REPORT OF ASSESSMENT OF THE OUTPUT AND OUTCOME OF THE ADVOCACY VISIT ON HEALTH SECTOR REFORM TO ABIA STATE BY THE HONOURABLE MINISTER OF HEALTH

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1.2 ABBREVIATIONS AND ACRONYMS

ABHSDP II	- Abia Health System Development Project II
CFH	- Commissioner for Health
HERFON	- Health Reform Foundation of Nigeria
HMB	- Hospitals Management Board
HMOH	- Honourable Minister of Health
HOD	- Head of Department
HSR	- Health Sector Reform
HSRP	- Health Sector Reform Programme
LOC	- Local Organizing Committee
MDGs	- Millennium Development Goals
MOU	- Memorandum of Understanding
NANNM	- National Association of Nigerian Nurses and Midwives
NCH	- National Council on Health
NLC	- Nigerian Labour Congress
NMA	- Nigerian Medical Association
PPP	- Public Private Partnership
PSN	- Pharmaceutical Society of Nigeria
SMOH	- State Ministry of Health

1.3 ACKNOWLEDGEMENTS

This assessment was made possible through the indefatigable efforts of several individuals and organizations. But appreciation goes first to the Abia state Honourable Commissioner for health, Dr Chika Emuchay who though was not in office at the time of the Minister’s visit, ensured that the assessment was successfully conducted in the state. We also appreciate the efforts of the ABHSDP II programme manager, Dr Okey Madukwe and NANNM State Chairman, Mrs Lovina Ijeoma and our field assistance who helped to identify and track down the respondents. We equally wish to acknowledge the efforts and support of HERFON head office staff. We thank all the respondents who took part in this assessment for their time and cooperation.

To our families, we acknowledge your support and endurance of our absence while running around for this project.

Finally we continue to express our eternal gratitude to our Almighty Father and Creator for his mercies.

1.4 EXECUTIVE SUMMARY

The second phase of the communication component of the HSRP is known as 'making it happen" – this involves widening the discussion on the HSR process to the general public. As part of this, the HMOH is to undertake advocacy visits to all the states with the objective of bringing into the public domain the issues, purpose and benefits of HSR through interactive and participatory sessions with stakeholders in health care delivery at state levels. The ministerial visit to Abia state took place on 14th and 15th of June 2005.

The purpose of this study was to use a survey instrument to establish the degree of reception and understanding of the Minister's advocacy message; to establish what HSR friendly actions have been taken by the states visited; to identify gaps and challenges if any; and to recommended implementable practical solutions.

16 respondents were interviewed during the study. Most of them were aware of the visit and have an idea of what the HSR is all about but only few could state the strategic components. Some of the areas they sought for clarification include resource availability/health sector funding, stewardship role of government and promoting effective partnership and coordination.

Not much has happened in terms of HSR friendly follow-up activities since the ministerial visit. The state is yet to develop an HSR strategic plan. There is no health policy as well as health bill. This is not surprising as almost all the key officers of the SMOH (which should be driving the process) who were present during the visit have been posted out as part of the State's civil service reforms.

The visit though well received and highly appreciated was considered to have been too short in duration to accomplish all it set out to achieve. Inadequate budgetary allocation/none or late release of budgeted funds for health services/programmes, corruption and lack of transparency in government transactions as well as lack of political will to address health problems particularly at state and LGA levels are some of the gaps and challenges the HSRP will need to overcome to achieve its objective.

Recommendations

1. Mass media campaigns and focused workshops on the strategic thrusts of HSR in the state so as to increase the knowledge and perceptions about HSR and to get the stakeholders to become active change agents. There should be a cascading of the workshop by the SMOH to LGA and the community level.
2. Advocacy visits/contacts should be undertaken to the executive at the Federal, State and LGA level to allocate/release more funds to the health sector.
3. Recruitment of skilled manpower and staff audit of people with the relevant skills to implement and manage the HSRP including the designation of a desk officer.

