EXISTING KEY POLICY THRUSTS TOWARDS UHC: DECENTRALIZATION OF HEALTH INSURANCE

BEING A PRESENTATION DURING CAPACITY DEVELOPMENT WORKSHOP OF LAWMAKERS FOR UNIVERSAL COVERAGE

BY

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TAHIR HOTEL, KANO ON 22ND NOVEMBER, 2017

PRESENTATION OUTLINE

- Introduction
- Contextual framework of SSHI
- Legal framework for State Health Insurance
- Governance and Administration
- Recommended Early Steps
- Conclusion

INTRODUCTION

- Universal Health Coverage (UHC)is a broad concept that has been implemented in several ways. The common denominator for all such programs is some form of government action aimed at extending access to health care as widely as possible and setting minimum standards.
- Most implement universal health care through legislation, regulation and taxation.
- Legislation and regulation direct what care must be provided, to whom, and on what basis.
- Usually some costs are borne by the patient at the time of consumption but the bulk of costs come from a combination of compulsory insurance and tax revenues.

INTRODUCTION: CONTD

- Some programs are paid for entirely out of tax revenues. In others tax revenues are used either to fund insurance for the very poor or for those needing long term chronic care.
- In some cases, government involvement also includes directly managing the health care system, but many countries use mixed public-private systems to deliver universal health care.
- Universal Coverage usually refers to a health care system that provides healthcare and financial protection to more than 90% of the citizens of a particular country.

COUNTRIES WITH UNIVERSAL HEALTH COVERAGE

Country	Start Date of Universal Health Care
Norway	1912
Japan	1938
New Zealand	1938
Belgium	1945
Germany	1941
United Kingdom	1948
Kuwait	1950
Sweden	1955
Bahrain	1957
Brunei	1958
Canada	1966
Netherlands	1966
Austria	1967
United Arab Emirates	1971
Slovenia	1972
Finland	1972

COUNTRIES WITH UNIVERSAL HEALTH COVERAGE(CONT)

Denmark	1973
Luxembourg	1973
France	1974
Australia	1975
Ireland	1977
Italy	1978
Portugal	1979
Cyprus	1980
Greece	1983
Spain	1986
South Korea	1988
Iceland	1990
Hong Kong	1993
Singapore	1993
Switzerland	1994
Israel	1995

NHIS

- National Health Insurance Scheme (NHIS): An agency of the Federal Government established under Act 35, 1999 to promote, regulate and administer the effective implementation of Social Health Insurance Programmes in order to ensure easy access to qualitative and affordable health care services to all Nigerians and Legal residents.

NHIS MANDATE

To secure access to adequate health care for all Nigerians at an affordable rate (Universal Coverage) by the year 2025.

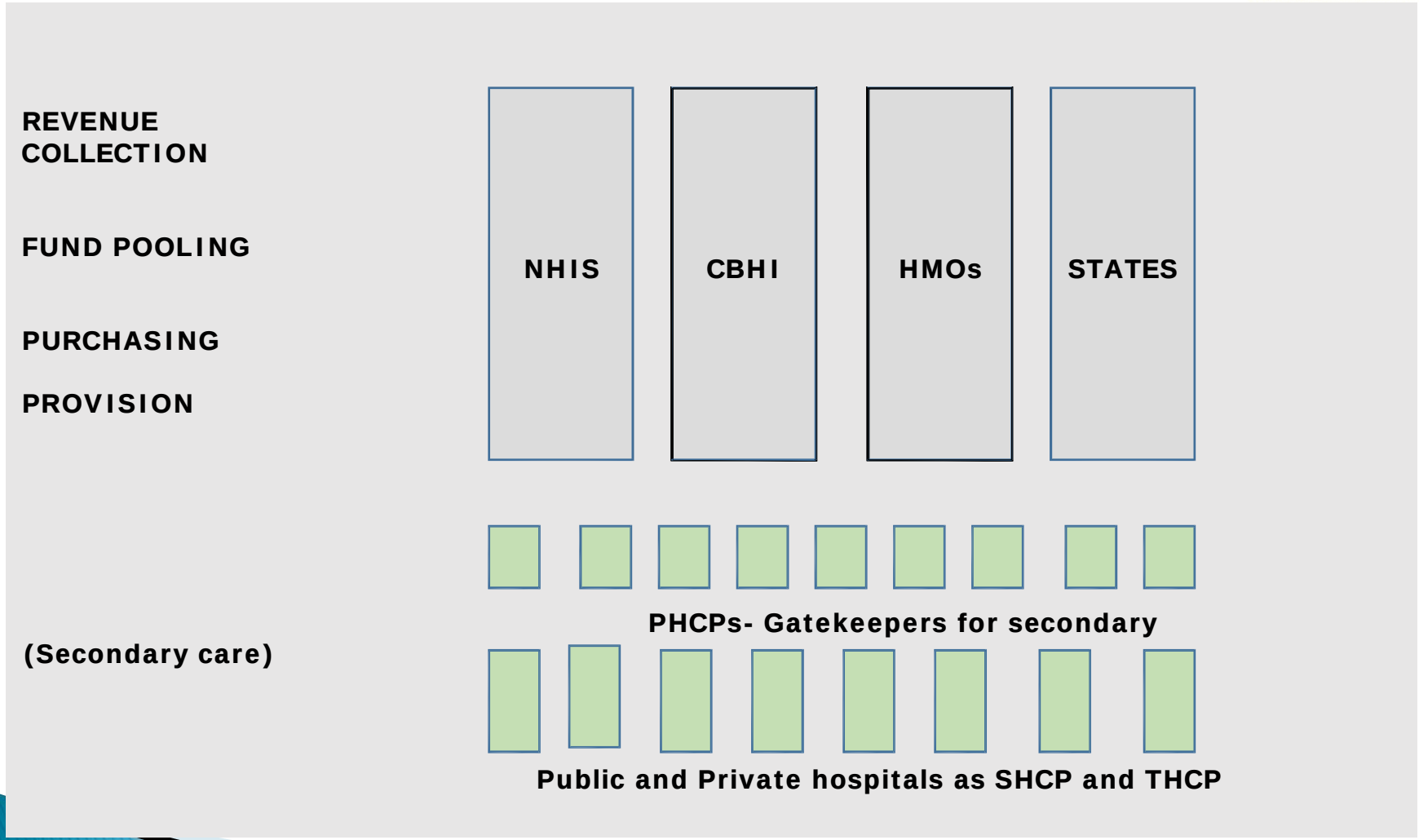
FACTORS RETARDING ACHIEVING NHIS MANDATE

- Health is in concurrent list in the Constitution making it impossible to mandate States to join NHIS.
- The NHIS Act does not make participation by citizens mandatory.
- The low coverage by NHIS is essentially because States are not participating, therefore, to cascade Health Insurance to the States, the State government should have legislation on Health Insurance.
- Under the new policy thrusts, NHIS proposed to give the State Governments power to create an organization that will manage the State's Contributory Healthcare Program to facilitate achieving Universal Health Coverage in the participating States with its supervision.

WHY STATE SOCIAL HEALTH INSURANCE?

