African Health Observatory

PLATFORM ON HEALTH SYSTEMS AND POLICIES

A regional partnership to promote evidence-informed policy-making

AHOP

Country Health Systems and Services Profile

Nigeria Kick off meeting

13 – 14 June, 2022

Meeting 'housekeeping'

- **Connecting to the call:** Please connect to the link shared in the invitation from your own computer.
- **Video and microphones:** Please turn on your video when you are speaking. Please also ensure your microphone is muted when you are not speaking to minimize background noise.
- **Technical problems:** If you have problems, please contact to the AHOP email address: Lsehealth.Ahop@lse.ac.uk
- **Questions and comments:** **Please utilize the** chat or the zoom 'hands up' feature. We will be monitoring both throughout the workshop.

CHSSP kick off meeting agenda: Day 1

Timing	Session	Facilitator
• 05 mins	• Welcome & objectives	• Editors
• 10 mins	• Introductions	• All
• 05 mins	• AHOP Overview	• LSE
• 05 mins	• Background on the National Centre	• NC PI/ Lead Author
• 20 mins	• Overview of existing national health system descriptors	• NC PI/ Lead Author & Editors
• 15 mins	• Rationale for a CHSSP	• Editors, NC PI & Comms lead
• 05 mins	• Break	• Editors, NC PI
• 30 mins	• CHSSP overview and development process	• Editors, NC PI
• 20 mins	• Discussion	• AFRO, LSE & NC Comms teams
• 05 mins	• Conclusions and close	

CHSSP kick off meeting

Meeting Objectives:	Expected outputs

• Author & Editors team familiarization with the CHSSP production process (see pre-reads) including, drafting, review and production processes and expected timelines
 	
• Discuss and agree on:
  • CHSSP production timelines
  • CHSSP writing distribution
  • Author and editor roles and responsibilities
  • CHSSP data sources and suitable countries for comparison
  • Communication during the writing process
  • CHSSP dissemination plan
	1. Clarity on the CHSSP production process
	2. Sharing of CHSSP writing workload
	3. Agreement on production timelines
	4. Agreement and scheduling of meetings

CHSSP Kick off meeting

Introductions

We will go round the “virtual” table to allow everyone to introduce themselves.

Please share your **name**, **organisation and role** as relates to the production of CHSSPs.

CHSSP Kick off meeting

AHOP Overview: vision

The African Health Observatory - Platform on Health Systems and Policies (AHOP) is a regional partnership to promote evidence-informed policy-making by supporting cross-country learning.

CHSSP Kick off meeting

AHOP Overview: structure

Regional Secretariat

The Platform is hosted by WHO AFRO who serve as the **technical secretariat at the regional level** and coordinate the Platform's activities.

National Centres

National Centres are the **focal points for analysis and knowledge brokering** within each country and are institutions of high-quality academic work and evidence for action.

They **lead the technical work** of the Platform, supported by and working with technical partners.

Governance

The Platform is governed by an **Advisory Group** – comprising Platform partners, senior representatives from national and international organisations, national ministries, policy-makers and academia – which will review the annual workplan and monitor progress to ensure Platform outputs respond to changing regional policy needs.

Technical Partners

Technical Partners are central to **supporting the research and dissemination activity** of the Platform.

They ensure National Centres are best placed to tap into existing research and evidence, maintain the **rigour and policy relevance of research**, and deliver the highest quality outputs.

Through institutional partnerships with the Platform, Technical Partners bring expertise from organisations working on health systems at **national, regional or global levels.**

CHSSP Kick off meeting

AHOP Overview: Remit

- Programme of work integrated across outputs
- Outputs sit within thematic focus on **'Re-engineering health systems'** for initial five-year period to 2023.
- AHOP PoW theme straddles the WHO's dual focus on **UHC and PHC**