4. A wider representation of stakeholders in the planning of the visits should be ensured and adequate time should be given to mobilise local stakeholders before either the HMOH or his representative visits.
5. In order for the workshops to be more successful in the future, the FMOH should ensure that they have enough workshop materials (at least for 200 people). If possible, a "John the Baptist" should visit the state from the FMOH and ensure that adequate preparations have been made and that all major stakeholders receive the workshop materials before the workshop. This will enable them to study them and raise pertinent issues during the workshop.
6. There should be sustained visits to states by either the HMOH, Hon Minister of State for Health or another high level officer from the FMOH on HSR.
8. There should be accelerated implementation of HSRP by the FMOH to serve as an example to states and LGAs and to convince the people that it is real. "Seeing is believing".
9. The FMOH should establish and implement a strategic framework for capacity building on HSR planning, implementation, monitoring and evaluation for the states and LGAs.
10. A committee in which all stakeholders should be represented should be set up to oversee the HSR programme. This committee should be chaired by the honourable Commissioner for health.
11. States should be requested to send progress report on the HSR to the NCH detailing verifiable activities and achievements.

2 INTRODUCTION AND BACKGROUND

The Health Sector Reform Programme, (HSRP) is a 3-year strategic plan response to the poor performing Health Systems in Nigeria, which resulted into deplorable health status of Nigerians, has 7 core components. Communication and Monitoring and Evaluation the 8th and 9th components respectively are over-arching.

The communication component has 3 mutually reinforcing activity phases namely:

1. **Engagement** – Get all the key stakeholders involved in the discussions of the HSR process, working through institutions, associations, private sector and non profit groups.

2. **Making it Happen** – Once the process of discussion and institutional engagement has gotten under way; widen the dialogue to the general public.

3. **Seeing is Believing** – Once improvements in the health system (both public and private) are well under way, demonstrate the differences and promote demand for quality and equitable services.

The HMH advocacy visits to all states of the Federation falls within communication phase of **"Making it Happen**".

The Objective of the visits is:

"To bring to the public domain the issues, purpose and benefits of HSR through interactive and participatory sessions by the HMH with (both primary and secondary) stakeholders in health care delivery at state levels"'

The Outputs are:

1) The HMH advocacy visit.
2) Successful workshop in line with the Programme made available to all states.
3) A state's ministerial visit report, that includes the workshop proceedings and also contains the State Health Plan of action for HSR, that was generated at the workshop which took into consideration the 7 strategic thrusts.
4) A communiqué.

The Expected Outcomes are:

1) Key public and elected officers knowledgeable about issues, content and context of HSR.
2) Actions being taking to institutionalize HSR and operationalize the state health plan.
3) Increase in consumer awareness about HSR.
4) Political will and commitment at the highest level of Government.

5) MDGs compliant in implementation strategies and service delivery.

The Ministerial visits commenced in the South East geo-political zone in the month of June 2005 and the HMOH visited Abia State on 14th and 15th of June 2005, hence this project.

3.1 THE PROJECT AIMS AND APPROACH

The purpose of this study was to use a survey instrument;

1. To establish the degree of reception and understanding of the Minister's advocacy message
2. To establish what HSR friendly actions have been taken by the states visited
3. To identify gaps and challenges if any
4. And to recommend implementable practical solutions.

The consultant was the in the state on 25th October 2005 to brief the officials of the Ministry of Health on the project. The consultant met and briefed the Honourable Commissioner, Dr Chika Emuchay who is new in office as Abia State had no executive council at the time of the Ministerial visit. The PS who was in charge of the ministry at the time of the visit and served as the LOC chairman has been posted to another Ministry and only 2 of the directors (Administration and Nursing) who were in the Ministry as at the time of the visit are still there. The rest including the DPRS who served as the secretary of the LOC have been posted to other Ministries or schedules in the state. This was said to be part of civil service reforms in the state. The 2 directors who were not moved claimed not to have been involved in the arrangements for the visit. The Hon Commissioner directed the DMS who was also acting for the PS, to facilitate the project in the state and supply the information requested on behalf of the LOC. However, up till the time the field work was concluded, the list of invitees, attendance list and report of the workshop could not be found though the communiqué was obtained from one of the participants.