- To rapidly expand coverage towards UHC.
- To bring states into health insurance implementation in Nigeria.
- To tackle governance and enforcement constraint occasioned by the political context of Nigeria
- To bypass the challenge of the "voluntary" nature of the extant NHIS law.
- To create sustainable mechanisms for funding for the poor and vulnerable
- To provide a framework for the disbursement of the 50% part of the BHCPF.

CURRENT NHIS MODEL



KEY CHALLENGES WITH PRESENT STRUCTURE

- Multiple fragmented system incapable of achieving UHC
- Equity issues on account of voluntary nature
- Poor cross subsidy on account of fragmentation of pools
- Constitutional provisions with health in concurrent list making it impossible to mandate states to joins NHIS
- Inefficiency due to weak purchasing structures and administrative costs
- Non mandatory nature of the NHIS reducing capacity to mobilize resources.

REFORM MODEL WITH STATES AS IMPLEMENTERS

REVENUE COLLECTION, POOLING & ALLOCATION

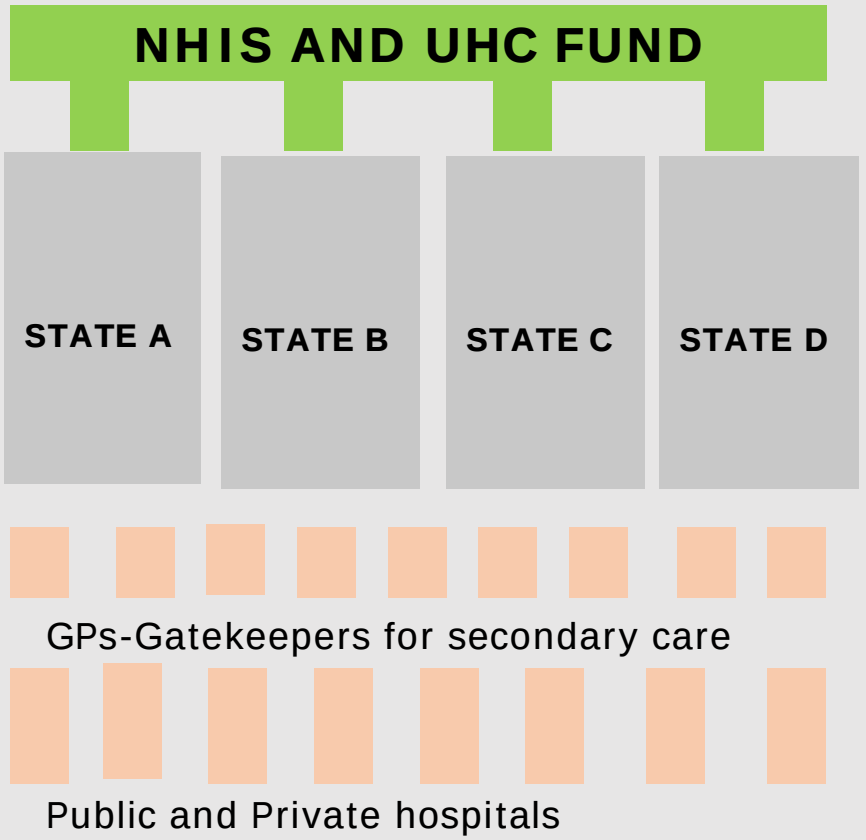
REVENUE COLLECTION

FUND POOLING

PURCHASING

PROVISION

(Secondary care)



LEGAL FRAMEWORK FOR THE SSHI

- Provides a framework for sustainable financing that all involved parties must obey. Outlives every administration.
- Defines how funds are generated, pooled and used to purchase services
- Defines the roles and responsibilities of all stakeholders in the system
- Creates a governance and institutional framework to enforce the rights and obligations of all stakeholders
- Defines the benefits for contributors in the Scheme

LEGAL FRAMEWORK FOR THE SSHI 2

Primary legal framework

- Law passed by the State legislature and signed by the Executive: define in general terms the guiding rules for the Scheme.

Secondary legal framework

- Draws inspiration from the letters of the primary law
- Defines the specifics of the Scheme as contained in the primary law
- Usually in the form of operational guidelines produced by technical persons

KEY DESIGN FEATURES OF LEGAL FRAMEWORK

- State laws must align with NHIS Act, to facilitate collaboration
- Health insurance must be mandatory for all residents of a State.
- State health insurance Agency must be autonomous with a budget line.
- State Agencies should limit administrative charges to not more than10% of funds.
- Law to prescribe establishment of
- Agency with board and its responsibilities,
- Roles for stakeholders,
- Contributions and rates
- Offences and penalties for defaulters

COMPONENT OF LEGAL FRAMEWORK

- Institutional and governance arrangement
- Core health care financing issues
- Accountability framework
- Dispute Resolution system
- Enforcement System

PARTS OF LEGAL FRAMEWORK

- PART 1: Establishment of the Scheme
- PART 11: Establishment of the Agency and Governing Board
- PART 111: Functions of the Board and Agency
- PART IV: Appointment and functions of Executive Secretary and other staff
- PART V: Components of the Scheme
- PART VI: Funds for the Scheme
- PART VII: Registration under the Scheme
- PART VIII: Legal proceedings against the Agency
- PART IX: Arbitration
- PART X: Offences
- PART XI: Miscellaneous

PROCESS OF DEVELOPING LEGAL FRAMEWORK

- Draft developed by relevant Ministry/Committee in collaboration with NHIS, Ministry of Justice, Ministry of Finance.
- Presentation of draft to the State Executive Council
- Transmission to the State House of Assembly
- Public Hearing - engagement with relevant Stakeholders for input
- Passage of Bill by the State House of Assembly
- Assent by the Governor.

DEFINING HEALTH CARE FINANCING FUNCTIONS IN SSHI LAW

- Resource Mobilization.
  - How is revenue raised for health services
  - Who pays and how much ?
  - How are payments collected.
- Risk and Resource Pooling
  - Pool size
  - Diversity of health risks of enrollees
  - Compulsory participation of residents
- Strategic purchasing of healthcare
  - Purchase services from what categories of HCFs
  - What type of provider payment system is used

RISK AND RESOURCE POOLING

- Create a single pool system.
- All funds need be channeled to the pool irrespective of source.
- Define formal sector to include employers with 5 employees and above
- Contributions from the formal sector (Public and Organized Private sector) should be wage-based (% of salary).
- No opportunity to opt out that could reduce viability of pool

THIRD PARTY ADMINISTRATORS AND THEIR ROLES

- TPAs include CSOs, Cooperatives, MHAs, HMOs
- TPAs should either receive admin fees or commission
- States may give any role to TPAs based on need
  - MHAs, CSOs etc. can be used for revenue generation, sensitization etc.
  - HMOs can be used for purchasing, quality assurance

INSTITUTIONAL STRUCTURE FOR STATE SOCIAL HEALTH INSURANCE

COVERAGE TARGETS

- Who should be covered? The aim is 100% population coverage.
  - all population groups and their families
  - formal sector employees, informal sector workers, self-employed, unemployed, students, retirees…
- What services should be covered? Defined package of services
  - available resources: what can the country/State afford
  - health priorities: prevalent disease conditions.
- How much of the costs should be covered?
  - not necessarily 100%.