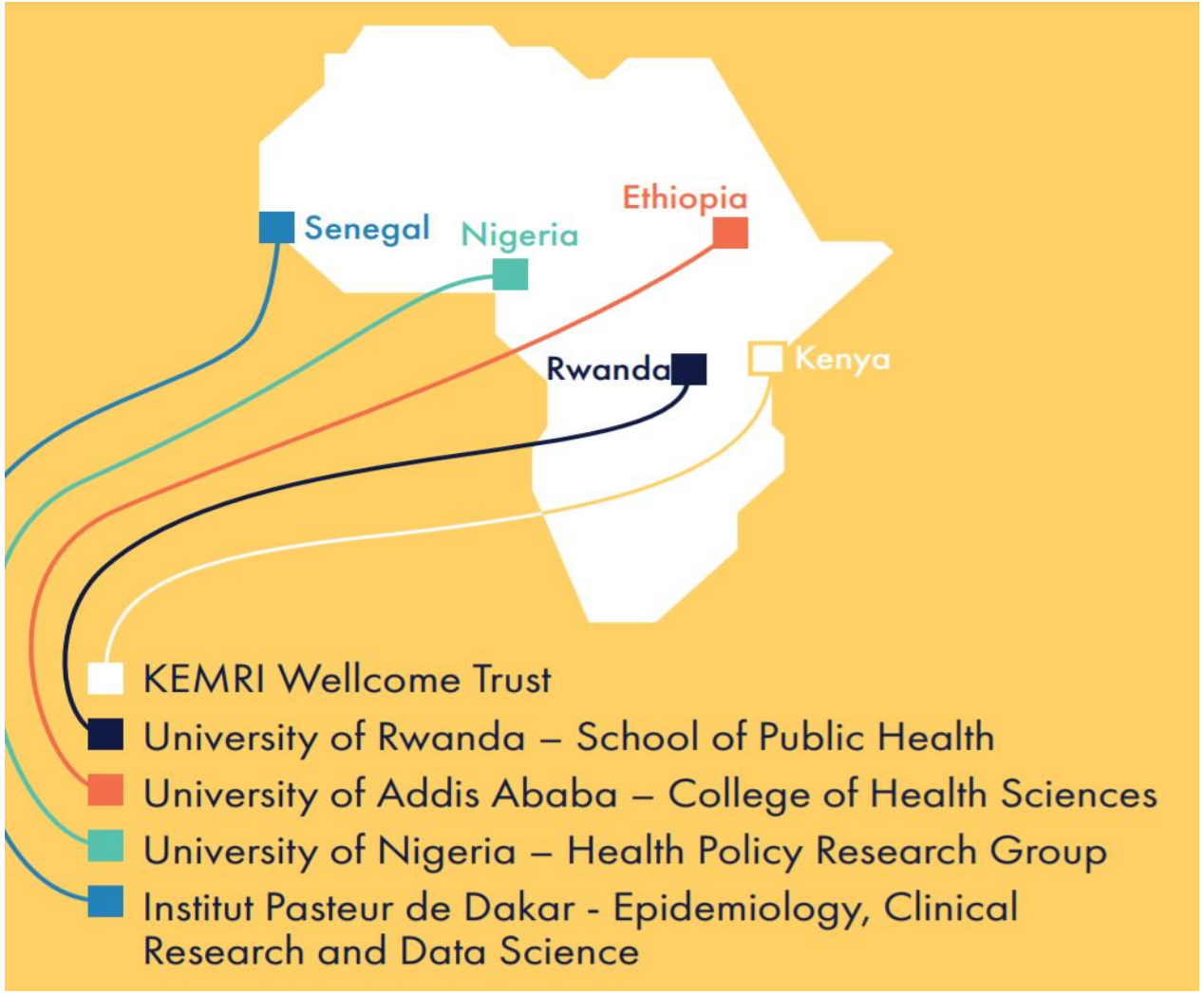
CHSSP Kick off meeting

Background to the National Centre

- Overview of the National Centre

- HPRG is a multidisciplinary research group in College of Medicine, University of Nigeria

- Dedicated to excellence in undertaking public health, health system and policy research to advance the frontiers of medical knowledge
- Highest concentration of health economists & Health Policy and Systems Analysts in Nigeria and West Africa
- Research and analytical skills on all aspects of health economics, health policy and systems research + analysis, qualitative analytical work, epidemiology and public health.



CHSSP Kick off meeting

Overview of existing national health system

- Country overview
- Administrative levels of the health system
- Levels of the health care delivery systems: types of service delivery points
- Investments in health systems elements/pillars/function: key outcomes, challenges and way forward
  - Health Governance
  - Health Financing
  - Health Information
  - Health workforce
  - Medicines, products & supplies
  - Health Infrastructures
  - National and sub national service delivery systems

Country overview

- Nigeria is a coastal West African country with a total area of 923,768 square kilometres.
- Population of 140,431,790 (2006), estimated to have reached 186 million in 2016, and projected to reach 392 million by 2050, to become the world's fourth most populous country
- Extremely culturally diversified, with about 374 identifiable ethnic groups and over 500 languages. However, there are three major ethnic groups, Igbo, Yoruba, and Hausa.
- Economically, Nigeria has a mixed public-private economy with a dependence on oil.
- The oil and gas sector is the major driver of the economy and contributes to over 90% of export earnings

Governance arrangements

- Presidential system of government
- Three arms of government-executive, legislative and judiciary
- Four yearly national and sub-national elections
- Administratively decentralized into the :
- - the national level
- - two Sub-national levels
    - 36 states and the federal capital territory (FCT)
    - 774 local governments (LGs)
- Six non-administrative zones for equitable distribution of resources

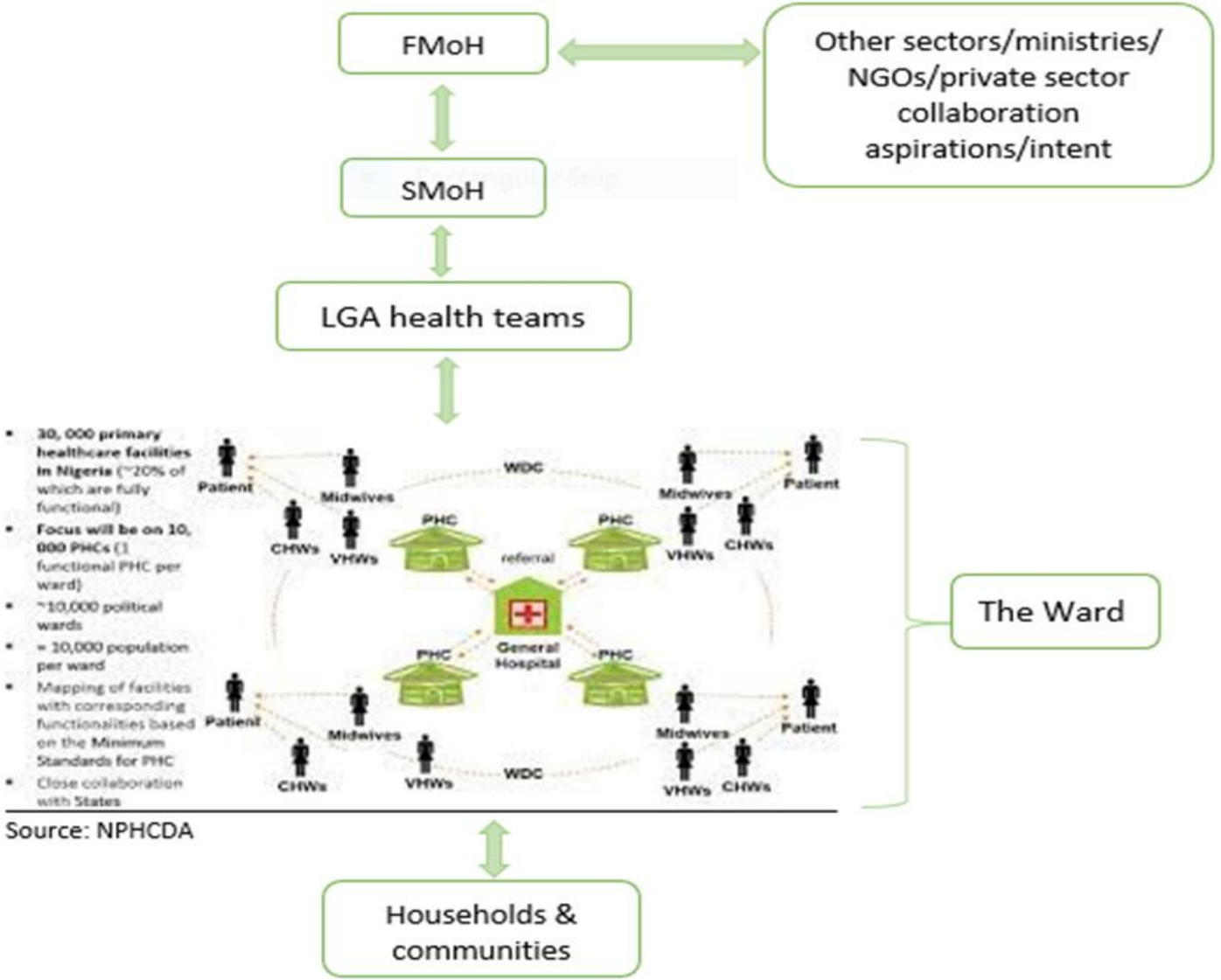
Health system context

- Healthcare is constitutionally a concurrent responsibility of the three tiers, however, specific roles not spelt out in the Constitution
- National Health Policy (NHP-2004) aligned responsibilities with the three-tier governance system as follows:

- **Federa**l-Health policy formulation, technical assistance/ service provision through tertiary teaching hospitals and federal medical centres
- **State**- Secondary services at cottage and general hospitals & comprehensive health centres, support and supervise LGAs
- **Local Govt. Areas** -Primary health services at PHCs (MNCH services (antenatal care, childbirth care, postnatal care & others). In the LGAs, the wards are the lowest levels of health service delivery through the **Ward Health System**.