In the absence of the lists of invitees and participants, the guideline on who should have been invited was then used to trace the participants and administer the questionnaires.

The data generated from the field work were analyzed manually.

3.2.3: Limitations

1. No baseline study before the honourable Minister's visit. Hence, the finding from this study cannot with all certainty be attributed to the visit.
2. There was no prior mobilisation of the states for the assessment
3. No provision for research assistants
4. Duration allowed for the study was too short, considering the length of time that it takes to locate and interview one person.

3.3 PROJECT FINDINGS

3.3.1: Characteristics of the respondents

A total of 16 respondents of which 9 or 53.3% were male and 7 or 46.7% female were interviewed. 6 or 37.5% were from ministries, 5 or 31.5% from other agencies, 3 or 18.8% from professional association and 2 or 12.5% from board/parastatals. 10 or 62.5% were directors/HODs from both State and LGAs, 5 or 31.5% were from other categories and 1 or 6.3% was a supervisory councillor. This sample size represents 16% of the expected participants but because the state could not produce the list of invitees or participants it is not possible to determine what percentage of the actual participants this represents.

3.3.2: Awareness of the Ministers visit

All the 16 or 100% of the respondents were aware of the visit. 9 or 56.3% was by written invitation, 5 or 31.2% got their invitation through the media and 2 or 12.5 % by oral invitation.

3.3.3: Knowledge and perceptions of health sector reform

8 or 50% had some idea of what HSR is, 4 or 25% of the respondents could explain correctly what HSR is while the remaining 4 or 25% had no idea of what the HSR was all about. 8 or 50% of the respondents could not state any component of the HSR, 5 or 31.2 % correctly stated all the strategic components of the HSR, 2 or 12.5% could state less than 4 and 1 or 6.3% could state more than 4 components.

3.3.4: Area of HSR where clarification is needed

Areas of the HSR which respondents indicated that they needed more clarification were;

- Resource availability/Health sector funding – 2 or 12.5% of respondents
- Stewardship role of government – 2 or 12.5% of respondents
- Promoting effective partnership and coordination – 2 or 12.5% of respondents
- Reducing disease burden – 1 or 6.3% of respondents

3.3.5: Possible gaps to HSR implementation

Possible gaps to the to the implementation of the HSR programme were identified as;

- Inadequate budgetary allocation to the health sector – 5 or 31.3% of the respondents
- Government mustering the political will particularly at the state and LGA level to carry the reform through – 2 or 12.5% of respondents
- The HSR programme is being planned and implemented in a top-down manner – 1 or 6.3%
- Poor information dissemination about the reform programme particularly at the grass root level – 1 or 6.3% of respondents

3.3.6: Possible challenges to the HSR

Possible challenges to the implementation of the HSR programme were identified as;

- Ability to mobilize enough funds for the programme – 4 or 25% of respondents

- Bringing about attitudinal/behavioural change among all stakeholders in the health sector and society at large – 3 or 18.8% of respondents
- Corruption and lack of transparency in operations – 2 or 12.5% of respondents
- Continuation of the programme after possible change in leadership – 1 or 6.3% of respondents

3.3.7: Suggestions on overcoming the gaps and challenges

The respondents made recommendations on ways of overcoming these gaps and challenges. These include;

- Sensitization and mobilization of support for the programme from every stakeholder and at every level – 5 or 31.3% of respondents
- Transparency in the operations of all tiers of government - 3 or 18.8% of respondents
- HSR implementation should have committees at the state and LGA levels – 3 or 18.8% of respondents
- Legislations relating to the health sector should be enforced – 2 or 12.5% of respondents
- Interactive sessions for professional brain storming should be encouraged – 2 or 12.5% of respondents
- There is need for capacity building in the area of health economics – 1 or 6.3% of respondents

3.3.8: Provision of workshop materials

6 or 60 % of the 10 respondents who participated in the workshop and responded to section two of the questionnaire received the workshop documents during the workshop, 4 or 40% did not get the materials at all while 1or 10% received them before the workshop.

