependent to a large extent on the size of a facility, the type of services that are available, the level of utilisation and the skills of the PPRHAA team. However, on average an appraisal visit to a PHC facility takes about two hours while one to a hospital takes between four and five hours. This is important for scheduling appraisal visits because at least two PHC facilities that are not too far from each other would usually be appraised by the same team on the same day, while only one hospital can be conveniently appraised in one day. PPRHAA teams are usually careful not to overly disrupt services to clients/patients.

The spider diagram shows the scores achieved (out of 20 possible points) on completion of a PPRHAA exercise. The method provides a means of visually assessing functioning at the time of the appraisal and over time (as the PPRHAA is an annual event, comparisons can be made with previous spider diagrams).

A PPRHAA spidergram from Bishop Shanahan Hospital, Enugu



A typical PPRHAA appraisal visit team for a PHC facility consists of a team leader, data collector, Client and Community Views Officer (CCVO) and a note-taker. The team leader is responsible for appraising patient care management, internal management and external linkages and finance/equipment thematic areas. S/he also helps gather information by interviewing key informants in the community. The CCVO conducts client interviews at the facility and two focus group discussions in communities near to the facilities – one with men and one with women. The focus group discussions include a ranking exercise where participants compare and score the performance of various local health providers using variables such as cost, staff attitudes, community participation and so on. The note-taker documents the findings. The CCVO and the note-taker are responsible for presenting findings from client interviews and focus group discussions during LGA Appraisal Feedback and Planning Workshops and the State/Zonal Summits. They produce CCV reports and ensure the inclusion of client and community views throughout the PPRHAA process. The Data Collector is largely responsible for reviewing/collecting the facility output data. The team leader is responsible for presenting findings in the other thematic areas. It is important to emphasise that the PPRHAA team members are drawn from the Districts/LGAs/Boards and health facilities to ensure the *peer* element of the appraisal process.

The team that visits a hospital is usually larger and may contain a doctor, a nurse, a pharmacist and an administrator in addition to the members mentioned above. The different thematic areas are appraised by this team.

One mechanism that has been used successfully to visually portray areas of strengths and weaknesses is the spider or radar graph.

STAGE 3
Facility/District/LGA/Board Appraisal Feedback and Planning Meeting

Immediately after each appraisal visit, health facility staff and community representatives meet to prioritise and analyse the problems identified and develop operational plans to address those they can manage at their own level. The operational plans usually identify a time frame, a problem statement, key activities and person(s) responsible to ensure that they are carried out, that required resources are identified, that the estimated time for the activity to take place is considered and an indicator to measure progress identified. The problems which cannot be addressed at the facility level are then referred to the next level and presented during the LGA and state summits.

Hospital Management Reviewing Operational Plan, Jigawa

© PATHS Photographer

STAGE 4
State/Zonal/LGA Appraisal Summit

The State summit is a form of health advocacy meeting. At the inception of PPRHAA, the State summit attracted policy makers, managers and other stakeholders to a one or two day-long event to share findings of the appraisal, especially cross cutting issues in the LGA or state. Later PPRHAA practitioners experimented with Zonal[4] summits involving more operational level stakeholders and a focused State summit targeted at key high level policy makers. This dual approach has led to improved attendance and allowed more time to discuss issues at both levels.

STAGE 5
Follow-up on PPRHAA and the plans

On a monthly basis, PPRHAA team members pay follow up visits to the facilities and LGAs to monitor the degree of implementation of operational plans, and to provide on-site support to staff. In places where Integrated Supportive Supervision (ISS) is practiced, the follow-up visits are incorporated into the ISS process. Quarterly reviews and smaller summits are also organised to generate continued support for the process and to facilitate a process of cross-fertilisation of ideas between the different facilities and LGAs.

STAGE 6
Repeat the process annually and include remaining Districts/LGAs/Boards and facilities in the State

As suggested in stage one, teams or states conducting a PPRHAA appraisal for the first time may consider appraising only a small and manageable number of facilities. Stage six involves a systematic scaling up of PPRHAA coverage to ensure that more Districts/LGAs/ Boards, health facilities and communities are covered. It also includes an annual re-visit to all appraised facilities to conduct another PPRHAA appraisal which allows progress to be tracked.

What Makes PPRHAA Work

Key features include:

- Allowing health managers with limited management, planning or appraisal skills to participate
- Working with facility teams to develop achievable plans
- Objectivity achieved through peer assessment
- A constructive, non-threatening exercise without fault finding
- Comprehensive assessment of the functioning of health facilities
- Focus on strengthening performance output and the systems, procedures and practices of management
- Increases communication within facilities
- Facilitates increased interaction between communities and facilities and opens up the opportunity for more responsive service delivery
- Assists in identifying practical measures to improve performance
- Promotes cross facility learning and sharing of best practices
- Avoids undue interruption of routine health service activities.

4 Each state is divided politically into three zones.

Results

"PPRHAA steered the health sector in the right direction. Before there were so many problems and we didn't know where to begin. If there's anything that I never forget, it will be PPRHAA. Before, we didn't know where to start… PPRHAA encourages community involvement. Communities start to get involved in budgeting and planning. There are community representatives in the HMCs…PPRHAA will be the main tool for listening to the people."

Baffa Mohd, Director of Dutse Gunduma Council

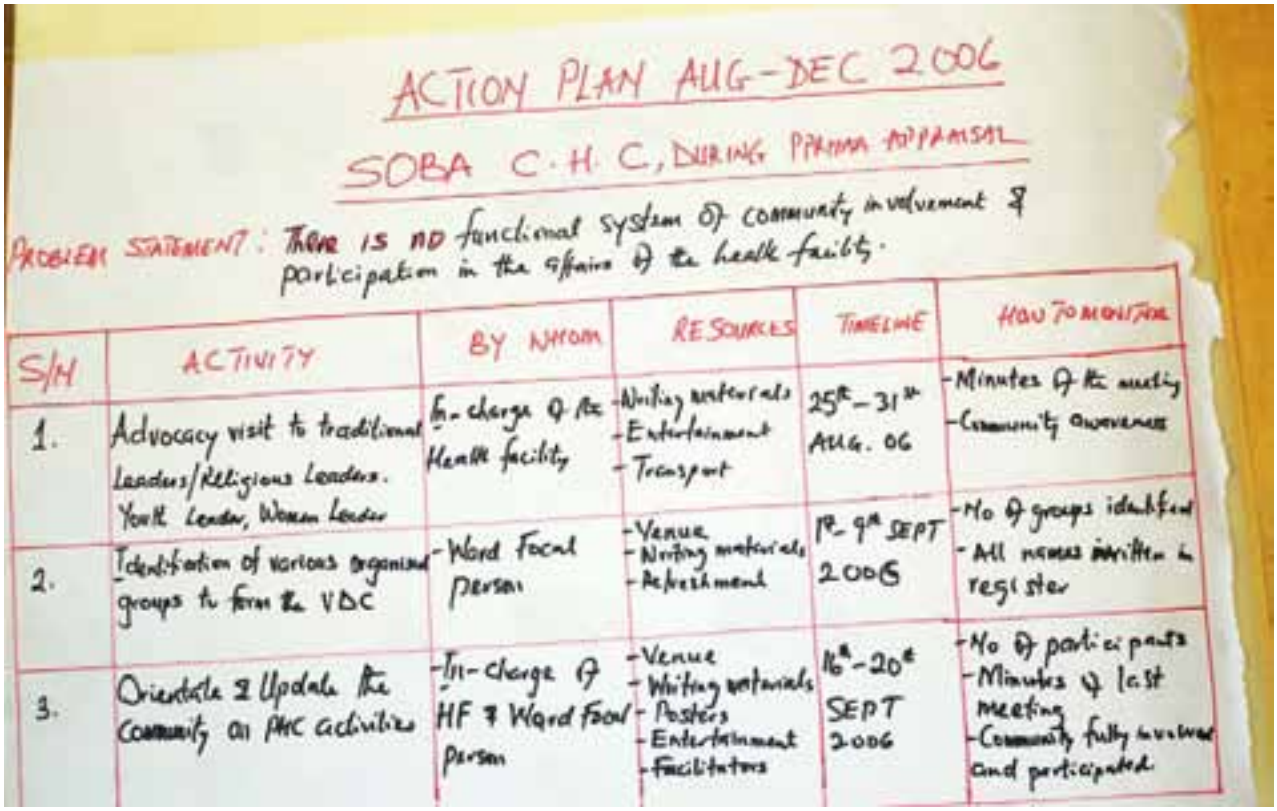
"The gains of PPRHAA are mostly intangible things like improved managerial skills"