The Ward Health System

The Nigeria Ward health system



Source: NPHCDA

Nigeria Health System blocks

-Current situation

-Challenges

-Way forward/Policy priorities

Health system governance
Current situation

- Health is constitutionally on the concurrent legislative list thereby providing for federal, state and local governments to legislate on health services with guidance from a robust health governance and policy framework including the following:

  - The National Health Policy, The National Council on Health

  -The National Health Act which includes the recently appropriated BHCPF

  -Specific policies to strengthen PHC e.g. Primary Health Care Under One Roof.

  -Institutional structures including MDAs and Health Management Boards, Regulatory Committees and other complementary committees.

- While the governance and management structures exist, the capacity for transparent and accountable health systems governance and leadership remains weak.

Health system governance
Way forward/policy priorities

There is need for:

- Evidence-informed decision making for health planning, by strengthening data systems.
- Transparency and accountability (& fighting corruption) in planning, budgeting and procurement processes.
- Governance structures for developing and deploying “Health in All policies (HiAP)” to enhance multi-sectoral actions
- Enactment of laws to strengthen PHC governance through the PHC under one roof (PHCUOR) framework.

Health Financing
Current situation

- Total health expenditure (THE) (USD): $14,798.6 billion (NHA, 2017) (FMOH, 2019)
- THE per capita (USD): $74 (NHA, 2017) (FMOH, 2019)
- Govt Expenditure to GDP ratio: 3,9% (FMOH, 2018)

Major Sources of financing:

- Government expenditure on health as % of THE : 14.4%
- Households/Individuals expenditure on health as % of THE : 76.6%
- Donor funding for health as a % of THE: 7.4%

The weaknesses in the Health Care Financing (HCF) arrangements include weak institutional structure and inconsistent policy implementation and low government investment in health

Health Financing
Way forward/policy priorities

- Fully implementing the Basic Healthcare Provision Fund (BHCPF) and increase health budget to 15%, in line with the Abuja declaration;
- Use of social insurance mechanism as main pooling mechanism, with efficient, equitable, accountable and corruption-free management of pooled funds.
- Strategic purchasing for health services so as to ensure value for money. Strengthen efficiency and accountability of public finance management (PFM) and provider payment mechanisms through appropriate reforms.
- Advocacy for political commitment towards domestic financing for UHC

Health Workforce
Current situation

- Critical shortage due to:
- High attrition rate across government levels (and emigration) as a result of poor remuneration
- Urban/rural maldistribution
- North/South maldistribution
- Different states are at various stages of establishing HRH units but weak capacity for HRH management, inadequate personnel and insufficient funding are current challenges affecting implementation of HRH units in the state

Health Workforce
Way forward/policy priorities

- Address inadequate numbers and maldistribution of HRH, by ensuring that facilities have the minimum quantity and skill mix
- Regular competency retraining and re-training of health workers to provide quality standard of care

Medicine/Products/Supplies Current situation

- Despite the existence of relevant institutions, the availability of medicines, vaccines and health technologies in Nigeria is characterised by disproportionate underfunding for essential medicines and other health products resulting in:
- persistent stock-outs and high expirations at service delivery points, irrational drug use, poor and parallel supply chain management systems, and inadequate warehousing with available ones not meeting minimum standards.
- Local manufacture is plagued by poor infrastructure and protection from unfair international
- competition.
- Local manufacture only supplies about 5% of the local needs of medicines and
- other health products.

Medicine/Products/Supplies Way forward/policy priorities

- Use of, and periodic review of approved Essential Drugs List in facilities.
- Ensuring availability and affordability of top quality medicines, vaccines, commodities and other technologies with a strengthened supply chain management.
- Establishment of a national blood transfusion service and local manufacture of drugs and consumables in the formulary.
- Promotion and development of standardised traditional medicine practice and products.

Health Infrastructure
Current situation

- About 80% of health facilities are reportedly at different states of dysfunctionality ranging from dilapidation, lack of water and electricity.
- Secondary and tertiary levels of care have obsolete and nonfunctional equipment due to lack of maintenance.
- In 2005, the FMOH established basic requirements for delivery of the essential package of health services (EPHS) across the tiers of healthcare services, but this standard is not being followed in most health facilities in the country.
- The delivery of this package was accompanied by specified standards in infrastructure, human resources and health commodities, which are yet to be implemented (NSHDP II).

Health Infrastructure
Way forward/Policy priorities

- At least 1 functional PHC per ward linked to a functional secondary health facility in each LGA.

- At least 1 functional secondary health facility in each LGA with qualified personnel and the establishment of a strong referral system to a contiguous tertiary health facility.

- Upgrade specialist and tertiary hospitals to meet local needs including the establishment of a comprehensive and efficient referral system.

Service delivery
Current situation

- FMOH aims to have at least one functional primary health centre (PHC) in each political ward with involvement of the Ward Development Committee (WDC) comprising selected community members to ensure community participation and accountability in service delivery.
- In addition, community based health care services are provided by various cadre of Volunteer Health Workers (VHWs) who are engaged by different public health programmes though inconsistent standards and incentives.
- However, the recently launched Community Health Influencers and Promoters of Services (CHIPS) initiative aims to harmonise CHWs and to better define their roles and coordination.
- In addition, Community Health Extension Workers (CHEWs) are expected to spend at least 60% of their time on community-based health care service delivery.

Service delivery
Way forward/policy priorities

- Quality basic minimum package of services to every citizen at every health facility (esp. For priority areas-MCH, NCDs)

- Technology, Innovation and better engagement of the private sector in health care delivery.

Health information
Current situation

- The revised Health Information System (HIS) policy provides the framework for inter-sectoral, comprehensive and integral structure for collection, collation, analysis, storage, dissemination and use of health and health-related data and information.
- The country's Health Information System (HIS) remains weak.
- Fragmented with numerous vertical programmes, which are mostly donor-driven, running parallel HIS systems
- HMIS coordination remains challenged due to multiplicity of data collection tools and non-availability of data reporting tools.

Health information
Way forward/policy priorities

- Strengthening institutional structures for HMIS governance and better coordination of data stakeholders (especially the private health sector) at all levels.
- Tracking of progress towards UHC by the country and state using information & knowledge dashboards
- Integration of Nigeria's Health Information System platforms (and comparative performance dashboards) into one HMIS that speaks to all disease areas and provides information for prioritizing national health needs.