These materials were made up of the HSR brochure and hand outs of the presentations of the facilitators.

3.3.9: Discussion of the State health plan at the workshop

9 or 90% stated that the state health plan was discussed while 1 or 10% stated it was not discussed.

3.3.10: HSR activity/programme since ministerial visit

8 or 80% claimed that they have embarked on HSR activity/programme.

These activities were listed as;

- Follow up workshop on objectives and scope of HSR and its implication for Nursing and Nurses by Nursing department of SMOH
- Introduction of health programmes on TV and radio channels of Abia Broadcasting Service
- Capacity building at all levels for the health sector by ABHSDPII

- Institutional capacity building (equipment) by ABHSDP II
- Enlightenment campaign by NANNM for its members

3.3.11: Observations and suggestions on the visit

The respondent made some observations (both positive and negative) and suggestion on the Ministerial visit and HSR workshop.

The positive observations were;

- The visit was very educative and gave state/LGA policy makers opportunity to get first hand information on the health sector reform – 4 or 25% of the respondents
- It shows that the Fed Govt is serious with the HSR – 3 or 18.8% of he respondents
- Sensitized stakeholders in the health sector on the need to go back to the basics for effective health care delivery which has been lost in the present confusion and decadence in the health care sector particularly in the PHC system – 2 or12.5% of the respondents
- The visit/advocacy to traditional rulers – 2 or12.5% of the respondents

The negative observations were;

- The duration of the visit/workshop was too short and did not give enough time for sober reflection and response on the issues raised – 6 or 37.5% of respondents
- All stakeholders were not carried along particularly the 3rd tier of government and this was worse in the planning phase. This allowed the SMOH to manipulate the visit – 3 or 18.8% of he respondents
- Shoddy workshop preparation and delivery in terms of handling 2 very important activities at the same time – 2 or 12.5% of the respondents

The following suggestions were made;

- More publicity and time for such visit/workshop with the people will go a long way in carrying the people along in the HSR programme – 4 or 25% of the respondents
- There should be more sensitization sessions and strengthening of the IEC component of health programmes at all levels for the reform to succeed – 2 or 12.5% of the respondents
- Other stakeholders should be involved right from the planning stage of such visits – 2 or 12.5% of the respondents
- There should be a repeat of the workshop at the LGA level – 1 or 6.3% of the respondents

3.3.12: Impact of the Honourable Ministers visit;

- No response to the question – 7 or 43.8% of the respondents
- The HMOH's visit and the workshop has created more awareness about the HSR programme – 6 or 37.5% of respondents
- Visit has motivated the Council Chairman to start supporting health programmes such as immunization – 1 or 6.3% of the respondents

- It has changed the perception that the HSR is an Abuja affair – 1 or 6.3% of the respondents
- Not sure of the impact – 1 or 6.3% of the respondents
- No impact – 1 or 6.3% of the respondents

Response by the LOC

3.3.13: List of invited guests and participants

No information was supplied on the number of invitees or participants. The lists could not be produced as all key officials of the SMOH who participated in the visit have been posted out as part of the state's civil service reforms. This also applies to the workshop report. Workshop materials were said to have been distributed during the workshop.

3.3.14: Discussion of State health plan

The state health plan was said to have been discussed during the workshop but it was also stated that the state is yet to have an HSR strategic plan.

3.3.15: HSR related actions since the visit

The SMOH/LOC is yet to embark on any follow up action since the visit.

3.3.16: State health policy, health bill and HSR strategic plan

Currently there is no State health policy, no state health bill or an HSR strategic plan, though it was claimed that there on-going efforts to produce these.

3.3.17: State council on health meeting

The state has never held a state council on health meeting.

3.4 CONCLUSIONS AND RECOMMENDATIONS

3.4.1: Conclusions

All the respondents were aware and participated actively in the HMOH's visit and while most had idea of what the HSR programme was all about, very few could list the strategic components..