Fola Falore, IMPACT focal person, Ekiti State

PPRHAA practitioners were often confronted with the need to clearly outline the 'achievements' of PPRHAA. This was difficult because PPRHAA was not meant to be a 'stand alone' activity whose outcomes could be measurable in the same way as other systemic change interventions. Mechanisms to formally assess the impact of PPRHAA were only being developed in 2008[5]. Therefore, most of what has been identified as resulting from PPRHAA is either based on anecdotal evidence or changes noted by the PPRHAA teams in subsequent years. These have included:

- PPRHAA has promoted attitudinal changes among service providers and managers, by supporting them to understand the situation in which they operate and enabling them to recognise they have the power to effect changes, without waiting for directives. As a result, managers are looking internally at what the problems are and how to address them.
- Most of the facilities implementing PPRHHA have witnessed an increase in utilisation. Whether this was attributable to better collection of data or an increase in utilisation as a result of PPRHAA-related changes or to other systems strengthening initiatives (e.g. establishing DRFs) needs further exploration.
- In the PPRHAA appraisal each facility develops action plans (initially for three months but over time these become for six or twelve months).

5 In May 2008 a proposal for operational research was approved by the Alliance for Health Policy and Systems Research

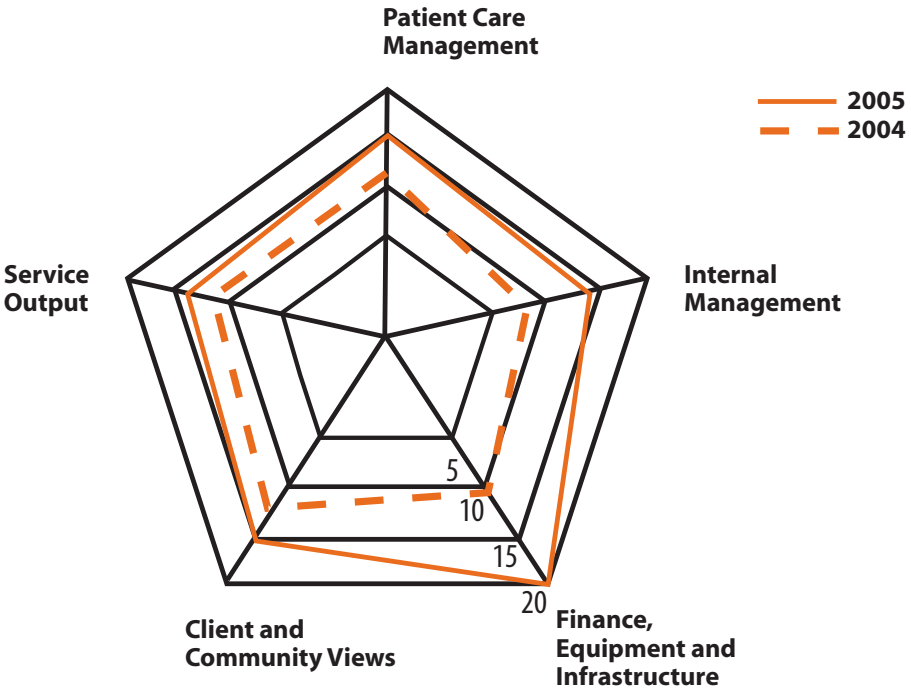

ACTION PLAN AUG-DEC 2006

SOBA C.H.C, DURING PPRHAA APPRAISAL

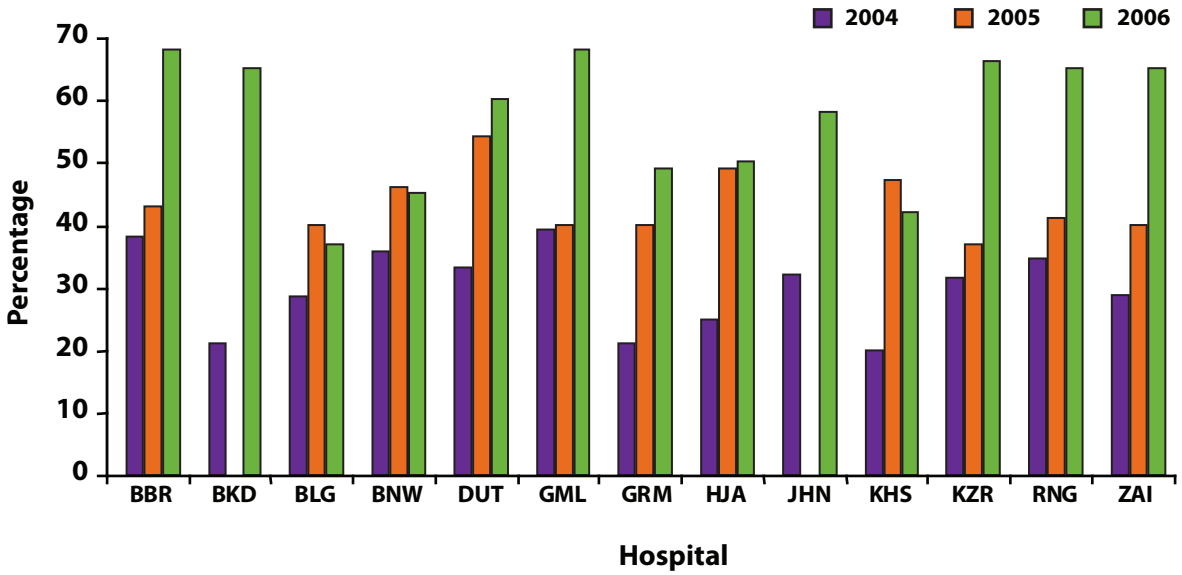
PROBLEM STATEMENT: There is no functional system of community involvement & participation in the affairs of the health facility.

S/N	ACTIVITY	BY WHOM	RESOURCES	TIMELINE	HOW TO MONITOR
1.	Advocacy visit to traditional Leaders/Religious Leaders. Youth Leader, Women Leader	In-charge of the Health facility	-Writing materials -Entertainment -Transport	25th–31st Aug. 06	-Minutes of the meeting -Community awareness
2.	Identification of various organised groups to form the VDC	-Ward Focal Person	-Venue -Writing materials -Refreshment	1st–9th SEPT 2006	-No of groups identified -All names written in register
3.	Orientate & Update the community on PHC activities	-In-charge of HF & Ward Focal Person	-Venue -Writing materials -Posters -Entertainment -Facilitators	16th–20th SEPT 2006	-No of participants -Minutes of last meeting -Community fully involved and participated

Changes in Scores, Ikole Hosital, Ekiti – as measured in the annual PPRHAA exercise



Jigawa Hospital Management Performance Scores, 2004-2006



Improvements in the management of most facilities were highlighted in the annual PPRHAA exercise. The graph shows an improvement in all hospitals over the three year period.