GUIDING PRINCIPLE

- First step is to have a law to guide implementation.
- Make health insurance mandatory in the law.
- Create Health Insurance Agencies to administer the scheme.
- Ensure the poor are included – have an equity fund.
- Create cost effective benefit package to address the local disease burden and need of residents.
- Establish a robust Monitoring & Evaluation framework.
- The deployment of a robust ICT framework to drive the overall process.
- Create a single pool shielded from taxation and Executive interference.
- Collapse existing free health programs into the State Health Insurance.

FUNDING STATE HEALTH INSURANCE SCHEME

- Define sources of raising funds
  - Mandatory contribution from those able to pay
  - Legislate a percentage of the State consolidated revenue fund for health insurance
  - Explore other sources of funding
  - Health levies- sin taxes (tobacco, pollution, etc)
- Channel existing free health programs into State Social Health Insurance Scheme for more efficiency and effectiveness.
- Have strategic policies to cover vulnerable groups
- Funds from Basic Healthcare Provision Fund
- Grants, donations, etc.

GOVERNANCE AND ADMINISTRATION

- State Health Insurance Agencies should be autonomous parastatals.
- There should be a budget line and an independent board.
- We advise private sector driven board for efficiency, accountability , transparency and public trust.
- Functions
  - Policy, implementation & regulation
  - Provider management
  - Fund holding/ Fund management
  - Communications/marketing

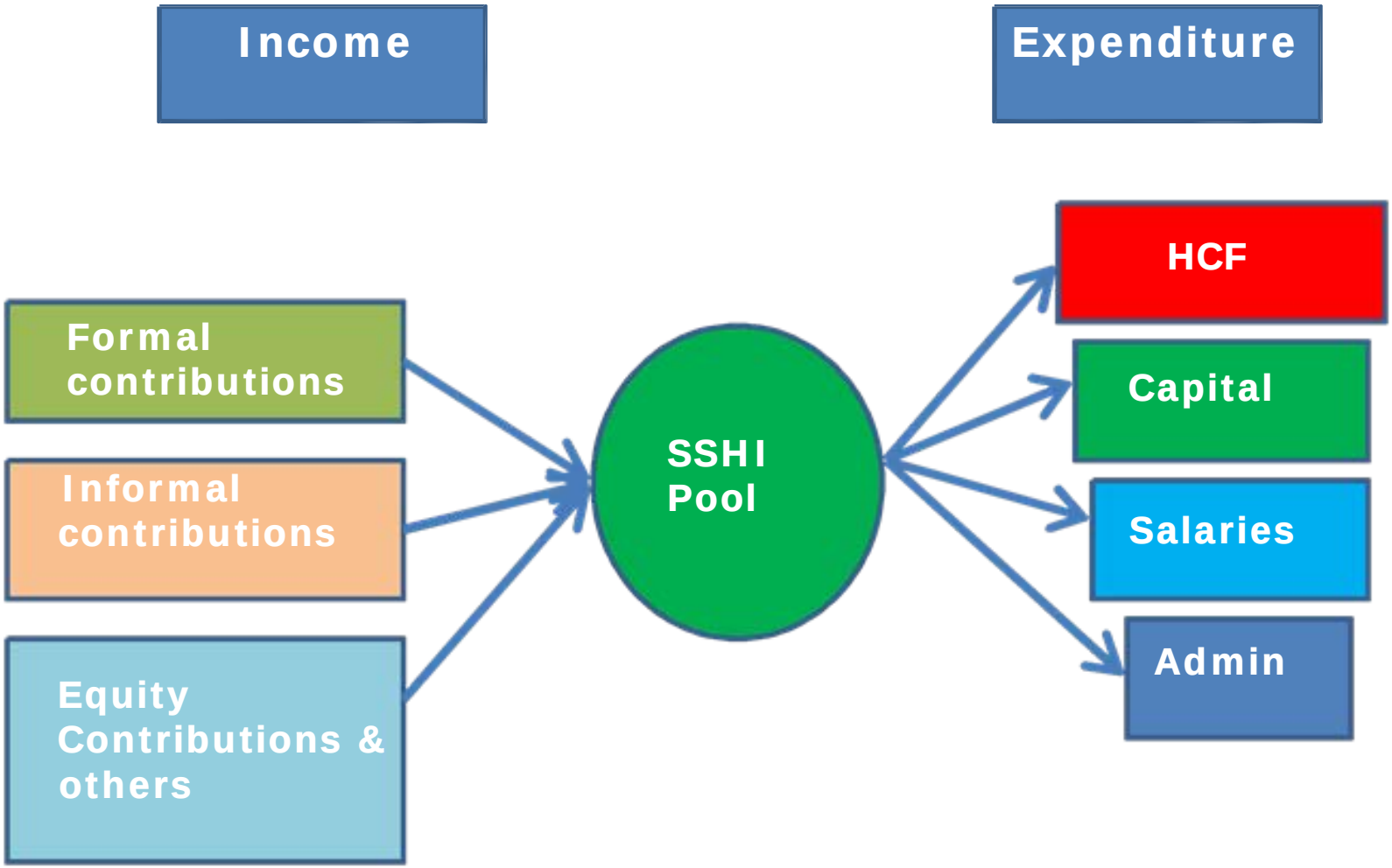
GOVERNANCE AND ADMINISTRATION (2)

- Single universal benefit package for all residents or groups with top up by third party administrators (TPAs).
- Make secondary laws in operational guidelines for more accountability.
- Financial audits of operations and annual reports to be rendered to stakeholders.
- Sanctions for all erring operators & enrollees.
- Single pool including equity funds for the vulnerable.

ACCOUNTABILITY

- Financial- tracking and reports on allocation, disbursement and utilization of financial resources.
- What processes govern budgeting, financial control and expenditure?
- Are there rigid financial rules on spending based on line items?
- Internal management controls of agency, internal audit.
- External Audits & Annual financial reports to stakeholders.
- Sanctions & Enforcement as well as arbitration.

FINANCIAL ADMINISTRATION



NHIS SUPPORT TO STATES (1)

- Assist the State Ministry of Health Technical Team in drafting legal framework i.e. provide guidance to the State in the development of the legal framework.
- Participate in the public hearing on the State Health Insurance Bill.
- Assist in drawing up a cost effective benefit package to address local disease burden and needs of residents of the State.
- Assist in development of policy and operational documents such as operational guidelines.
- Guidance on the structure of the State Health Insurance Agency.

NHIS SUPPORT TO STATES (2)

- ICT –assist in biometric registration of enrollees
- Inspection and accreditation of Healthcare Facilities
- Quality Assurance
- Monitoring and Evaluation
- Capacity building of staff- Workshops, Sharing best practices, Membership of country core group of Joint Learning Network
- Channel funds from Basic Health Care Provision Fund to the State Health Insurance Agency. The Health Act provides that 50% of the fund shall be used for the provision of basic minimum package of health services to citizens, in eligible primary/or secondary health care facilities through NHIS.