Resource availability/Health sector funding, promoting effective partnership and coordination and stewardship role of government are some of the areas respondents will need more clarification.

The HMOH's visit/workshop was well received and appreciated but many complained about the short duration of the visit considering all the activities involved and that it could have been better publicised and organised.

Not much has been done in terms of HSR related follow-up activities and this is not surprising considering the fact that most of the key officers of the SMOH who should be the driving force behind the programme have been posted out. Their replacements are just settling down to their new positions. However, the CFH did promise to initiate actions that will kick start the HSR programme.

The most reported impact of the HMOH visit is that it raised awareness about the reform.

Poor public awareness, inadequate resources and capacity, corruption and lack of transparency and political will and commitment to ensure sustainability are the major gaps/challenges to HSR implementation identified.

3.4.2: Recommendations

1. Mass media campaigns and focused workshops on the strategic thrusts of HSR in the state so as to increase the knowledge and perceptions about HSR and to get the stakeholders to become active change agents. There should be a cascading of the workshop by the SMOH to LGA and the community level.
2. More advocacy visits/contacts should be undertaken to the executive at the Federal, State and LGA level to allocate/release more funds to the health sector.
3. Recruitment of skilled manpower and staff audit of people with the relevant skills to implement and manage the HSRP including the designation of a desk officer
4. A wider representation of stakeholders in the planning of the visits should be ensured and adequate time should be given to mobilise local stakeholders before either the HMOH or his representative visits.
5. In order for the workshops to be more successful in the future, the FMOH should ensure that they have enough workshop materials (at least for 200 people). If possible, a "John the Baptist" should visit the state from the FMOH and ensure that adequate preparations have been made and that all major stakeholders receive the workshop materials before the workshop. This will enable them to study them and raise pertinent issues during the workshop.

6. There should be sustained visits to states by either the HMOH, Hon Minister of State for Health or another high level officer from the FMOH on HSR.
8. There should be accelerated implementation of HSRP by the FMOH to serve as an example to a states and LGAs and to convince the people that it is real. “Seeing is believing”.
9. The FMOH should establish and implement a strategic framework for capacity building on HSRP planning, implementation, monitoring and evaluation for the states and LGAs.
10. The state should be motivated or cajoled to cascade the HSRP workshops to LGAs and the communities.
11. The members of the mass media should be given copies of HSRP documents in future workshops.
12. A committee in which all stakeholders should be represented should be set up to oversee the HSR programme. This committee should be chaired by the honourable commissioner for health.
13. States should be requested to send progress report on the HSR to the NCH detailing verifiable activities and achievements.

4 ANNEXES

TERMS OF REFERENCE ON MONITORING THE OUTPUT, OUTCOME, GAPS AND CHALLENGES OF HONOURABLE MINISTER OF HEALTH (HMON) ADVOCACY VISITS TO THE STATES.

Reference number: HERFON/05/3/04	**Output:** 3
Date: 4/10/05	**Lead PTA:** Dr. Ben Anyene
Decision Date: 4/10/05	**Expected starting date:** 10/10/05
Drafted by: Executive Secretary	**Draft/Final:** Final

BACKGROUND

The Health Sector Reform Programme, (HSRP) is a 3-year strategic plan response to the poor performing Health Systems in Nigeria, which resulted into deplorable health status of Nigerians, has 7 core components. Communication, which is regarded as the 8th component, and Monitoring and Evaluation the 9th component are over-arching.

During the development of advocacy kits for Health Sector Reform, communication component was broken down into 3 mutually reinforcing activity phases namely:

1. **Engagement** – Get all the key stakeholders involved in the discussions of the HSR process, working through institutions, associations, private sector and non profit groups.

2. **Making it Happen** – Once the process of discussion and institutional engagement has gotten under way, widen the dialogue to the general public.

3. **Seeing is Believing** – Once improvements in the health system (both public and private) are well under way, demonstrate the differences and promote demand for quality and equitable services.