Large numbers of LGAs, PHC facilities and hospitals have been preparing these plans, often for the first time. In addition PPRHAA has catalysed the preparation of facility budgets, which in addition to building the capacity of managers and staff in developing realistic budgets (coupled with realistic plans), has had a positive impact on the wider planning and budgeting processes in the states.

- PPRHAA showed us that women's voices were not being heard. For example, the PHC facility at Tudun Wada, Kaduna was involved in a PPRHAA exercise in August 2006. Male and female community members were interviewed separately during the assessment processes, and the results were very revealing. While men rated the facility's performance on community participation very highly, giving this aspect of facility performance the highest score in the assessment exercise, women gave community participation a zero. The facility responded by appointing four women to the FHC who were encouraged to engage with local women and ensure that their voices were heard.
- Health facilities have increasingly benefited from philanthropic activities and community self help projects.
- PPRHAA summits serve as an arena for bringing policy, management, operational levels and community members together. By attending State PPRHAA Summits and review meetings, top level policy makers get directly involved in discussing challenges and provide the necessary co-operation for taking initiatives forward.
- Significant improvements in facility management have been recorded in PPRHAA facilities as evidenced by improvements in the performance ranking tools and the spider graphs.

Improvements in the management of most facilities were highlighted in the annual PPRHAA exercise. The bar graph on the next page shows an improvement in all hospitals over the three year period.

© PATHS Photographer

Recognising Well-performing Facilities in Jigawa

Challenges and the strategies adopted to address them

Cost/Funding: PPRHAA is an evolving process still being developed and improved by those who use it, in response to the specific needs and peculiarities of diverse institutions. Although the adaptability of PPRHAA is one of its major strong points, each adaptation exercise has made PPRHAA a little more complex with attendant cost implications. This has raised questions about the claim that PPRHAA is simple, affordable and sustainable. To date, most of the funding of PPRHAA events in Nigeria has been provided by development partners. Exceptions included Jigawa State where the State Ministry of Health and State Ministry of Local Government funded significant parts of PPRHAA events; in 2006 after the withdrawal of PATHS funding, Benue Hospitals Management Board was able to organise a PPRHAA exercise for hospitals; and the Ekiti State budget for 2007 had an IMPACT budget line within which PPRHAA was subsumed. However, many states and institutions did not have budget lines for PPRHAA. In order to reduce the costs of PPRHAA exercises and increase sustainability, various steps were taken:

- Encouraging States and LGAs to contribute counterpart funding for the process and providing support to the SMoH to facilitate the

timely release of funds budgeted for IMPACT activities

- Development of LGA/District level teams which enabled team members to work closer to where they were based, thus reducing transportation and other costs

- Reducing logistic costs even further by excluding overnight allowances and encouraging PPRHAA team members to 'come from home' rather than putting them up in hotel accommodation; and direct payment of transport allowances to team members allowing them to make their own transport arrangements to PPRHAA sites rather than hiring cars and buses, often at higher than local rates.

PPRHAA Reports: Typing up and producing PPRHAA reports on time has continued to be an issue. Each facility's appraisal report and plan is typed. When over 100 facilities are appraised this can lead to a lot of paper work. The employment of ad hoc support secretarial staff has proved very helpful.

'Home' for IMPACT/PPRHAA: In order to be owned and sustained, IMPACT processes in general and PPRHAA in particular need to be embedded in the existing structures within each State/institution. Apart from the fact that these structures vary from state to state, capacity and skill gaps may exist in places that would otherwise have served as ideal 'homes' for a component or initiative. PPRHAA practitioners need to be cautious and flexible in supporting stakeholders to find and agree on the most appropriate home(s).

Availability of financial and other data: In general, financial data was hard to come by during the PPRHAA appraisals. Utilisation and other facility records were also either absent, incomplete or incoherent - especially when a facility was being appraised for the first time. Some of these gaps were narrowed through a pre-visit to the facility and reference to HMIS data and other records available at the level to which the facility reports.

PPRHAA data management: At inception, PPRHAA data systems were paper-based and manually handled. Later, specific PPRHAA software was developed, but only a few experts were able to use it. In 2006, it was decided that PPRHAA data should be fed into the DHIS software which had been adopted by the Nigerian Government as the database for the National Health Information System.

Ensuring responsiveness to community views: PPRHAA appraisals face a number of challenges when trying to involve communities and ensure operational plans address their concerns. Few health service staff have experience of working directly with communities in an empowering way. CCVOs therefore need training and field-based support to enable them to work effectively with communities. Logistical difficulties and time constraints during the field often means that the richness of CCVs is not adequately captured in reports and, as a result, evaporates from the appraisal. Finally, it can be difficult to identify suitable community members who can represent the views of the community during the planning of the operational plans and at summits. In some cases, States which have invested in developing Facility Health Committees have found this easier as often community representatives on the Committees have a knowledge base about health issues and credibility within communities.

Lessons learned

- The IMPACT initiative was reviewed annually by a small core team. This review process strengthened PPRHAA through regularly adapting the approach and responding to challenges.

- As part of the PPRHAA quality control strategy, more PPRHAA team members than required should always be recruited. It was also important to develop criteria for assessing PPRHAA team member skills and share the assessments so that team members who perform below expectation could be either supported or dropped.

- The more senior people there were on PPRHAA Teams, the easier it was to 'open doors' to the health service challenges identified through the PPRHAA events.

- Keeping the PATHS consultant team largely consistent across the components of IMPACT was valuable as this enabled trust to be built.

- Getting facility data before the PPRHAA from the HMIS or from the health facility itself, greatly reduced the workload during appraisal visits.

- It proved useful to integrate PHC and SHC PPRHAA exercises. Teams would appraise either PHC or SHC facilities and team membership would span both levels of service.

- Categorising the problems identified during the PPRHAA exercise into "things we can do for ourselves" and "things other people can do for us" led to greater inward reflection by health care providers and communities.
- The attendance, participation and output of top level policy makers at State PPRHAA Summits and review meetings improved due to better planning and keeping the meetings short, focused and small.
- Supportive supervision was better than PPRHAA for team building at facility level. ISS allowed more time for identification of skills and needs.
- Field-based consultant support for PPRHAA teams was essential in the initial PPRHAA appraisals to iron out teething problems at an early stage. The level of consultancy support can taper off during later appraisals.
- Community involvement in the PPRHAA appraisals can be more effective in situations where additional interventions are in place to support community involvement in health service planning delivery. For example, investing in Facility Health Committees can help develop a small number of community members who have a knowledge base about the health system, are in touch with the community about health issues and have credibility both in the community and within the health facility. These individuals can be important voices in the appraisal and also help keep the wider community informed of follow up action from the PPRHAA.

CASE STUDY

PPRHAA and ISS in Enugu State

Annual PPRHAA appraisals were held in Enugu State from 2003 to 2007. In September 2003, three core facilitators from the State were trained. In November/December of the same year, the first PPRHAA appraisal took place - five secondary health care facilities and six primary care facilities. The exercise was supported by a Regional Consultant.

Following the decision to introduce the District Health System (DHS), a major restructuring of the public health system took place in 2005. The DHS was introduced with 56 Local Health Authorities (LHAs) and seven District Health Boards (DHBs) under a State Health Board (SHB). The Ministry of Health was restructured into a Policy Development and Planning Directorate. Against this backdrop, in March/April 2005 the State PPRHAA team was expanded and the third PPRHAA appraisal was undertaken in the context of the re-structured District Health System. The appraisal was DHS-focussed.