CHALLENGES

- Political will on the part of the Governors to support the process.
- How to enforce the mandatory provisions in the law.
- How to collect contributions from the informal sector.
- Fiscal constraint to provide funding for the vulnerable persons.
- How to ensure the independence of State Health Insurance Agency from interferences of supervising Ministry and the Chief Executive of the State.

RECOMMENDED EARLY STEPS (1)

- Develop and ensure passage of legal framework.
- Establish State Health Insurance Agency.
- Conduct baseline studies for impact evaluation.
- Have an initial lean administrative structure for the Health Insurance Agency.
- Develop operational documents such as operational guidelines, benefit package, etc.
- Define and prioritize coverage populations.
- Prioritize covered services based on funds availability; add more services when funding improves.

Recommended early steps (2)

- Collaboration with Development partners for capacity building and knowledge sharing on issues such as:
  - concept of social health insurance
  - costing of services and cost containment
  - provider payment systems and options
  - blending of various payment systems
  - developing monitoring toolkit to track provider payments
  - opportunity at global level for shared perspectives on provider payment.
  - addressing the challenges of resource mobilization from the informal sector population groups.

CONCLUSION

- The Legislative Network on Universal Health Coverage is a welcome development, as it has a great role to play in making the necessary legislation across the States.
- This workshop is timely, therefore, I commend the organizers for bringing highly respected legislatures from North West Zone to participate and have clear understanding of what is expected of them toward achieving UHC.


NATIONAL HEALTH INSURANCE SCHEME
EASY ACCESS TO
HEALTH CARE FOR ALL

THANK YOU

Bringing primary health care

under one roof

PRESENTED BY

KABIRU MUSTAPHA YAKASAI

NPHCDA STATE COORDINATOR KANO STATE

PRESENTATION OUTLINES

1. PHC UNDER ONE ROOF

- Background
- The Concept
- Principles of PHC under one roof
- Methodology: step by step approach for the implementation of PHUOR
- Benefits of the PHCUOR
- Progress on PHCOUR
- Challenges
- Way Forward

2. PHC Revitalization

Rethinking our Approach for PHC service delivery

BACKGROUND

- PHC made its entry into Nigerian Policy Agenda between 1986 to 1993
- The National Health Policy recognizes PHC as the core of the Nigerian Health System
- In spite of the potential capacity of PHC to meet the health needs of majority of Nigerians, over the years the output has been suboptimal owing to a weak system particularly at the implementation level

Background – Why PHCUOR IN NIGERIA?

- **Factors fueling the weak *PHC system in Nigeria***
  - Fragmentation
  - Leadership Conflicts
  - Wide span of control
  - Duplication of roles as wastage of resources
  - Weak collaboration and coordination
  - PHC structure and organization is out of tune with international best practice

Background – continuation……

- PHCUOR initiative was introduced in Nigerian in 2005 with support of DFID funded projects –PATHS & PRRINN-MNCH
- It became a national policy agenda after its endorsement by 56th National Council on Health (NCH) in May 2011
- The Council in its 58th session in 2013 further approved the national guidelines for implementation as well as policy document through resolution 29
- The guideline identify conceptual framework for implementing the policy which consist of the nine domains

The concept of PHCUOR

- To Harmonize the PHC sub-system, overcome structural constraints and improve coordination at the state level.
- To create unitary, integrated and decentralised management bodies/structures and systems.
- Preposition States for Implementation of Health Act.

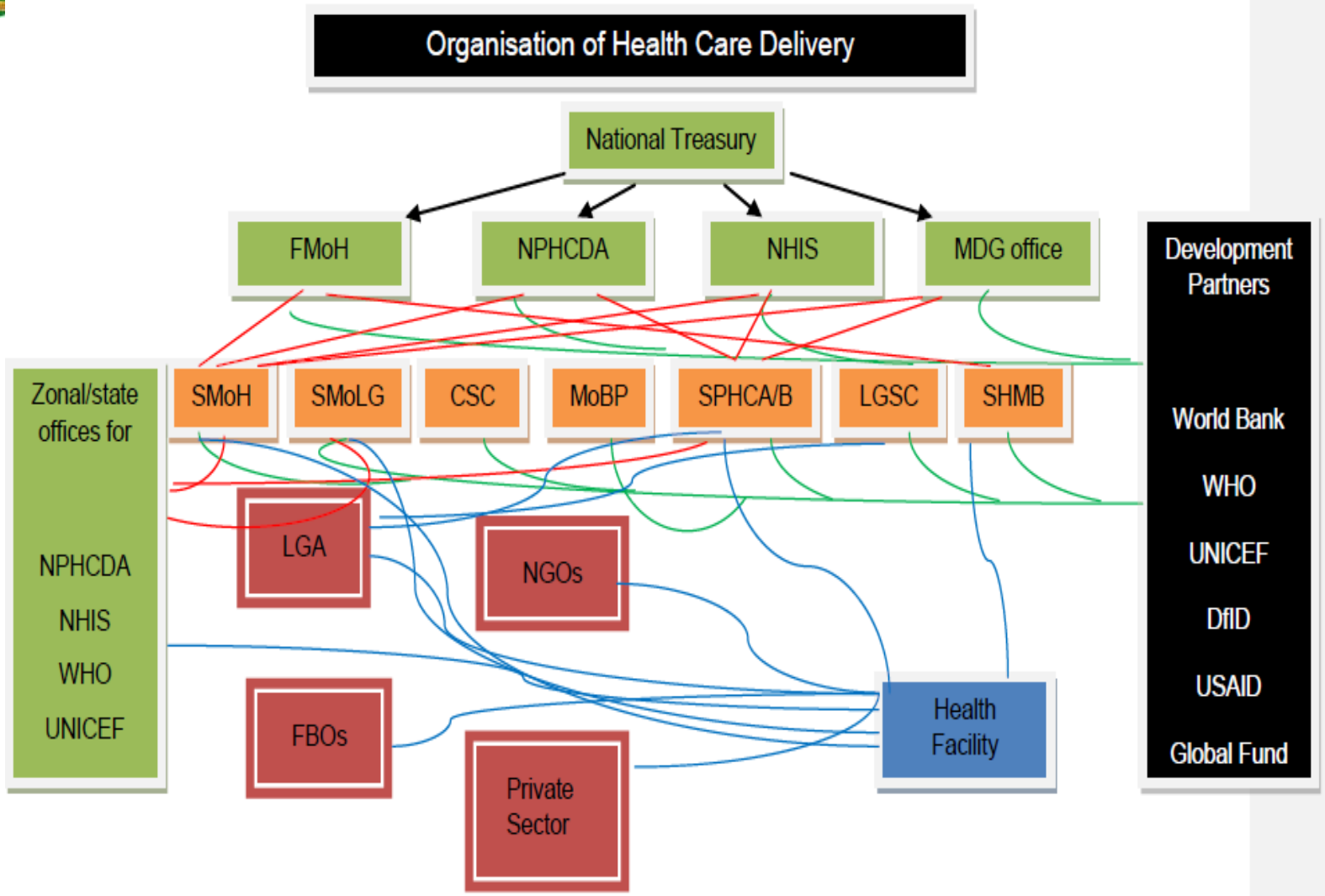


Figure 1: Organisation of the Nigerian Health Service[67]