The HMH advocacy visits to all states of the Federation falls within communication phase of **"Making it Happen**".

The Objective of the visits is:

"To bring to the public domain the issues, purpose and benefits of HSR through interactive and participatory sessions by the HMH with (both primary and secondary) stakeholders in health care delivery at state levels"'

The Outputs are:

5) The HMH advocacy visit.

6) Successful workshop in line with the Programme made available to all states.
7) A state's ministerial visit report, that includes the workshop proceedings and also contains the State Health Plan of action for HSR, that was generated at the workshop which took into consideration the 7 strategic thrusts.
8) A communiqué.

The Expected Outcomes are:

6) Key public and elected officers knowledgeable about issues, content and context of HSR.
7) Actions being taking to institutionalize HSR and operationalize the state health plan.
8) Increase in consumer awareness about HSR.
9) Political will and commitment at the highest level of Government.
10) MDGs compliant in implementation strategies and service delivery.

The Ministerial advocacy is programmed to be geo-political zonal visits and it commenced with the South East Zone in the month of June 2005 and it has since moved to other zones.

PURPOSE OF THE MONITORING

The purpose of the monitoring is to use a survey instrument to establish the degree of reception and understanding of the Minister advocacy message; to establish what HSR friendly actions have been taken by the states visited; to identify gaps and challenges if any; and to recommended implement able practical solutions.

This is important because without positive actions taken by the State and LGA, the desired outcome of the HSR may not be achieved.

SCOPE

All states visited by the HMH should be covered not less than 3 months post the Honourable Minister for Health's advocacy.

Sample populations for administering the instrument should be drawn from all the stakeholders invited to the workshops and the public. They include His Excellency, the Governor, members of the State Executive Council, top civil servants, Honourable Commissioner for Health and senior and junior staff of the SMOH, Chairman State Health Committee in the State House of Assembly, representatives of all Health Professional Associations, Faith-based organizations, CSOs, women groups change agents, trained journalists on HSR, representatives of alternative and trado-medical practitioners, Chairmen of LGs, youths, labour unions and ordinary men and women in the streets (consumers). Efforts should be made to ensure that the activity is not limited to state capitals and urban centres only. Rural areas and different strata in social status and educational background should be included. This will ensure adequate sensitivity of the sample population.

OUTPUT

A documented field monitoring report.

OUTCOME
HSR knowledge base and acceptability in various states identified
Gaps and challenges identified and remedies proffered
Adjustment of the HMH visit to accommodate the recommendations.

METHODOLOGY

1) Monitoring shall be based on zonal consultancy team/s. A team of 2 Consultants shall handle the States in the Zone. Their report would be on each State and not collective Zonal findings.
2) A monitoring instrument will be developed for standardization Compilation and analyses of the reports.
3) Final report per State in standard template and should include recommendations on how to tackle the gaps and challenges identified.
4) Ministerial debriefing.

TYPE OF CONSULTANTS
All the Consultants to be engaged shall be national Consultants. They should be persons with good understanding and familiarity with the HSRP. They should be able to work across the various stakeholders in Nigeria Health Sector and write clear, understandable report.

CHOICE OF CONSULTANTS
Dr Ben Anyene is being proposed as Lead Consultant for the assignment. This is based on his experience, knowledge and familiarity on the subject mater. He has worked on the conduct of training of Journalist on HSR and Monitoring of the activity. He has done several other works with PATHS on HSR.

Other Consultants shall be chosen from among various Change Agents with required capacity for the work.