Apart from the appraisal exercises, there were ancillary activities that complemented the PPRHAA process. These included: monthly meetings of the PPRHAA team, follow-up visits and quarterly reviews. These commenced in 2004. One key purpose was to review and support the activities identified in the facility action plans. The quarterly review exercises also served as opportunities to build the capacity of the PPRHAA team members in analysis, planning, budgeting, team work, facilitation, presentation, advocacy and report writing skills.

The PPRHAA team members formed the nucleus for introducing Integrated Supportive Supervision. As a deliberate effort to mainstream the roles of IMPACT/PPRHAA team members as 'change agents' or catalysts in their respective institutions, 'Operation Charity' was instituted. Members committed themselves to '3 things I will do to improve the system in my institution during the next 3 months'. The commitments were peer-reviewed at subsequent review meetings. By the end of 2005, the State PPRHHAA team began to show signs of maturity. One of the initial facilitators was invited to provide Technical Assistance to the PPRHAA team in Kaduna State and he has been doing

CASE STUDY

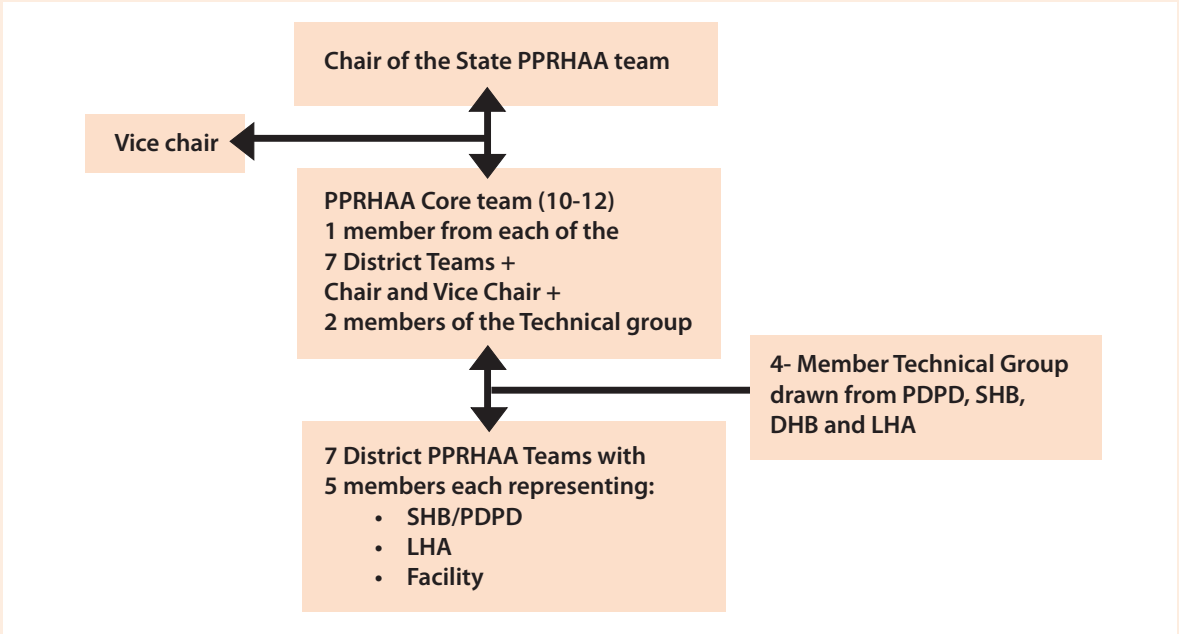
PPRHAA and ISS in Enugu State (continued)

that since 2006. The team also demonstrated increased responsibility for managing the review and PPRHAA processes (e.g. handling logistics, coordinating fieldwork).

A new structure for managing the team was agreed to represent the DHS structure (see diagramme).

In June 2006, the State PPRHAA team was decentralised to seven District PPRHAA Teams. This necessitated the recruitment of more members. The fourth PPRHAA exercise took place in June 2006 and appraised all seven DHBs, six District Hospitals and fifty-two PHC facilities. The last PPRHAA appraisal took place in 2007. This scaled up the number of appraised facilities to 10 per district.

Unfortunately, the seven District PPRHAA Teams set up in June 2006 did not include key functionaries of the District Health Boards - a missing link that began to pose a big challenge to embedding PPRHAA at district level. To resolve this, the State PPRHAA core team decided to expand the District Teams to include the District Chief Executive Officers, Finance managers and the PHC managers. More members were also selected from the facilities or Local Health Authorities to build a large pool of officers for the transition to the introduction and implementation of Integrated Supportive Supervision. This in turn was rolled out in the State in three phases, during 2007. By December 2007, the first state wide ISS exercise was carried out involving all the DHBs and LHAs.



Component 2: Strengthening Systems and Capacity Building

Overview

Over the years, findings from PPRHAA have shown that most of the challenges that lead to inefficient health care delivery in Nigeria are due to weak or non-existent management systems, structures, skills and capacity. *Component 2* identified six *systems* where assistance may be required in developing models that collectively aim at *institutional and management strengthening*. The six systems are:

- Health Management Information System (HMIS)
- Financial Management (including accounting and budgeting)
- Sustainable Drug and Medical Supplies (including DRFs and D&E schemes)
- Internal General Management (including Community Accountability and Performance Management)
- Quality Assurance emphasising a patient focus, clinical quality and Planned Preventive Maintenance
- Human Resource Development and Management.

PATHS strengthened some of the above management systems through four priority health service *programmes;* Emergency Obstetric Care and Safe Motherhood, Integrated Management of Childhood Infections (IMCI), Malaria and HIV/AIDS/STD/TB (HAST).[6]

Each of these systems and programmes are critical for functional health care delivery. However, since the PATHS programme had a limited life-span and funds, states concentrated on addressing their own priorities. For instance Enugu might be way ahead in terms of management of infrastructure and equipment; while Jigawa was strong on Quality Assurance and Ekiti implemented a DRF model that outlived PATHS support. Despite these differences, many of the priority areas (e.g. Health Management Information System, Financial Management, Sustainable Drug and Medical Supplies) were common across PATHS-supported States.

As similar needs emerged across the different states, efforts were intensified to share experiences, good practices and useful models in order to avoid duplication, save costs and speed up roll out across and within states. It was also anticipated that additional states might need to roll out these models in future. It was agreed that this would be much easier if tried-and-tested models for each management system were documented in manuals and guidelines and experienced facilitators were available. Therefore, for several of these priority areas manuals detailing the content and the process of implementation were developed.

6 Service programmes have systems elements. For more details on these programmes see the relevant PATHS Technical Briefs.

CASE STUDY

PFQA - Gumel General Hospital, Jigawa

PFQA started in 2004. There were four members of the PFQA team in the hospital. They held an open day to sensitise the community about their services, how to respond, and to be aware of what was available. *"We wanted to sell our services, to show our services to the community and increase utilisation"* There was a special session at the end of the open day for CBOs, NGOs, state government staff and local VIPs. It provided an opportunity for participants to air their suggestions and complaints. *"They told us their problems with the hospital and we told them our problems with the community".*

"CBOs and NGOs meet weekly at the facility, and participate in the Radio Distance Learning programme. There is always an opportunity for an exchange of views on perceived problems. This is all in the effort to strengthen the relationship. One view expressed for example was that providers harassed members of the community when they used the facility. In response, we said that community members didn't understand that it isn't convenient for any member of the community to enter the facility at any time of day when visiting a patient. We explained the system of visiting hours, and that this system was for the benefit of the patients. There are times when ward rounds are taking place, when drugs are being administered etc, and it isn't convenient to have relatives around at these times. This session helped with the understanding on both sides."