"All PHC services under one roof"

SPHCB maintains and coordinates all PHC activities in the State

PHC Services

- Coordinates plans budgets and monitors all PHC services

Human Resources

- Pays salaries and allowances of all PHC staff
- Maintains personnel records of all PHC employees

PHC advisory services

- Advices commissioner and local government on all matters concerning PHC

9 Components for PHCUOR

1. **LEGISLATION**
2. **SYSTEMS DEVELOPMENT**
3. **HUMAN RESOURCES**
4. **FUNDING STRUCTURE AND SOURCES OF FUNDS**
5. **REPOSITIONING**
6. **OPERATIONAL GUIDELINES**
7. **COMMUNITY OWNERSHIP**
8. **INFRASTRUCTURE AND FURNITURE**
9. **MINIMUM SERVICE PACKAGE (MSP)**

Elements of PHCUOR

- **Integration** of all PHC services delivered under one authority
- A **single management body** with adequate capacity that has **control over services and resources**
- **Decentralized authority, responsibility and accountability**
- Principle of “three ones” (**one management, one plan and one M&E system).**
- An **integrated supportive supervision**
- Enabling **legislation and concomitant regulations** (inclusive of the key elements).
- An **effective referral system**

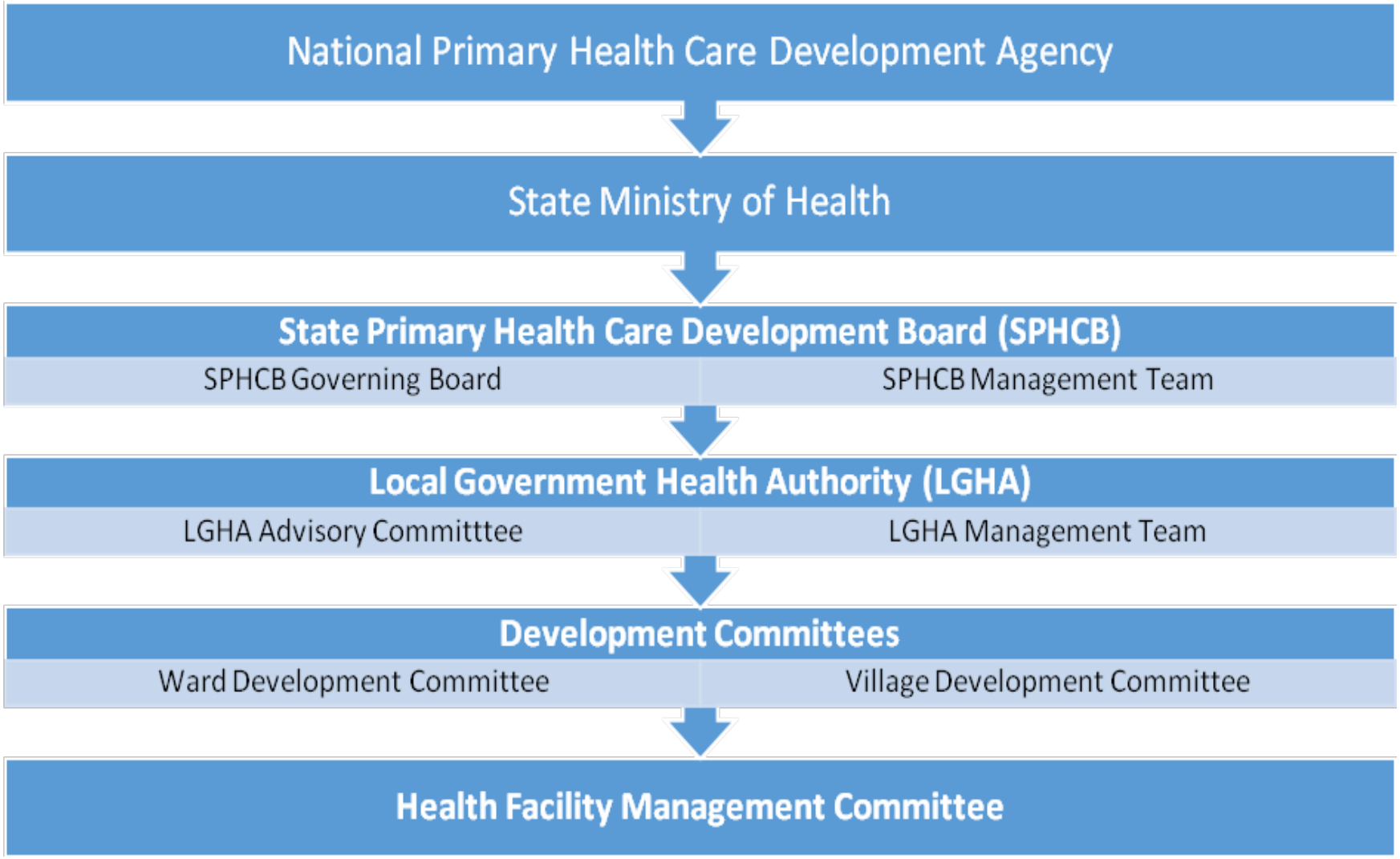
Benefits of the PHCUOR approach

- **Enhances** coordination, collaboration, effectiveness & efficiency
- **Eliminates** constraints, fragmentation and managerial uncertainty, wastage of resources
- **Creates** enabling environment for implementation of the proposed Health Act.

A number of issues impose a high need of urgency for all key Agencies stakeholders of PHC in Nigeria, under the leadership of NPHCDA.

- Unacceptable levels of basic health indicators.
- Perceived and absolute weaknesses of PHC over the years.

Current structures



Progress on PHCUOR so far

1st National Stakeholders meeting-

- Held 2009 in Kaduna
- PHC system challenges discussed
- The concept of PHCUOR introduced

2nd National Stakeholders meeting

- Held 2010 in Abuja
- Policies and guidelines developed and circulated.
- Good results were achieved at the outcome level
  - More states established PHC Boards (Lagos, Nasarawa, FCT, kebbi, Yobe, Abia, etc).
  - Concept, policy and guidelines approved by the 56 NCH.

Progress on PHCUOR Contd

3rd National Stakeholders' Meeting on PHCUOR on September 2-3, 2012 in Abuja.

- Progress & challenges (including State-specific issues) were presented.
- Good practice approaches & inter-state lessons were shared and used to proffer potential solutions to identified challenges.
- Plans of action for addressing challenges in implementing states were developed & draft Plans of action for establishment of State PHC Board in non-implementing states were considered.