ACTIVITY/TIMING:

The Health Minister has visited 13 states so far, viz the whole 5 states in South East, 3 states (Sokoto, Kebbi and Zamfara) in North West, 5 States in North East (Borno, Bauchi, Adamawa, Taraba and Gombe)

1) Engagement of Consultants for Development and Standardization of Monitoring Instruments. 10th – 11th October 2005.
2) Design and Development of Monitoring Instruments. 3 days – 12th – 14th October, 2005.
3) Pre testing of the instrument in one state. 3 days – 18th – 20th October 2005.
4) Field Work.

a) South East: 5 States (10 days) – October 24th – November 4th, 2005
Report writing – 7th – 8th November 2005
Debriefing: 9th November 2005

b) North West: 3 States 24th October – 29th October 2005 (6 days)
Report Writing: 31st October – 1st November, 2005
Debriefing: 2nd November 2005

(c) North East: 5 States: November 7th – 25th , 2005 (15 days)
Report Writing: 28th – 29th November 2005
Debriefing 30th November 2005

LIST OF CONSULTED MATERIALS

1. Communique Issued At The End Of The One Day Workshop On The Issues,Challenges, Purpose And Benefits Of Health Sector Reform In Abia State, Organized By FMOH In Collaboration With The FMOH On Wednesday 15th June 2005 At Michael Okpara Auditorium, Umuahia

APPENDIX

LIST OF RESPONDENTS FOR ABIA STATE STUDY TO MONITOR MINISTERIAL ADVOCACY VISIT ON HSR

S/N	*Designation*	*Name*
1	Hon Commissioner for Health	Dr Chika O Emuchay
2	Director Medical Services/Ag. Permanent Secretary, SMOH	Dr Okwun
3	Director of Public Health/PHC, SMOH	Dr. O. U. Oji
4	Director of Pharmaceutical Services, SMOH	Pharm. Unoma N. Nwoke
5	Director of Nursing Services, SMOH	Mrs Alice Chukwuocha
6	Director of Planning, Research and Statistics, SMOH	Mr U N Agomoh
7	Director of Administration, SMOH	Mrs T. E Okpara
8	Project Manager ABSHSDP II	Dr O. O. Madukwe
9	Director of News and Current Affairs, Abia Broadcasting Corp.	Mr Ogbonnaya Iheaki
10	Supervisor for Health, Umuahia South LGA	Hon C M Ekueku Martins
11	State Chairman, NANNM	Mrs Lovina E Okoro
12	State Secretary, NANNM	Miss Genevive-Gold C Ndukwe
13	State Chairman, NLC	Comrade Lucky Akabuike
14	Chairman, Caretaker Committee, FMC, NANNM	Sir O C Ugwuege
15	HOD Umuahia North LGA, Health Department	Mrs Gerty U Uchendu
16	HOD Ugwunnagbo LGA, Health Department	Mr Michael Agha Okoro
17	HOD Isiala Ngwa LGA, Health Department	Mrs Nwaobiala

Interview Schedule for the Assessment of the Output and Outcome of the Advocacy Visits to States by the Honourable Minister of Health

The Federal Ministry of Health in conjunction with the Health Reform Foundation of Nigeria (HERFON) is conducting consultations with relevant stakeholders on the recent advocacy visits to states by the Honourable Minister of Health, Professor Eyitayo Lambo on Health Sector Reforms. The consultation is aimed at assessing the output and outcome of the visits as well as outline possible gaps and challenges. The bearer is one of the Consultants assigned to perform this assessment and we will greatly appreciate if you could spare your time to answer the following questions.

SECTION ONE

(To be administered to all respondents)

1) State (……………………………………………………)

2) Name of Respondent (……………………………………………………)

3) Sex (Tick as appropriate)
   a) Male
   b) Female

4) Organization (indicate name within the brackets provided)
   a) Ministry (……………………...……………………………..)
   b) Board/Parastatal (………………..……………………….……………..)
   c) Department/Unit (………………..……………………….……………..)
   d) NGO (…………………...……………………………….)
   e) Professional Association (……………………………………………………....)
   f) Consumer (..…………………………….……………………..)
   g) Others (*specify*…………...……………………………….)

5) Position: (Tick the most appropriate)
   a) Legislator
   b) Commissioner
   c) Permanent Secretary
   d) Deputy Permanent Secretary/ Ministerial Secretary
   e) Director/ HOD
   f) LGA Chairman
   g) Supervisory Councillor
   h) Others (*specify*………………..…………………………..)