Drama at Hospital Open Day, Jigawa

Methodology/process

Although strengthening systems and capacity building came under component two of IMPACT, most of the systems strengthening was implemented through Technical Assistance by experts outside the IMPACT core team. These experts worked with national/local consultants, developed appropriate tools and materials to fit the local environment, provided the necessary resources and trained the staff involved. Post-implementation support was critical in ensuring sustainability.

An IMPACT review process identified seven basic elements or steps that need to be followed in developing and strengthening the various systems.

PATHS Jigawa had considerable experience in using the steps for implementing various systems and programmes. Rather than use one of the systems to share the step-by-step implementation experience, this brief uses as many of the systems as possible to illustrate the various steps.

Steps to Develop and Strengthen Management Systems

STEP I	System selection /clarification of the purpose
STEP II	Situation analysis
STEP III	Modify/redesign system
STEP IV	Planning the process of introducing the new system including identification of enabling factors
STEP V	Implementation of system in phases (sequence)
STEP VI	Supervision, mentoring and reviews to ensure fit for purpose
STEP VII	Continue support and roll out

CASE STUDY

Strengthening Systems and Capacity Building in Jigawa State

PATHS commenced activities in Jigawa state in July 2002. Over the years, PATHS worked very closely with the Jigawa State Health Sector Reform Forum (HSRF) to explore reasons for the poor performance of the health sector and to identify challenges faced by various key institutions in the state such as the State Ministry of Health, the State Primary Health Care Agency (SPHCA), the Ministry for Local Government (MoLG); Ministry of Women Affairs and Social Development, the Departments of Health (DoH) of selected Local Government Authorities (LGAs), primary and secondary health facilities and various communities in Jigawa. The forum provided support for stakeholder-driven priorities to address the reasons for the poor performance and to address the challenges faced by the health institutions.

The Forum provided strategic guidance, approved and reviewed implementation progress of the various systems strengthening activities supported through PATHS. The systems that were strengthened in Jigawa between 2003 and 2008 included Health Management Information System (HMIS), Financial Management including the budget management system, Sustainable Drug and Medical Supplies and Deferral & Exemption schemes. Others were Internal General Management, Quality Assurance using Patient Focused Quality Assurance (PFQA) as an entry point and Planned Preventive Maintenance in collaboration with the State and Local Government Programme (SLGP).

CASE STUDY

Strengthening Systems and Capacity Building in Jigawa State (continued)

STEP I – *System selection/clarification of the purpose*

The PPRHAA appraisal of 2003 identified the need for a demand-driven and people-centred health care delivery system with built-in safety nets for vulnerable groups like women, children and the poor. The appraisal pointed to the need for the introduction of the systems listed above in order to improve health sector performance. After due consultation with stakeholders and the HSRF, agreement was reached to prioritise the implementation of these systems; and a clear purpose was identified in the Terms of Reference for PATHS technical support which commenced in December 2003:

> "…to kick-start an appropriate approach and institutionalise Quality Assurance (QA) in the health facilities of Jigawa state".

It was this purpose that guided the PFQA work in Jigawa state for almost 5 years of implementation. Similar steps were taken for the other system strengthening initiatives.

STEP II - *Situation analysis*

PPRHAA served as a broad baseline situation analysis in Jigawa. However, whenever an issue needed particular attention, steps were taken to carry out a situation analysis that focused specifically on that issue. One such issue was the institutional analysis of the Jigawa health sector which eventually led to the establishment of the *Gunduma Health System*, in Jigawa.

> It was … decided to commission an institutional analysis of the health system in Jigawa State. The main objective of the assignment was to carry out an evaluation of the health policy-making organisations in the state and draw-up a framework to facilitate locally led and owned reforms that would enable these organs to spearhead transformation of the whole health system in the state.
>
> … The scope of work included reviewing existing documentation, visiting selected health facilities, undertaking structured interviews and discussions with key managers in the Ministries, Departments and Agencies, holding a consultation workshop to present findings and a preliminary draft framework for health sector reform and …
>
> From Rodion Kraus and Kwame Adogboba: Final Report to PATHS on Health Sector analysis in Jigawa; Aug 2003

STEP III - *Modify/redesign system*

PATHS' approach involved working through consultants and very closely with the stakeholders themselves. Together they participated throughout the development of systems, implementation and monitoring. This approach ensured that the system templates were modified and tailored to address the peculiarities of the focal LGAs in particular and Jigawa State in general.

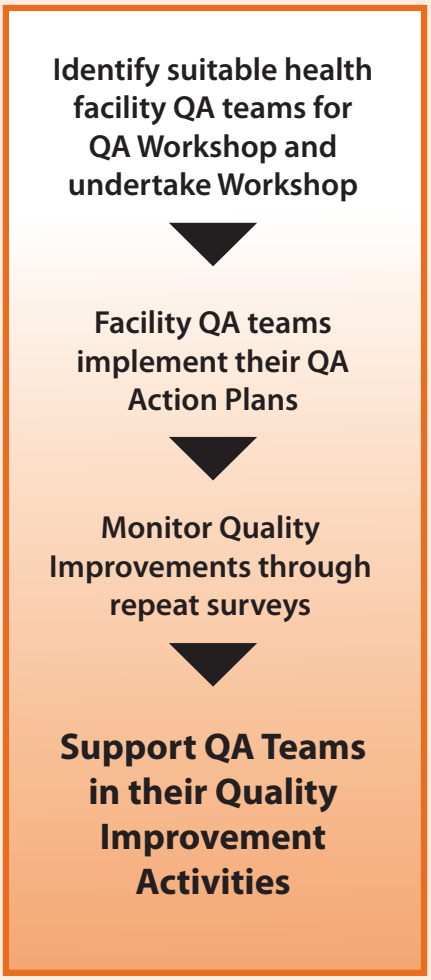
CASE STUDY

Strengthening Systems and Capacity Building in Jigawa State (continued)

STEP IV - *Planning the process of introducing the new system*

As noted earlier, PATHS worked very closely with the Jigawa State HSRF which provided strategic guidance, approved and reviewed implementation progress of the various systems strengthening activities. Part of the information the Forum required before approving a systems strengthening initiative was a clear outline of the steps for implementation, including how the system would be introduced. The common steps involved consultations with key stakeholders; development and presentation/ review of the systems framework; deciding on an institutional 'home' for the system; deciding on the coverage (pilot/roll-out) and agreeing on the implementation work plan.

The Process of Introducing Quality Assurance in Jigawa State



STEP V - *Implementation of a system in phases*

PATHS in Jigawa made significant strides in supporting the State to strengthen the HMIS system. The support was implemented in a phased manner and aimed at providing technical and material support and building local stakeholder capacity to lead, manage and drive the process. For HMIS the focus was to (1) improve reporting rates, (2) help the managers in the health sector to use information to improve service delivery, (3) decentralise data capture to zones, and (4) support the development of a group of HMIS focal persons at the zonal (Gunduma) levels. The implementation of each phase was characterised by focused training events, hands-on support and periodic reviews. For instance, the Jigawa HMIS Work Plan for June to December 2004 included follow-up visits to collect outstanding data, quarterly meetings of M&E officers to review HMIS activities, facility level re-training on HMIS and advocacy to the Ministry for Local Government by SMoH and PATHS.