States With Established SPHCDA/B from Scorecard III Report

S/N	Zone	States with SPHCDA/B	States without SPHCDA/B
1	North Central	Nasarawa, Kogi, FCT, Niger, Kwara, Benue, Plateau	
2	North East	Bauchi, Yobe, Adamawa, Gombe, Borno, Taraba	
3	North West	Jigawa, Kaduna, Kano, Katsina, Kebbi, Sokoto, Zamfara	
4	South East	Abia, Anambra,	Ebonyi, Enugu, Imo,
5	South South	Delta, Rivers,	Akwa Ibom, Cross River, Edo, Bayelsa
6	South West	Lagos, Ondo, Ekiti, Ogun, Oyo, Osun	

METHODOLOGY: STEP BY STEP APPROACH FOR THE IMPLEMENTATION OF PHUOR

- **Step 1**: Establishment of Technical Committee for PHCUOR
- **Step 2**: Advocacy stakeholders engagement and building strong consensus around PHCUOR
- **Step 3:** Step 3: Establishment of a technical subcommittee to draft the SPHCB bill, facilitate process of passage into law, assent by the Executive Governor and publishing of its gazette**.**
- **Step 4**: Development of SPHCB Regulations, Policy Document and Annual Work
- Step 5: Establishment of SPHCB Governing Board and Management Team
- **Step 6:** Reposition MDAs to transfer PHC responsibilities in the State to SPHCB
- **Step 7:** Allocate well-equipped office building at State capital and all LGAs for SPHCB and LGHAs respectively. Release of take-off grant for the SPHCB
- **Step 8**: Establishment of Local Government Health Authority Management Team and Advisory Committee
- **Step 9**: Build Capacity of Governing Board and Management Team of

Activities implemented so far

- Three Annual National Stakeholders' Workshop – 2010, 2011, 2012
- National Capacity Building Workshop for members of NSC and taskforce on PHCUOR implementation – June, 2013
- 2 sub-Committees on Knowledge Management and Score card development were established
- Orientation exercise for Scorecard II data collection – Sept, 2013
- Development of Scorecard II – Sept, 2013
- Partnership meetings
- Development of IEC materials – Sept, 2013
- North West Zonal Sensitization Workshop – Sept, 2013
- Orientation exercise for data collectors for Scorecard III development – August-Sept, 2015
- Development of Scorecard 3- Dec 2015
- Preparatory meeting for Public Dissemination of Scorecard III-Feb 2016
- Regular meetings of NSC- monthly and as necessary

Challenges

- Poorly defined structures at the SPHCDA/B and LGAs
- Lack of uniformity in implementing PHCUOR mainly due to none adherence to National guidelines
- Use of different nomenclature for CEOs of States PHC Boards which causes confusion
- Difficulties with integrating governance and management
- **Inadequate funding of States PHC Boards and LGHA by the States and LGA**
- Lingering duplication of functions at both SPHCDAs and SMOH
- Inadequate provision of technical support to LGHA by SPHCDA/B
- Undue preference of dealing with SMOH on PHC related projects rather than SPHCDA by development

Recommendations: 1

FEDERAL LEVEL

NPHCDA to

- Develop management guidelines and training manual on PHCUOR that would serve as reference material to SPHCDA/B and LGHA for effective implementation of PHCOUR
- Provide Technical support to States without PHC Boards
- Mandate all SPHCDA/B to ensure LGA health departments are collapsed to LGHA
- To pay advocacy visit to the Governors of States without SPHCDA/B and advocate for more funding of the boards

Recommendations 2

STATE GOVERNMENTS:

- To mandate partners to comply with donor assistance protocol of the state
- Increase budgetary allocation to PHCUOR
    - Increase state disbursement for PHCUOR
    - Establish state integrated funding architecture & systems

Recommendations 3: Cont…….

SMOH

- All departments with PHC related functions should be collapsed and functions transferred to SPHCDA/B

SPHCDA/B

- Review implementation status of PHCUOR from Scorecard III report
- Identify bottlenecks and proffer realistic solutions
- Integration of **governance and management**
- Address th**e role and involvement of LGAHs**
- Involvement in planning PHCUOR and governance,
- Integration of staff and finances, etc.
- Provide Technical support to LGHA
- **Share experience** – visit other states for lesson learning

Recommendations 4

LOCAL GOVERNMENT

- LGA Health Department to be collapsed into LGA PHCD
- LGHA to work closely with and report to SPHCDA/B
- LGA to increase funding for PHC activities

Recommendations 5

PARTNERS:

- Strict compliance with guidance for donor assistance
- **Coordinated support** for PHCUOR/SPHC Board in areas of funding, technical assistance etc

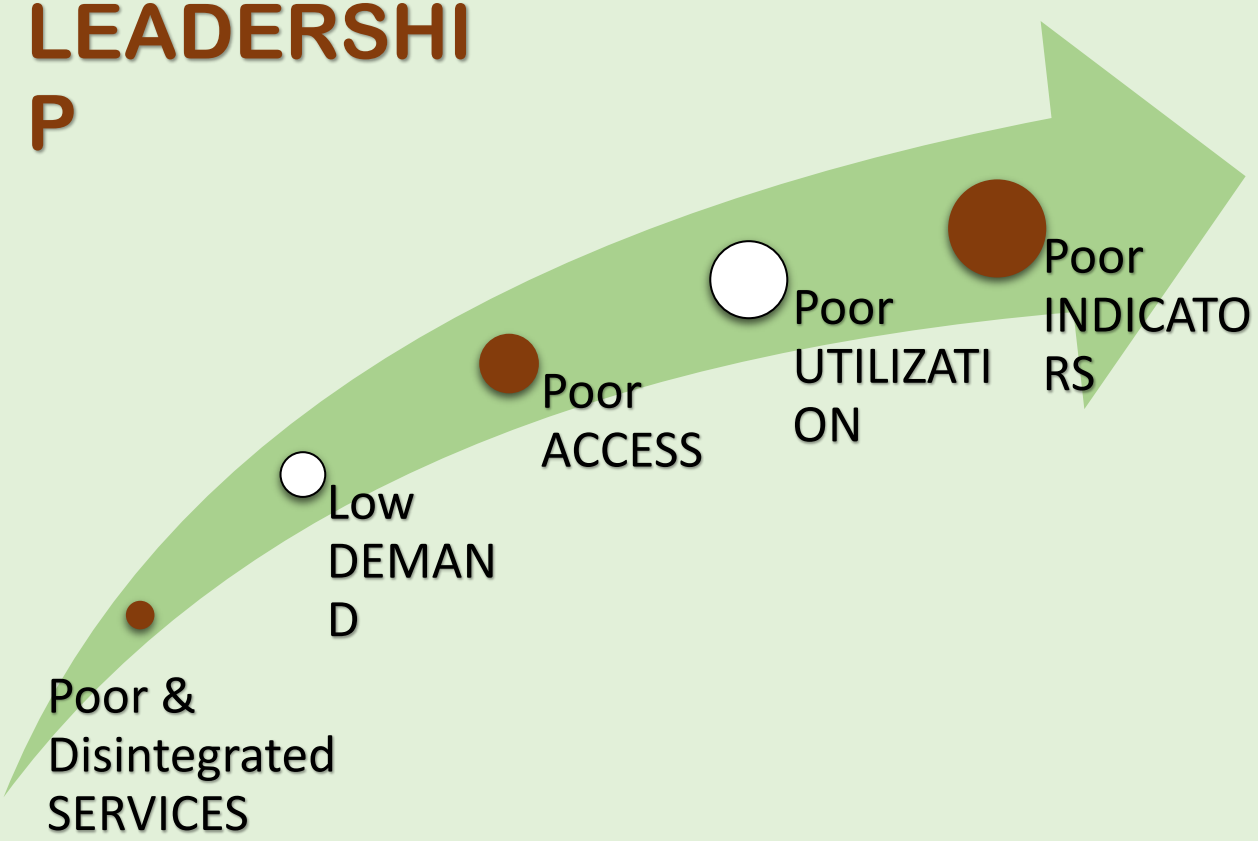
For Focused PHC Revitalization

WHY REVITILIZATION OF PHC?