6) Are you aware of the advocacy visit paid to this state by the Honourable Minister of Health, Professor Eyitayo Lambo?
   a) Yes
   b) No

c) Not sure

7) Were you or your organization formally invited to the one-day workshop?
   a) Yes
   b) No
   c) Not sure.

8) If yes through what means?
   a) Oral
   b) Written
   c) Media
   d) Others (*specify*………………………………………………………………….)

9) Did you or your organization attend the workshop?
   a) Yes
   b) No (*why?* ……………………………..……………………..…………………

   ……………………………………………..………………………………………..)

   c) Not sure

10) What do you understand by the Health Sector Reform?

    …………………………………………………………………………………………

    …………………………………………………………………………………………

    …………………………………………………………………………………………

    …………………………………………………………………………………………..

11) What are the strategic components of the Health Sector Reform?

    a) ………………………………………………………………………………………
    b) ………………………………………...……………………………………………
    c) …………………………………………...…………………….…………………
    d) ………………………………………………………………………………………
    e) ………………………………………………………………………………………
    f) ………………………………………………………………………………………
    g) ………………………………………………………………………………………
    h) ………………………………………………………………………………………

12) Which areas of the Health Sector Reform do you need more clarification?

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13) What in your opinion are the possible gaps to the implementation of the HSR?

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14) What in your opinion are the possible challenges to the implementation of the HSR?

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15) In what ways can these gaps and challenges be overcome?

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SECTION TWO

(To be administered to respondents who attended the workshop)

16) Were workshop documents/papers given to you?
   a) Yes, before the workshop
   b) Yes, during the workshop
   c) No

17) If yes to Q16, list the documents and the source(s)

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18) Was the state health plan discussed during the visit/workshop?
   a) Yes

b) No

19) Have you or your organization embarked upon any Health Sector Reform activity/programme after the ministerial visit?
    a) Yes
    b) No
    c) Don't Know

20) If yes to Q19, describe the activity

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21) If no to Q19 above, why not?

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22) What are your observations about the ministerial visit/workshop?

Positives

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Negatives

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Suggestions

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23) What impact has the visit of the Honourable Minister of Health made on you or to your organization?

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SECTION THREE

(To be administered to the LOC Chairman i.e Honourable Commissioner for Health or the LOC Secretary or any member so designated by the chairman or secretary)

24) How many participants were invited to the workshop? (Collect copy of the list of invitees)

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25) How many people attended the workshop? (Collect copy of attendance list and classify by organization in your analysis)

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26) Were workshop documents/papers distributed? (collect copies)
   a) Yes, before the workshop
   b) Yes, during the workshop
   c) No

27) Was the state health plan discussed during the visit/workshop?
   a) Yes
   b) No (*Explain*……………………………………………………………………,,,

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28) If yes to Q27, what was the outcome?

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29) Was there a report at the end of the workshop?

a) Yes (if yes, Collect a copy)
b) No (*why not?*...

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30) Was there a communiqué at the end of the workshop?
a) Yes (if yes, Collect a copy)
b) No (*why not?*...

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31) What follow up action(s) (health reform related) has the SMOH/LOC undertaken after the ministerial visit?

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32) What factors enabled or constrained the action(s) or inaction(s) in Q29 above?

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33) Does the state currently have a State Health Policy?
a) Yes *(collect a copy if available)*
b) No (*any on going efforts to have one?*……………………………………………..)

34) Does the state currently have a Health Bill?
a) Yes *(collect a copy if available)*
b) No *(any on going efforts to have one?……………………………………………….)*

35) Does the state currently have a HSR strategic plan?
a) Yes *(collect a copy if available)*
b) No *(any on going effort to have one? …………………………………………..)*

36) When last was a state council on health held in the state?
a) This year (2005)
b) Last year (2004)
c) Years ago (*specify the year*……………..……………………………………)
d) Never

e) Don't Know

37) What Health Sector Reform related resolutions were reached at the end of the council? *(collect a copy if available)*

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