CASE STUDY

Strengthening Systems and Capacity Building in Jigawa State (continued)

STEP VI - *Supervision, mentoring and reviews to ensure fit for purpose*

In Jigawa, management capacity was built through targeting senior health managers in the State Ministry of Health, Local Government Service Commission, PHC Agency and Health Management Committee members. This process served as a model for ensuring appropriate supervision and mentoring across all initiatives.

The managers were trained to prepare facility and ministry plans, budgets and supervisory schedules. Supervisory tools were developed and they were trained to effectively supervise lower level managers. In addition, the management training included developing projects to address specific needs and challenges within the participants' own workplaces. Projects were then followed through as part of the training modules. Moreover, the process had an in-built component on monitoring and support during the implementation phase. The key elements included:

- Internal review meetings for the teams to assess their own performance and further clarify roles and responsibilities where necessary
- Use of local facilitators for following up and reminding their colleagues about deadlines and applying "soft pressure" on the teams to get them to meet and review implementation of their plans
- Retired or serving senior managers who had a good track record and were willing, provided mentoring support to teams during the implementation stage
- Consultants visited during the implementation phase to assess progress and provide support to teams.

STEP VII - *Support and roll out*

The implementation of each of the systems started with 'manageable' numbers of health facilities and LGAs. The table gives an overview of the extent to which some of the systems were able to roll out.

Roll out of systems in Jigawa State

SYSTEMS		Start date	Status at inception					Status at the end Dec 07				
			#LGA	#Districts (Gunduma)	#PHC	#SHC	#total Facility	#LGA	#District* (Gunduma)	#PHC	#SHC	#total Facility
PFQA		Dec. 2003	6	2	2	5	7	18	6	11	12	23
HMIS		Dec. 2003	8	3	180	6	186	27	9	495	14	509
DRF	PHC	Jan. 2006	3	1	38	NA	38	23	8	132	NA	132
	SHC	Jan. 2005	8	3	NA	8	8	12	5	NA	12	12
D&E		Mar. 2005	11	4	3	8	11	17	6	9	8	17

Challenges:

- Most of the systems strengthening initiatives were implemented through Technical Assistance provided by a wide range of experts. Consequently, ensuring synergy and coordination was difficult.
- Each system strengthening initiative had a capacity building component which targeted the key cadre of staff that delivered that system. HMIS for instance, focused on M&E officers and Financial Management focused on accountants and finance officers. With weak internal management systems for coordination of facility and ministerial activities, these initiatives almost became vertical programs in the eyes of stakeholders requiring extra efforts to ensure synergy and sustainability in the health sector.
- Shortages of staff, poor mix of skills and a tendency to relapse to old practices needed continuous strengthening to reinforce the newly acquired knowledge.
- The frequent changes in the political leadership at LGA level were also issues confronting sustainable system strengthening and change that required high level political buy-in and interest.
- Development partners continued to push parallel programmes which conflicted with some of the systems strengthening efforts.

Lessons learned

Systems, no matter how well designed can achieve little if there is a dearth of capacity to manage new initiatives or existing systems. A recent IMPACT review meeting[7] concluded that more attention was given to systems development and implementation than to build the capacity to manage the systems. In future, priority needs to be given to developing the management capabilities of facility managers and build their capacity to integrate implementation of systems strengthening initiatives.

7 Draft report on the impact review meeting, Accra, 5th – 7th March 2008

Component 3:
Integrated Supportive Supervision (ISS)

Overview

During the PATHS project, the State health sector in collaboration with partners was supporting various health initiatives and programmes aimed at improving health care delivery. These included routine immunisation, family planning, HIV/AIDS, DRF, IMCI, HMIS, D&E, Safe Motherhood, infection control. Most of these initiatives had separate supervisory arrangements for health facilities implementing them.

Integrated Supportive Supervision (ISS) was a unitary supervisory system which used a common checklist and reporting format based on a harmonisation of the major indicators from as many initiatives/ programmes as possible. It was driven by a common supervisory team with skills in the supervision process and the analysis and use of the data collected for decision making. ISS ensured that state and LGA managers were in the field supervising on a regular basis (monthly to quarterly). To accommodate the needs of different programmes, each integrated supervision visit had a different programme focus in addition to general supervision; and problems identified in the general supervision were referred to the appropriate programme managers. Some of the benefits of the Integrated Supportive Supervision model included:

- Ensuring a common approach and model to supervision
- Reducing the cost of supervision and monitoring as vertical supervisory activities were phased out.
- Increasing staff attendance at work as frontline staff involved in the different programmes no longer had to attend multiple monitoring events
- Reducing provider fatigue as they were no longer subjected to multiple supervisory visits
- Improving quality of care to clients of health services as providers spent less time attending to multiple supervisory visitors

Discussing ISS data in Jigawa

- Improving the working relationship between different programme staff
- Enhancing synergy and sustainability in the sector.

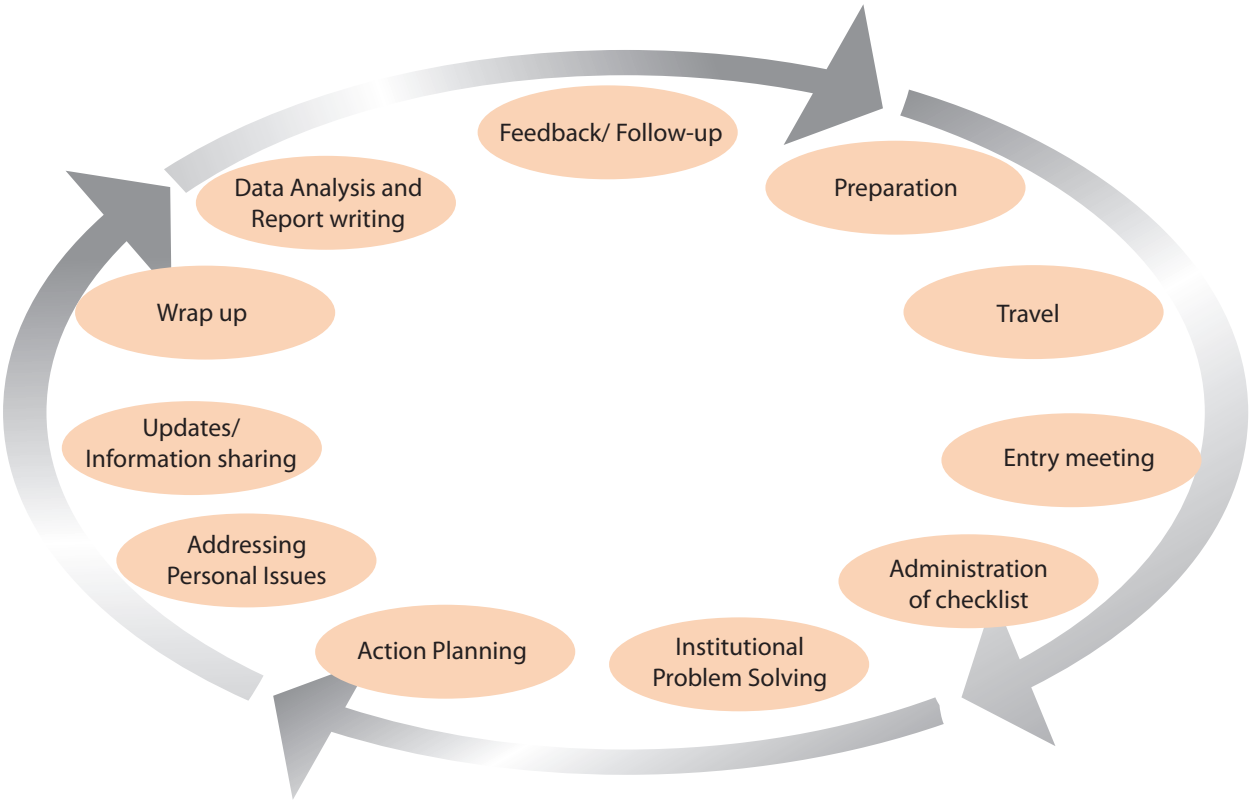
Methodology/process

The first stage in introducing the ISS process commenced with the decision to adopt ISS by a state and the relevant LGAs. Usually, this would entail consultation and consensus meetings with senior managers of the LGSC, SMoH and HMB. It was also important that all development partners such as HSDP II, WHO, UNICEF participate in the decision making process. Once all stakeholders subscribed to the common system, they needed to decide on a 'home' for the initiative and develop the ISS framework - agreeing on the management structure, supervisory levels and frequency. They also needed to decide on how many LGAs and health facilities would pilot ISS and how many of them would be ultimately covered. As with PPRHAA, a state initiating ISS usually required some consultancy support to get to grips with the methodology.