Community Participation
Current situation

- Traditional and religious leaders are playing a critical leadership and gatekeeping role to improve access to and utilisation of health care services
- The establishment of Ward Development Committees (WDCs) in more than 800 political wards across the country under the leadership of community members
- Community representation in Hospital Management Committees
- Facility health committees comprising community members and staff of the health facility have been established and are functional
- Active engagement and involvement of various cadre of community health workers in different public health programmes.
- Plans to harmonise the different community-based health workers under the CHIPS initiative are underway.

Community Participation
Way forward/policy priorities

- Community involvement and participation in the planning and implementation of heath programmes at the PHC level through the following:

i. Revitalization/initiation of Village/Community Development Committees according to National Guidelines and PHC principles

ii. Harmonization of the CHIPS

iii. Building the capacity of the committees for advocacy and effective delivery of assigned tasks.

Research
Current situation

- Several institutions involved in health research at the academic level and as government research agencies.
- These institutions are faced with serious challenges ranging from gross under funding, leadership and governance issues, poor legal and regulatory environment, infrastructural challenges, non-passage of intellectual property rights laws, and weak linkages between health research institutes, the private sector and local needs
- Hardly any domestic funding for research at sub-national level.
- The private investment in health research and development is also very poor

Research
Way forward/policy priorities

- Strengthen the conduct and use of research data for evidence-based decision making and ensure research agenda focus on HS priorities.
- Strengthening the research component of the Departments of Planning, Research and Statistics (DPRS) at all levels
- Establishment of Evidence-to-Policy units within the DPRS to shepherd the translation of evidence from research into policy and practice.
- Adequate funding of health research from domestic resources.

Partnerships
Current situation

- Nigeria is a signatory to the 2008 Global Compact of the International Health Partnerships and related initiatives (IHP+), an international partnership that aimed to improve effective development cooperation in health to help meet the MDGs
- Partnership with the private sector, NGOs, communities and development partners, other social and economic sectors, is recognized as essential for service delivery.
- A PPP Policy (2005) was developed by FMoH to provide a framework for the involvement of the private sector in the development of infrastructure and services in the country including health infrastructure and services.
- However, coordination of all these groups has been weak

Partnerships
Way forward/policy priorities

- Development of stronger coordination platforms to foster multi-sectoral collaboration

- Build on existing successes of the PPP to further actively involve the private sector

CHSSP Kick off meeting

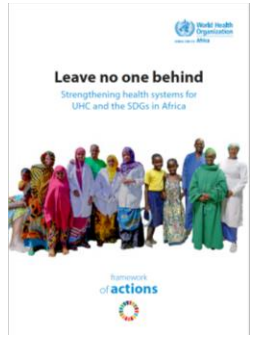
Rationale for a CHSSP

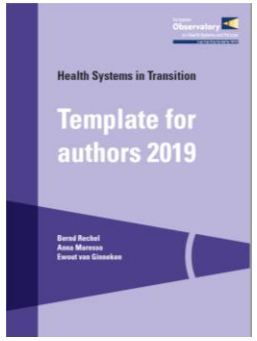
Where does the CHSSP fit in with existing available M& E tools?

CHSSP Kick off meeting

CHSSP Overview

- Country Health Systems & Services Profile (CHSSP) flagship AHOP product
- CHSSPs offer a descriptive and analytical snapshot of health systems in the African region
- CHSSP template development based on WHO/AFRO UHC Framework of Actions + Health in Transition (HIT)
- Template will be improved with the production of the first country profiles : "Leaning by Doing"

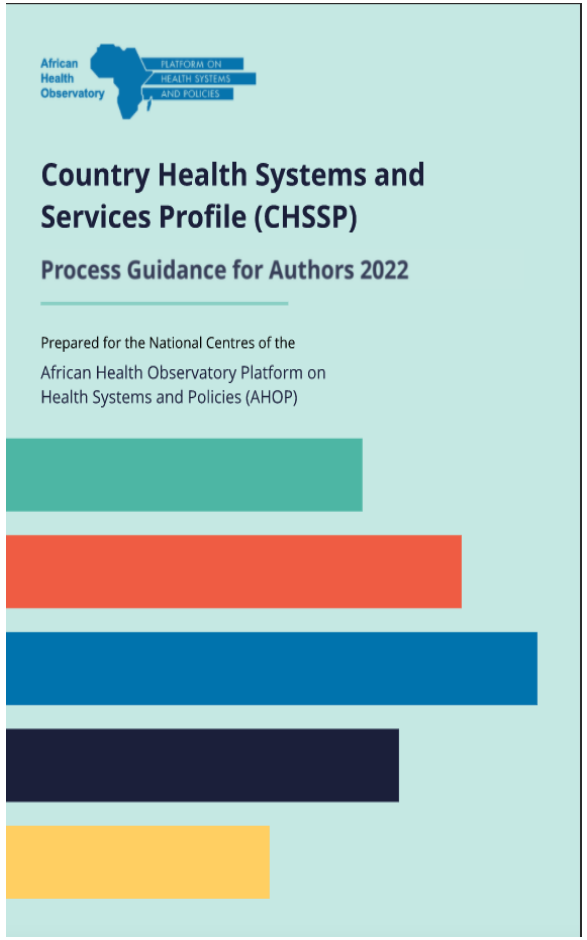


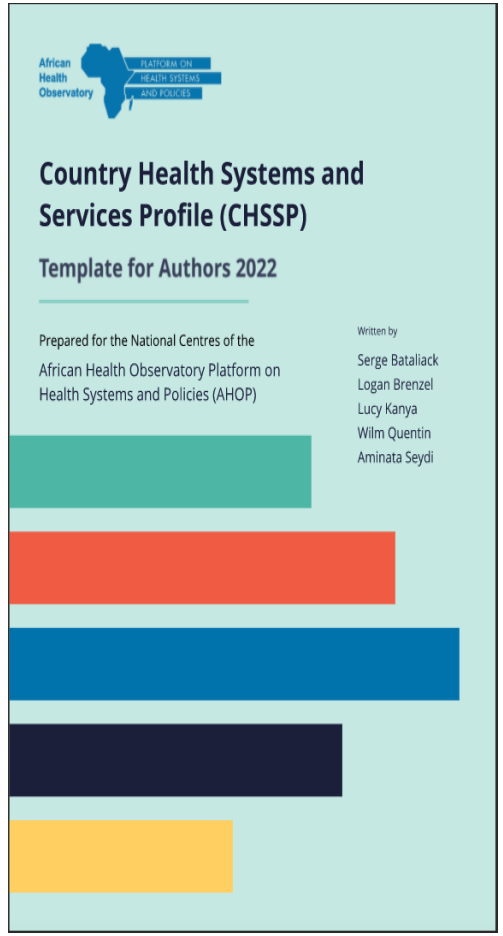


AHOP

CHSSP Kick off meeting

CHSSP Overview





CHSSP Kick off meeting

CHSSP uses and audiences

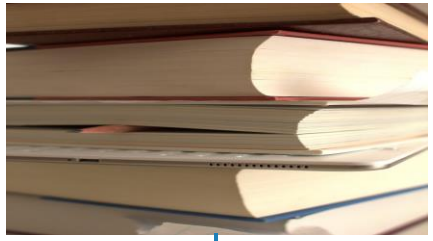
- examine different approaches to the organisation, financing and delivery of health services, and the role of key health system actors;
- describe the institutional framework for and the process, content and implementation of health policy;
- highlight challenges and areas requiring more detailed analysis;
- provide a tool for disseminating information on health systems;
- facilitate the exchange of reform experiences across countries;
- establish a baseline for assessing the impact of reforms; and
- inform cross-country comparative analysis