"The goal of revitalizing the PHC is to ensure that quality basic health care services are delivered to the majority of Nigerians irrespective of their location in the country in order to achieve the following objectives:

- To promote coordinated leadership to make PHC facilities functional
- To provide the right facility to make PHC functional and operational
- To provide the right package of service for PHC & data quality assurance
- To bring people back to the facility through a coordinated CHIPS PROGRAMME that integrates and scales up demand side interventions

The Problem (leadership involvement in PHC improve access & utilization of services)

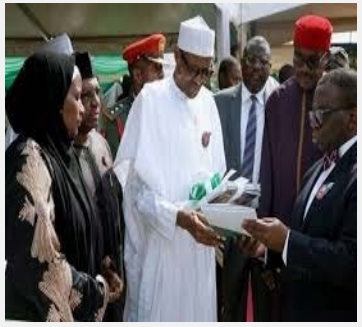


Nigeria has an obligation to change the situation and make healthcare a cardinal pillar of Sustainable Development

Restoration of political accountability…

- **Restoring integrity of governance systems and dealing effectively with corruption and poor performance**
- **Global recognition of progress in certain areas** – Nigeria's recent progress in tackling Ebola and drastically reducing transmission of wild polio virus

… as a first step, Mr. President flagged off the Primary Health Care Revitalization Program…



QUOTES FROM MR. PRESIDENT

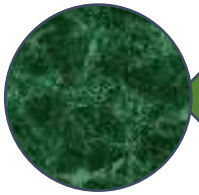
'Our vision is to reverse this unsatisfactory situation and better care for the poor and needy'

'This PHC revitalization programme is in alignment with the agenda of our party, the All Progressive Congress (APC)… we did promise to provide succor to the poor'

'Health Workers should also play their parts in ensuring the sustainability of this Primary Health Care Revitalization'

'Revamping the primary healthcare system is the platform for achieving UHC'

Changing the Landscape for effective PHC revitalization requires…….



Coordinated leadership for PHC through PHCUOR strategy

Providing the right health facility

Providing the right package of integrated interventions for care

Bringing people back to the health facility to receive the right care

Accountability

Direction for Primary Health Care

Leadership

- Provide the necessary guidance and support to states and zones through Agency Champions
- Scale up the agenda for PHCUOR

PHC Facility

- Identify already renovated facilities
- Renovate additional facilities
- Score all facilities and use for advocacy for improvement

PHC Service

- Routine Immunization
- Using data for action
- Commodities: Vaccines, Drugs, etc.
- MSS, WASH, etc.
- Volunteer Obstetrician Scheme

Demand side interventions

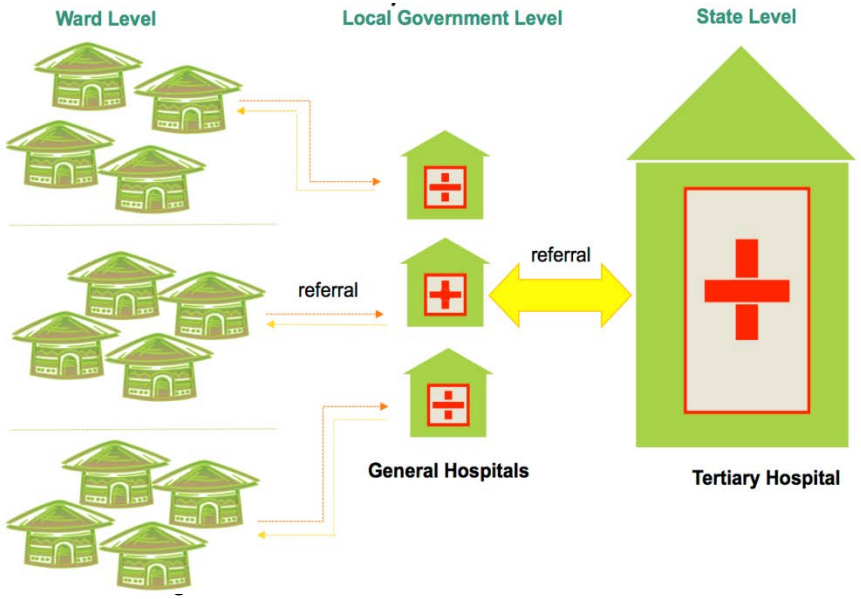
- Village health workers, WDC
- Voluntary Community Mobilizers
- IMCI trainees
- TBA linkage, PMV linkage

CHIPS

The goal is to reach 100 million Nigerians through at least 10,000 revitalized PHCs as part of the Ministry of Health's Universal Health Coverage agenda

- **30,000 primary healthcare facilities in Nigeria** (~20% of which are fully functional)
- **Focus will be on at least 10,000 PHCs** (At least 1 functional PHC per ward)
- **~10,000 political wards**
- **≈ 10,000 population per ward**

At least One functional PHC per ward; 10,000 wards



States like Niger, Lagos, Borno, Abia, Kaduna , Kano and others have commenced work at different stages on revitalizing their PHCs

The NPHCDA is driving a Community Health Influencers, Promoters and Services (CHIPS) program and linking it to the revitalization of 10,000 PHCs. Plan is to have 200,000 CHIPS across the country, to strengthen the "1 functional PHC per ward strategy" of the federal government

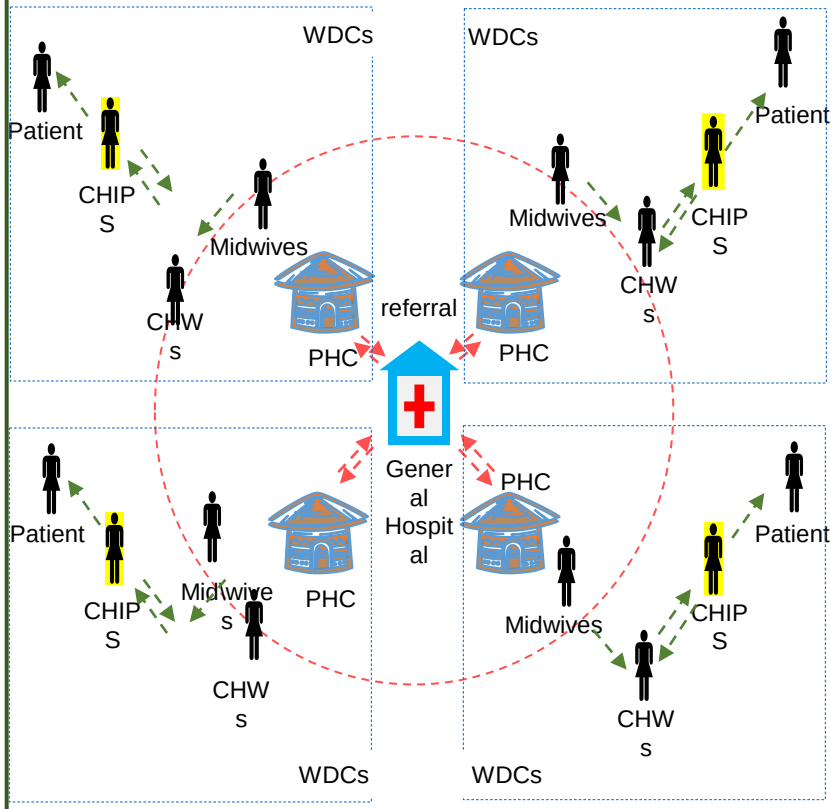
The aspiration

"Reducing maternal and child mortality by addressing supply and demand constraints"

The 3 delays;

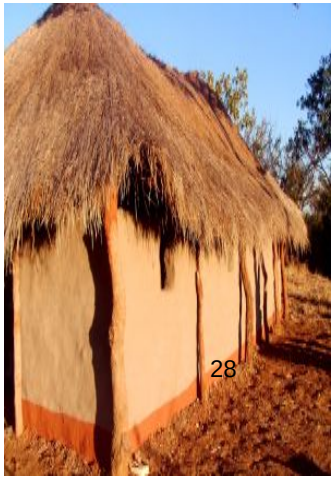
- **Delay in decision to seek care**
- **Delay in reaching care**
- **Delay in receiving adequate healthcare**

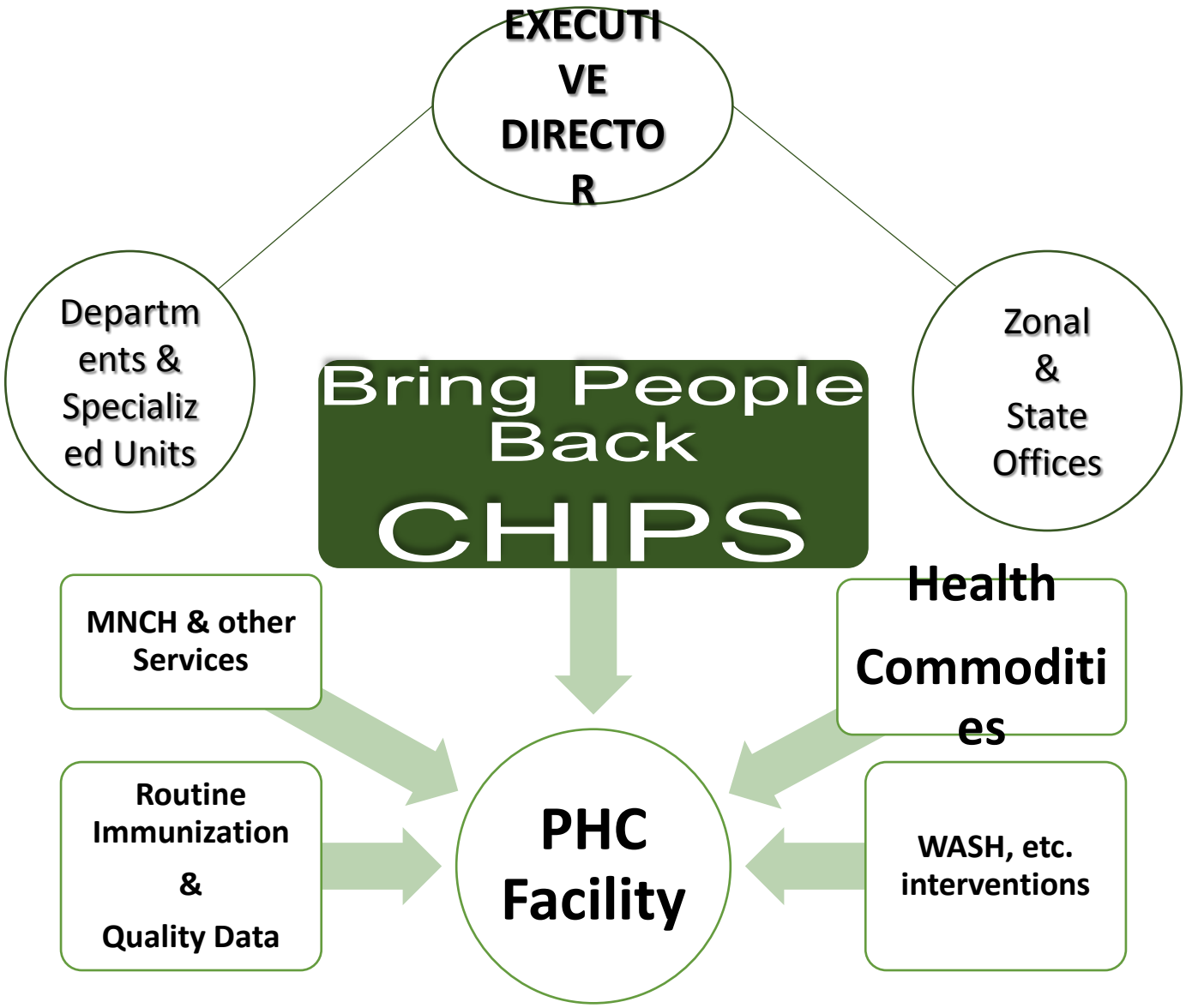
CHIPS will Increase the demand and utilization of MCH services in vulnerable communities through recruitment of 20 women per ward



The role of a CHIPS is to influence, promote and offer first line treatment of common diseases in the community

	Description
Community outreach	▪ **Identify** pregnant women in the community ▪ Conduct **home visits** (e.g. follow up on
MNCH	▪ **Educate** pregnant women on the importance of **MNCH** services (e.g. ANC, birth in a health facility, postnatal care) ▪ Provide basic health **education** to community on **key household practices** (e.g. nutrition)
First aid	▪ Provide basic **first aid** services (e.g. wound dressing) ▪ Administer basic analgesics (PCM) for mild pain
Referrals	▪ **Refer** pregnant women to the PHC for ANC, delivery and other MNCH services ▪ **Refer** community members to PHC as needed for illnesses that require referral
Record keeping	▪ Create, compile, and maintain **records** on pregnant women in community and other relevant health data and report to CHEW





The right package of integrated care - For the people that need them - Where they need them most

Action call to legislators

- Facilitates review and passage of health bills towards UHC
- Advocate full support for the implementation of PHCUOR (funding of SPHCA/Boards)
- Participation in immunization program (routine immunization & Supplemental imumunization (polio eradication initiatives & NPSIAs programme).
- Support the ongoing effort of PHC revitalization towards one functional PHC/Ward.

Thank You

Current Reforms towards attaining UHC: State Level (Where the action is!)

- Demand side
  - National Health Act- BHCPF
  - **Decentralization of NHI- Compulsory SHIS**
- Supply side
  - PHC revitalization for UHC
  - PHC Under One Roof

Successful implementation of all/any of these initiatives requires **consensus** and **capacity building**