During the second stage, the consultants, in conjunction with key stakeholders identified the members of a common supervisory team - usually made up of Programme Officers who had hitherto been involved in the supervisory activities of the health sector. Later in the PATHS programme, community representatives were also involved in the ISS team, thereby maintaining community involvement in health service planning and delivery initiated in PPRHAA. The PPRHAA team needed to integrate with the new team. The combined teams were supported to develop a common checklist, skills in the supervision process, and skills in the analysis and use of the data collected. Thereafter, the supervisory visits to LGAs and health facilities commenced. At this stage, it was recommended that the initial focus should be on these two supervisory levels[8]. While the state level team was an integrated PHC and SHC team, the LGA team for first level supervision was a PHC LGA team only. Collaboration between the two teams was imperative.

Each supervisory visit to a health facility included review, problem solving, training and information sharing. The teams used the eleven step supervision cycle as a guide for their visits to facilities.

The Eleven Steps in the Supervision Cycle



8 In states that have districts or Gundumas, the system is adjusted accordingly.

CASE STUDY

Building and Sustaining Integrated Supportive Supervision in Ekiti State

The Ekiti SMoH in collaboration with PATHS had supported various health initiatives aimed at improving health care delivery in the state. They included PPRHAA, DRF, IMCI, HMIS, D&E, SMI, IC. Each of these initiatives had separate supervisory arrangements. The State started ISS in September 2005. The framework, checklist and reporting formats were developed in consultation with all state role players including state programme focal persons, and PPRHAA team members for primary and secondary care facilities; and piloted in 3 LGAs. By the end of 2006, integrated monitoring, supervision and support had been institutionalised in the health system and the process rolled out to all LGAs in the state.

The supervisory tools harmonised the major indicators from the different initiatives into the checklists. LGA and State supervision teams were formed and team members were trained to use the tools and in general supervision skills including data analysis and use of data in decision making. LGA teams, regarded as the most cost effective way of supervising PHC facilities, do monthly visits while the state teams do quarterly visits. Based on the time allocated to each facility and LGA, state teams supervise each hospital twice in a year and each LGA once in a year. Ekiti has established 3 state teams, one covering each zone, because covering the whole state with one centrally-organised state team did not work well.

PATHS Ekiti closed its office in December 2006. Over a year later, between February 14th and March 5th 2008, the SMoH in Ado-Ekiti undertook an integrated supportive supervision visit to six SHC and 12 PHC facilities located in six LGAs spread across the three Senatorial zones of Ekiti State. The process, which involved ten members of the trained state team, included pre-planning, preparation, field visits and report writing. The Ekiti State HSDP II purchased two buses to facilitate the supervisory visits.

The Ekiti ISS Team Compiling Reports

One of the New ISS Vehicles Purchased by HSDP II, Ekiti

Photos © Folake Falore

Challenges

- There was a need for ongoing training as new members joined the team
- Senior officials were often called away for high level meetings, etc. which disrupted the team and the visits, yet their participation added greatly to the value of the exercise
- Most of the recurrent funding for transport and allowances came from partners, and might not be immediately available from state and LGA budgets to sustain supportive supervision. In the long-term, capital funds for vehicles also need to be secured.
- New programmes, particularly from different agencies and donors, usually want to organise their own separate systems for follow-up so it was often difficult to persuade them to join a common effort.
- ISS does not allow for an in-depth assessment of particular systems. When new systems are being introduced, the general ISS checklist may need to be complemented by an in-depth assessment of the new system.

Results

Feedback to frontline staff on findings of supervision and monitoring activities was increasingly becoming institutionalised through the process, as frontline staff were encouraged to seek feedback and managers were equally encouraged to give feedback.

At least as important as improved planning and budgeting has been the follow-up of these plans and budgets that PPRHAA initiated. ISS was successful in helping ensure that plans are turned into action.

Lessons learned

- ISS can only succeed if it is embedded within State and LGA structures and driven by their functionaries.
- When each supervisory visit focuses on a particular initiative (e.g. DRFs or immunisation), it ensures that different areas can get in-depth attention from time to time.
- When supervisory teams include some senior health officials who are directly linked to state bodies, issues identified during the supervisory visits are more easily addressed.
- Checklists for the supervisory visits should cover the important areas but should not be overly long or complicated. Getting managers into the field is often more important than using a checklist.
- Involving community members in ISS teams is an important means of strengthening community involvement in health service planning and delivery and enhancing the accountability of health providers to communities.

Component 4:
Quality Assessment and Recognition (QAR)

Overview

PATHS worked with stakeholders and local partners and made extensive investments to improve the Nigerian Health System. Concurrently, a number of state initiatives were focused on demand creation for increased service utilisation and community involvement in service delivery and management. Many of these processes and activities focused on improving the quality of health services. But they also created demand for quality services and increased expectations among providers, community members and stakeholders.

About three years into the implementation of the first three components of IMPACT, the fourth component – Quality Assessment and Recognition (QAR) was approved, in May 2005. QAR is an approach to assess, recognise and promote quality improvements within health facilities. In this component, facilities performing well are benchmarked using an assessment tool and if the recognition 'bar' is achieved they would be publicly recognised and promoted.

Following this, the key role of ISS in supporting QAR was agreed.

> …"an integrated support and supervision process in each state and at LGA and facility level will assist facilities to implement their plans, build their systems and work towards achieving quality indicators and recognition. This will include tools for integrated supportive supervision and including among other things, the quality indicators so that facilities can determine where they are in relation to the identified targets"
>
> *QAR meeting October 2005*

Because of the strides Ekiti State had made with the first three components of IMPACT, it was decided to develop the assessment tools for QAR and pilot them in Ekiti. Similarly, the recognition framework and tools were pre-tested in Ekiti. Using the integrated supervision manual, indicators for quality recognition were developed. The piloting occurred towards the middle of 2006 which unfortunately left little time for Ekiti to enjoy the fruits of the Quality Assessment and Recognition Component of IMPACT[9]. Following this, the PATHS programme in Kaduna State decided to build on the Ekiti foundation and thus became the first State in Nigeria to roll out the QAR model.

Methodology/process

The QAR User's Guide (2006), identified a step-by-step procedure for effective administration of the QAR process and developed tools to assess quality of care at health facilities. The four major components of the process are *planning, implementation, reporting and recognition* steps.