CHSSP Kick off meeting

CHSSP target audiences at national level

- Key stakeholders? Reflect on stakeholder mapping conducted at the beginning of the project
- Target audiences
  - Who they are
  - How to engage them
  - Engagement points

Partners and collaborators that will assist with providing and/or validating data for the NC



Academia
(researchers, librarians, academics, archivers, community of academics e.g. African Health Economics Association, Health Systems Global, etc.)

Policy makers
(legislators and relevant house committees, federal/states ministries of health and related departments and agencies; National Bureau of Statistics; Nigeria Centre for Disease Control; Primary healthcare agencies; Health Units in local governments, and other relevant authorities at the federal, state and local government levels)

Media
(News houses, including health-focused media e.g. healthwatch, etc.)

Development partners, Civil Society Groups and Communities
(WHO and other United Nations Groups; African Union; ECOWAS; Non-governmental Organizations; Health Facility Committees and Ward Development Commission, and community-level research respondents)

Ways to engage stakeholders and possible challenges

S/N	Stakeholder(s)	Engagement means	Challenges (Revise post COVID)
1	Academics and researchers	Conferences, publications, policy briefs, blogs, workshops, and social media	• Physical distancing • Gradual growing acceptance of virtual meetings • Funding
2	Ministries of Health and other health agencies and departments at federal and state levels	Workshops, tweets, and research debriefing	• Physical distancing • Tight office schedules and bureaucratic bottlenecks
3	Local government authorities and primary healthcare agencies	Workshops and debriefing	• Physical distancing • Penchant for pecuniary benefits • Low ability and lack of resources to make use of virtual platforms
4	Citizens and community-level respondents	Research interviews and discussions, invitation of representatives to workshops and debriefing	• Physical distancing • Penchant for pecuniary benefits • Low ability and lack of resources to make use of virtual platforms
5	Politicians and law makers	Workshops, tweets, and research debriefing	• Physical distancing • Tight office schedules and bureaucratic bottlenecks • Insincerity • Misconception about the study to have political undertones
6	Media and CSOs	Tweets and workshops	

Discussions/ feedback

Break

CHSSP Development Process

Key Actors

National Stakeholders

Reviewers

Editorial Board

Authors

Editors

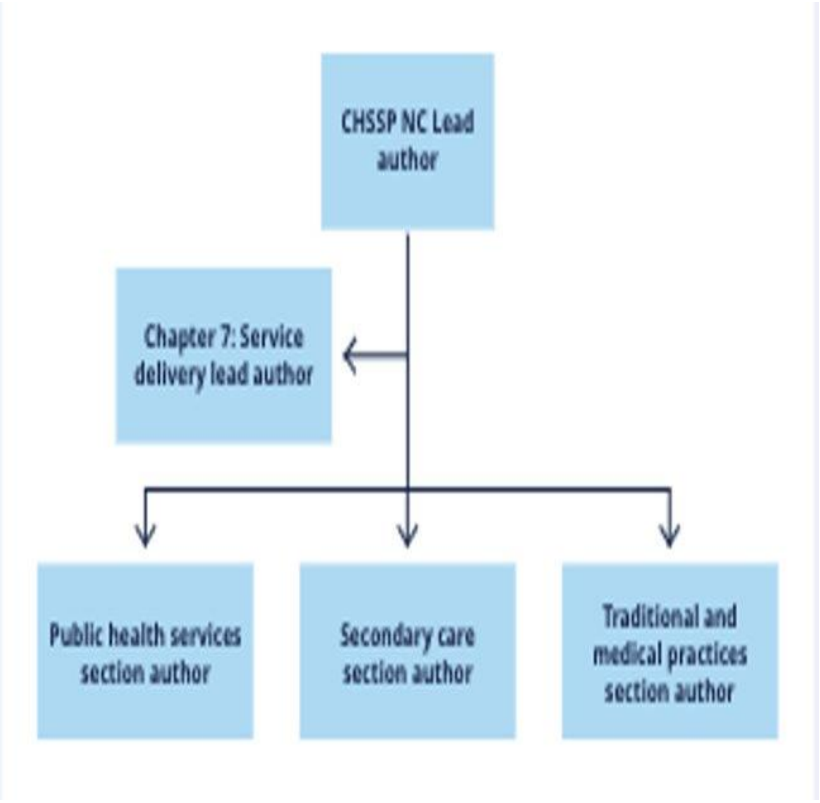
Production team

Communications team

CHSSP development process

Author roles: lead author

- Author team identified and led by NC **lead author** who:
  - liaises with editor & coordinates NC writing process including distributing writing tasks
  - liaises with **co-authors** who:
    - write concisely following the CHSSP template
    - discuss tables & figure with lead author and editor
    - cite reports on implementation of reforms and comment on factual events
    - state explicitly where data are not available
    - cross-reference between sections to avoid repetition



CHSSP development process

Author roles: co-authors

- **Profile authors**
  - Core group of NC writers who work across chapters.
  - Ensure consistency and flow across chapters
  - Led by NC lead author who coordinates production of all chapters
- **Chapter & section authors**
  - Chapter lead author for each chapter, coordinates inputs from authors working on the chapter
  - Section authors draft / contribute to individual chapters or sections of them

CHSSP development process

NC CHSSP author team

- Profile authors
- Chapter authors
- Section authors

CHSSP development process

Reviewer categories

1. **Independent reviewers external to the Platform**: Subject experts / health systems experts in NC countries or WHO African region
2. **Independent reviewers:** AHOP platform partners independent of author and editorial team: CHSSP Editorial board & AHOP AG members
3. **Factual accuracy reviewers:** National stakeholders, AHOP partners and AG Members

CHSSP development process

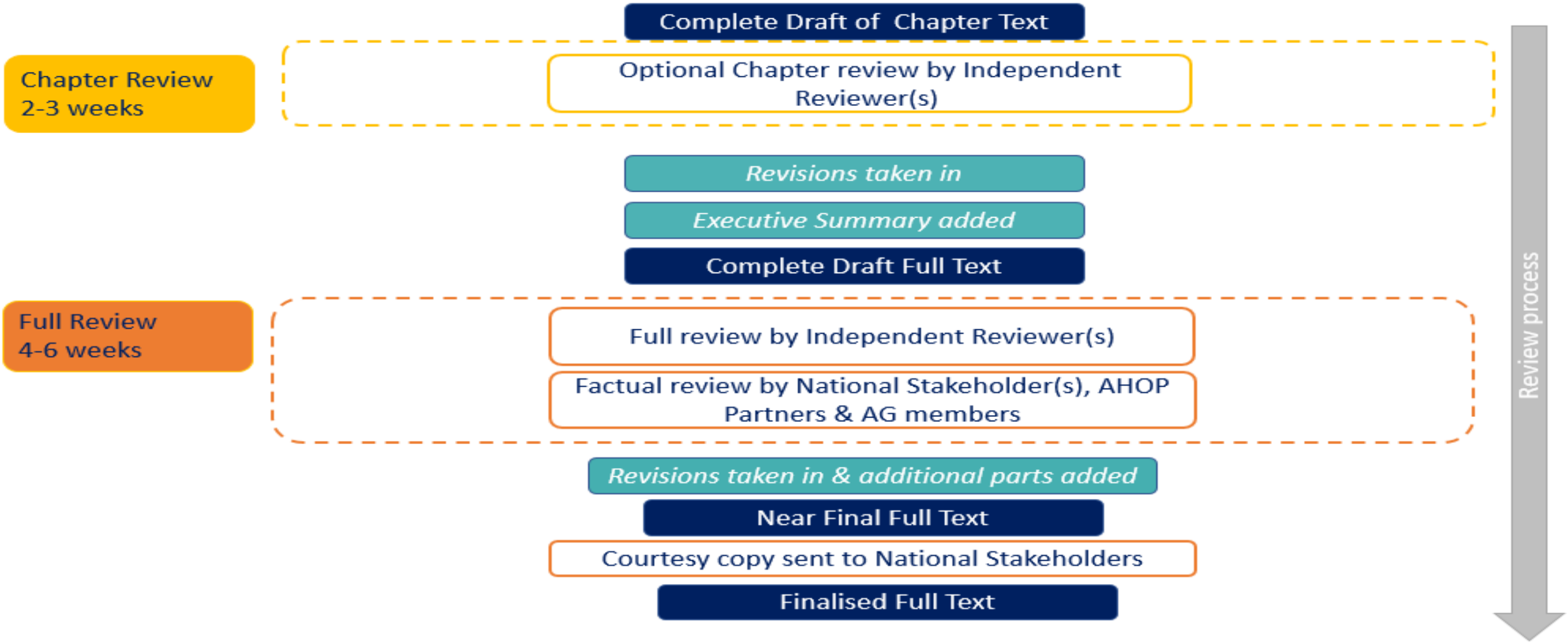
Reviewer roles

1. **Independent reviewers**:
   - External: critical review of chapters or full profile addressing both technical content and accessibility
   - AHOP Platform members will also check for consistency to enable cross-country comparability between profiles

2. **Checking for factual accuracy:**
   - correct factual errors or errors arising from incorrect analysis of data or policies

CHSSP development process

CHSSP review and revisions process



CHSSP Development Process

Editorial board

- Clearing house for all CHSSPs
- AHOP Core partners and NCs
  - reviewing CHSSP chapters and complete profiles
  - identifying and allocating external reviewers for CHSSP chapters and complete profile
  - allocating CHSSP chapters and complete profile among NCs and partners for internal (peer) review
  - reviewing complete profiles for quality
  - signing off complete CHSSPs for dissemination and publication
  - informing the development and future revisions of the CHSSP template

CHSSP development process

Series & Country Editors

- Drawn from AHOP technical partners
- Dedicated CHSSP editor(s) per country (LSE & WHO)
  - Lead Editor (LSE) – Beth
  - Co-Editor (AFRO) - Serge
  - CHSSP Series Editor (LSE) - Lucy
- CHSSP Series Editor checks for consistency and quality across series

CHSSP Development Process

Country editors roles

- Project Management
  - set up realistic timelines, deadlines & milestones with authors – lead editor
  - participate in regular scheduled and impromptu meetings – both editors
  - AFRO co-editor will provide core data set and cross-check data tables for all figures and tables
- Author liaison
  - work with lead author to agree on the distribution of CHSSP chapters among co-authors – both editors
  - brief authors at the beginning and ensure regular, clear communication with author teams – lead editor

CHSSP Development Process

Country editors roles

- Editing & revising – Split between LSE and AFRO
  - manage various iterations
  - editing CHSSP chapter & full drafts
  - discuss and agree additional (sub)national data sources and tables with authors
  - help make text concise, engaging & accessible
  - encourage use of innovative graphs and figures beyond core set

CHSSP Development Process

Country Editor(s) role

- Review Process
  - working with editorial board, identify suitable reviewers – both editors
  - manage review process – lead editor
  - liaise with series editor to ensure cross-platform comparability & quality – both editors
- Production & Dissemination
  - liaise with production and communication teams to develop dissemination plan – lead editor

CHSSP Development Process

Copyright & Authorship policy

- CHSSP Copyright held by WHO Afro on behalf of the Platform
- CHSSP profile authorship guidelines have been agreed and outlined in the CHSSPs template and process documents
- Authorship policy in line with academic norms (ICMJE http://www.icmje.org/recommendations)
- Authorship policy gives credit to all who make a substantiative contribution by writing or rewriting parts of the text

CHSSP Development Process

Copyright & Authorship policy

- **Profile authorship:** First author of the overall profile will be NC lead author, then NC co-authors (profile authors) with the editors listed last
  - lead editor will be the last author while co-lead editor will be listed as the penultimate author
  - ideally aim for no more than 6 overall profile authors to allow all to be included in cover & standard databases, but flexibility on this
- **Chapter authorship:** chapter and section authors will be acknowledged as authors of individual chapters as appropriate depending on their contribution, but not as authors of the overall profile. Profile authors may in addition be named as individual chapter authors where warranted.
- **Other contributors** (data providers, reviewers, limited section authors etc) will be thanked and acknowledged in a dedicated acknowledgements section, provided they have consented to be named.
- **Series editor** will be named in acknowledgements section of all published profiles

Conclusions and close

CHSSP kick off meeting agenda: Day 2

Timing	Session	Facilitator
• 05 mins	• Day 1 recap	• All
• 30 mins	• CHSSP template and process guidance document	• Editors & NC PI/ Lead Author
• 20 mins	• CHSSP development process	• Editors & NC PI/ Lead Author
• 30 mins	• Work approach	• NC PI/ Lead Author & Editors
• 20 mins	• Planning for dissemination	• NC & LSE Comms lead
• 05 mins	• Next steps	• Editors, NC PI
• 05 mins	• Workshop evaluation	• All
• 05 mins	• Conclusions and close	• All

CHSSP Kick off meeting

CHSSP template and process guidance

- Overview of CHSSP template and process guidance document
- Discussions and clarification as may be requested

Chapter 1sections that need to be clarified

- On the impact of COVID-19, what should be the focus? Health, economy, social, etc.
- It appears the figures do not have an AFRO comparison – is that deliberate?
- Who populates the AFRO details? Will the already populated ones be updated?

Chapter 4 sections that need to be clarified

It not clear what we meant by “traditional and religious practitioners” in terms of definition and scope? We need to be clarified on this!

For the traditional practitioners, do we mean informal providers such traditional medicine dealers?

For religious practitioners, faith based hospitals?

Where do we place the PMVs?

Why do we lump dental practioners and technicians? I think they should be captured separately for accurate information. Same also for Pharmacists.

Chapter 5-Questions/ Comments and Clarifications

- What if we are unable to find data to populate included tables, or if data found is incomplete or from different sources and for varying years ? E.g for the prescribing indicators, What are we to do then?

- How do we get data for annual expenditures within informal private sectors?

- There also seems to be an overlap between health technologies such as diagnostic and imaging technologies that should be described and discussed in chapter 5 with the medical equipment and supplies to be discussed in Chapter 6, where do we draw the line?

Chapter 6.sections that need to be clarified

- Need to be clear in number of years for tables 6.1, 6.2, 6.3 and 6.4 (Which years are we looking at, e.g. the last 5 years, last 10 years, etc.)
- Are we expected to address this chapter from a definitional standpoint by focusing specifically on these five elements:
  - **health organizations (training schools, hospitals, laboratories, etc.);**
  - **Equipment (what types of equipment: diagnostic, therapeutic, preventative, rehabilitative/assistive, etc.) and**
  - **physical/operational infrastructure: power, water, roads, communication, etc.**
  - **research infrastructure (biomedical, clinical, diagnostic, therapeutic, preventative, rehabilitative/assistive, etc.)**

Chapter 7-sections that need to be clarified

- Is it Primary care or Primary Health Care?
- Community based services and Community participation (both are closely related, any need for being separate units)
- Table 7.2: Hospital indicators related to secondary care

(Source of information for Table 7.2. where? and will the information be from all the states in Nigeria)

Chapter 10-sections that need to be clarified

- **Table 10.1 -** Some essential services on the table do not have prepopulated indicators
  a) Adult nutrition services
  b) Clinical and rehabilitative services
  c) Elderly persons social support services
  d) Clinical and rehabilitative services for the elderly
- ?appropriateness of "ANC1-ANC4 dropout rate" for "Pregnancy and **newborn**"
- Indicator for screening for NCDs and risk factors
- Child nutrition – under rather than over

Table 10.2 - Basic sanitation needs to be clarified

Table 10.5 – User satisfaction

- Population surveys – we may need to go back 5 years

CHSSP development process: Time commitment and timelines

Complete CHSSP profile development phase: **Best case scenario** 12 months

Production, Publication & Dissemination phase: 2-4 months

Kick-off
4% (4 weeks)

- NC Author team confirmed
- MoH & WHO CO notified
- MOH focal point person identified
- Kick off meeting held: timelines agreed & dissemination strategy discussed
- Excel data for pre-populated tables prepared

Writing & Editorial Review
47% (46 weeks)

- Drafting CHSSP chapters & complete profile
- Editorial review of CHSSP chapters & complete profile
- Revising CHSSP chapters & complete profile
- Finalising figures and tables for inclusion in complete profile

Reviews
27% (26 weeks)

- Independent reviews of CHSSP chapters & complete profile
- Author & editor revisions
- Factual reviews of complete profile
- Finalisation of complete profile

Internal Quality Assurance
4% (4 weeks)

- CHSSP review for:
  - Quality control
  - Series consistency
  - Comparability

Production
10% (10 weeks)

- Production of overheads, webpage & news item text
- Copyediting
- Proof corrections
- Translation
- CHSSP design

Publication & Dissemination
8% (8 weeks)

- CHSSP launch
- CHSSP online publication
- Print CHSSP copies
- CHSSP dissemination through established networks

AHOP

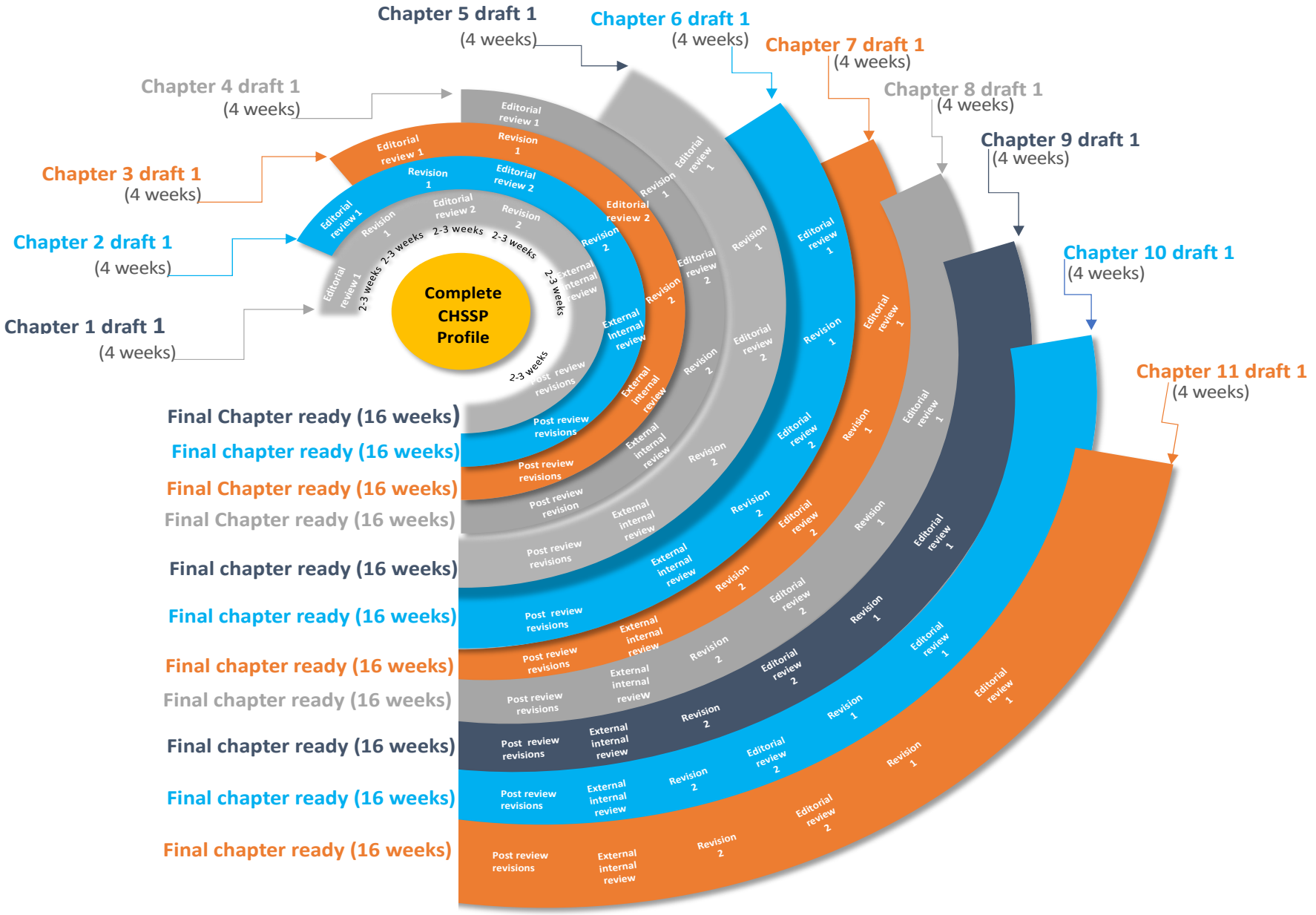
CHSSP Kick off meeting

Single chapter production timeline (best case scenario)

Task	Approximate time	Indicative timeline
Initial chapter drafting	4 weeks	Complete by 11 July
First round of editing	2-3 weeks	Complete by 25 Jul
First revision post editing	2-3 weeks	Complete by 8 Aug
Second round of editing	2-3 weeks	Complete by 22 Aug
Second revision post editing	2 weeks	Complete by 5 Sep
Final round of editing	2 weeks	Complete by 19 Sep
Chapter final revision	2 weeks	Complete by 3 Oct
Optional independent chapter review	2-3 weeks	Complete by 17 Oct
Chapter revision post independent review	2 weeks	Complete by 31 Oct

CHSSP Development Process

Development overview



CHSSP Kick off meeting

CHSSP production timeline: profile (best case scenario)

Task	Approximate time
Complete profile drafting	48 weeks
First round of editing	4-6 weeks
First revision post editing	4-6 weeks
Final round of editing	4-6 weeks
Profile final revision post editing	4-6 weeks
Executive summary drafting	1-2 weeks
Independent & factual review	4-6 weeks
Post independent review revision	4-6 weeks
Drafting additional parts	2-3 weeks
Editorial review of complete CHSSP	2 weeks
QA review of complete CHSSP	2 weeks

CHSSP Kick off meeting

CHSSP production timeline: profile (best case scenario)

- Agree on detailed timeline for production of CHSSP chapters and entire profile

- Populate the timeline tool / excel tracker with agreed dates

CHSSP Kick off meeting

CHSSP production and publishing phase

Phase takes approximately 8-16 weeks and includes:

- Production of overheads, webpage & news item text
- Copy editing
- Proof of corrections
- Translation
- CHSSP design
- CHSSP launch
- Online & print publication of CHSSP
- CHSSP dissemination

CHSSP Kick off meeting

Work approach: Editorial support

- Editors will:
  - provide necessary organizational support throughout writing process
  - work with authors to identify suitable countries for comparison purposes.
  - discuss and review national level data identified by NC

- Any other requests for support

CHSSP Kick off meeting

Work approach: Data

- Documents to supplement the template including a standard set of figures and graphs available
  - Reviewed and updated before finalization of CHSSP
- Relevant data on the comparator countries will be provided
- National level data
  - Discuss with lead author and editors
- Data and literature availability for each chapter

CHSSP Kick off meeting

Work approach: Authors

- NC lead author will be the national contact person to coordinate the CHSSP writing process and liaise with Editor
  - Submit draft chapters
  - Share editor & reviewer comments
  - Coordinate chapter revisions

- Chapter lead authors can coordinate the writing of individual chapters

CHSSP Kick off meeting

Work approach: document version

- Only one working document at a time for each chapter
- Document naming system. NC to name drafts
  - Chapter 1 Nigeria_draft 1 ddmmyy
  - Chapter 1 Nigeria_revision 1 ddmmyy
  - Chapter 1 Nigeria_draft 2 ddmmyy etc
  - Chater 1 Nigeria_final ddmmyy
  - Earlier versions will be locked for editing once document is renamed

- Author team will have access to core documents on SharePoint

CHSSP Kick off meeting

Work approach

Division of writing roles – NC lead author

CHSSP Kick off meeting

Work approach: Chapter writing

- NC team to agree on writing approach e.g. dedicated writing workshops

CHSSP Kick off meeting

Work approach

- AHOP style guidelines
- Word count

CHSSP Kick off meeting

Work approach: Meetings

Meeting	Frequency	Purpose	Organizer
NC author team	Fortnightly	Updates ➢ Chapter writing ➢ Feedback from editors ➢ Reviews	NC team
NC lead author & editors	Monthly	Updates ➢ Chapter writing ➢ Feedback from editors ➢ Reviews	LSE
NC author team, editor & communications teams	Bi-monthly	Updates ➢ Chapter writing ➢ Feedback from editors ➢ Reviews	LSE
AHOP platform author meetings	TBC for first one then Quarterly	Updates Share lessons Share best practices Discuss dissemination	LSE
NC author team with national stakeholders	Initial one ASAP Quarterly and as requested	Updates Discuss dissemination	NC

CHSSP Kick off meeting

CHSSP dissemination plan

Dissemination strategy/ plans

- Key stakeholders
- Networks to target
- Policy windows and events
- Related content

- See process guidance document and annex with AHOP dissemination template. For now, you can simply outline any initial thoughts for launch of the CHSSP. We will attempt to build upon the plan as we go along, deciding what type of launch would be most appropriate etc. The recent launch of the Lancet Commission on Nigeria might be helpful inspiration: https://nigeriahealthwatch.com/live/

CHSSP Kick off meeting

Next steps

- MoH letter sent by Afro
- Author letters sent by LSE
- Confirm access to SP folder for all
- Meeting dates set up
- Tracker to be updated with timelines and shared

Workshop evaluation

Could you please share your feedback in this evaluation form

Conclusions and close

CHSSP Kick off meeting

www.ahop.aho.afro.who.int