PLANNING STEP

The planning step is facilitated by an independent senior body (QAR Committee) at state level made up of respected individuals who are seen as objective and independent, so they give credibility to the process. Specific activities include:

Facility selection and notification

They compile a list of health facilities to participate in the QAR assessment, based on predetermined criteria. PPRHAA data was utilised by the pilot team and found to be useful. The facilities are notified and expected to confirm the dates for the assessment visits in writing, no later than two weeks prior to the date of assessment.

Setting up assessment teams

The QAR Committee identifies members of an operational level team to carry out the actual assessments. The operational team is made up of several smaller assessment teams. Each assessment team has a team leader and is made up of three members with complementary community development, clinical and health information skills.

9 The PATHS programme in Ekiti closed in December 2006

It is helpful for all team members to be familiar with the PPRHA process.

Production of assessment tools

Assessment tools for secondary and primary health care facilities produced in sufficient numbers for the team training, field-testing and actual facility assessment visits.

Training/Orientation of team members

This two-day training/orientation should be conducted at least 3 days prior to the first QAR visit. An additional day is dedicated to field testing the tools.

IMPLEMENTATION STEP

The facility assessment visit includes a brief entry meeting, administration of the tools and providing feedback to the staff. At the end of the assessment, the QAR team members briefly compare notes and ensure that all indicators have been assessed; discussing any unusual situation or findings that might have arisen. The visit ends with an exit meeting with the facility management. The QAR tools assess 3 major sets of indicators which include:

- Client and Community Indicators
- Patient Care Management Indicators
- Management Indicators

Some of the indicators carry absolute scores while others carry regular scores. Indicators with absolute scores carry a higher scoring significance and must be present for a facility to be recognised for quality care.

REPORT WRITING STEP

This step involves the post-assessment review during which team members work together to determine the overall QAR tool score for each facility. They also write a brief report on issues/concerns not captured by the assessment instruments. Team leaders then submit their reports to the committee for ratification of the QAR assessment results upon which the recognition process is kick-started.

RECOGNITION STEP

This step consists of activities associated with the recognition, promotion and public rewarding of facilities, communities and individual providers after their facility has been found suitable to receive a "brand" of recognition. This ensures that the public can easily recognise where to go for good quality care. Recognition should happen at various levels: facility, community, and Health Management Committee (HMC); and could include exemplary community leaders, HMC members and other personalities. Recognizing the effort of all these social actors contributes to the process of social and behavioural change. Those that do not succeed the first time will be assisted to improve their performance, including receiving a "qualitometer" to indicate their progress.

Qualitometer and Plaque

Results

At the time of writing this brief, Kaduna State had just completed the first three steps of the QAR process and was preparing for the fourth step.

In May 2008, Kafanchan and Dr Gwamna Awan General Hospitals, recipients of the excellent award for quality health services celebrated with a public recognition event. The first of its kind, the event attracted large crowds (over 450 and 350 respectively) with formidable representation from the Kaduna State Ministry of Health, the private sector, staff of the health facilities, Royal Fathers and community members. This award included a qualitometer with an excellent rating, and signage located at the entrance of the health facility. Awards (certificates) were given to three units within each health facility, while four individuals (facility staff and community members) received plaques. The public event was covered live by radio and television, and by radio magazine and interview programs before and after the event. During the event the facilities were encouraged to build on their strengths and do all within their power to overcome their weaknesses and turn them into strengths.

While the facility management and staff could not hold back their pride and joy, they expressed their strong determination to "hold on to this position of excellence and not let go, no matter how tough it may be". In addition, the Commissioner of Health charged management and community members to "work hard towards addressing the weaknesses and jealously guard this position of excellence so that nobody takes it away from you"

The technical assistance report of the team that supported the piloting of the QAR assessment tools in Ekiti noted that:

"The QAR Pilot has been well received by the facilities. Facility management and staff feel that QAR is "added value," as it provides a supportive external assessment of their services, highlighting quality performance and identifying areas for continued improvement. An indication of the value placed on the QAR process is the numerous requests made for quarterly facility QAR assessments, rather than the annual QAR planned."

© Kolawole Maxwell

Kafanchan award ceremony

Challenges

Anticipated challenges for QAR included (1) how to communicate to the community and facility staff that the emphasis was not on the prize or the competition but rather to reward and appreciate efforts and ensuring that every facility can attain the quality level for recognition, and (2) developing mechanisms for embedding the QAR component within the States.

> "QAR is not meant to merely engender competition but to motivate ALL facilities in Kaduna State to provide qualitative health services..."
>
> *Alhaji Mustapha Jumare, Director of Nursing Services & Chair of QAR Committee, Kaduna State Ministry of Health*

Lessons learned

- Facilities must be assisted through Components 1, 2 and 3 (of IMPACT) to set up systems and procedures that will allow them to achieve the standards required for QAR.
- Sustainability of the QAR initiative and the performance of the recognised facilities must be linked to continued support and supervision.
- QAR may only succeed if quality service provision is made a valued "political commodity".
- The selection of recognised facilities must be seen as an objective and independent process.

CASE STUDY

QAR in Kaduna State

The Partnership for Transforming Health Systems (PATHS) commenced its engagement in Kaduna in March 2006. Less than six months later, in August 2006, the office supported the National Primary Health Care Development Agency (NPHCDA) and Evangelical Church of West Africa (ECWA) to implement the PPRHAA methodology in their facilities. NPHCDA implemented the initiative in seven LGAs and 55 PHC facilities and ECWA in three ECWA health districts and 12 ECWA facilities. The second PPRHAA annual exercise took place in August 2007 and involved 100 facilities including hospitals.

PATHS also supported systems building activities (component 2) to enable health facilities to deliver quality services in the State, including the free Maternal and Child Health policy. In May 2007, Integrated Supportive Supervision (component 3) was piloted in three Local Government Areas. It has now replaced the quarterly PPRHAA follow-up and was the key mechanism used to identify facilities to be assessed for QAR. QAR was rolled out in Kaduna State in March/April 2008.

QAR in Kaduna State was driven by a small coordinating body headed by the Director of Nursing Services in the State Ministry of Health. There was also an operational level team made up of 28 technical staff drawn from the State Ministry of Health and the State Ministry for Local Government. This team was actually an enlarged version of what used to be the Quality Assurance team of the State Ministry of Health. The team attended two training events led by external facilitators between December 2007 and February 2008 and undertook 2 trial facility visits before undertaking the actual appraisal visits in March 2008.

> "we are happy to be the best qualified General Hospital for recognition. Any hospital aspiring to beat us in next year's QAR exercise must brace up, as General Hospital Kafanchan intends to break the record it has set this year"
>
> *Dr Samson Mafori Dogo, Chief Medical Director, General Hospital Kafanchan*

A total of 25 health facilities were appraised, including eight hospitals and 17 Primary Health Care facilities spread across six Local Government Areas. The appraisal tool for hospitals differed from the one used for Primary Health Care facilities. However, each tool assessed Patient Care Management, Client and Community Views and Management. A post assessment review took place to compile the scores for each facility and to write a brief report on the exercise. Kaduna State held a QAR results Dissemination and Validation meeting which proved very useful. The meeting involved the heads of all the appraised facilities, the Heads of LGA Primary Health Care departments whose facilities were appraised and the QAR team. The meeting validated the findings and approved the recognition of two Hospitals i.e. General Hospital Kafanchan and General Hospital G/Awan. Unfortunately, no PHC facility qualified for recognition.

Partnership for Transforming Health Systems (PATHS)

PATHS is a programme of collaboration with Nigerian partners to develop partnerships for transforming health systems in Nigeria. It is funded by the UK Department for International Development (DFID).

The PATHS Programme is managed by an international consortium on behalf of DFID. Members of the consortium are: