



**Developing
Integrated and
Decentralised
Health Systems**

DFID Department for
International
Development

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Developing Integrated and Decentralised Health Systems

Summary

Efforts to improve Nigerian health services are being undermined by a variety of institutional weaknesses. Health services remain fragmented among multiple health providers (local government, state, federal, faith-based and private for profit organisations). Overlap in service provision between private and public sectors has resulted in wasteful duplication. The public sector faces shortages of staff, equipment and supplies and health facilities are in need of rehabilitation. Many programmes are organised along vertical lines resulting in poor integration and limited co-ordination between them. There is no organised referral system in place. Multiple management structures co-exist and roles and responsibilities remain unclear and are often duplicated within and between the three tiers of government. There is only limited supervision and staff morale is low. The quality of services is often poor and communities have little confidence in these. As a result, utilisation is poor.

PATHS supported a number of states to address these difficulties, with emphasis on the development of an *integrated¹ health system* as one of the

¹ Note that besides the integration aspect, these models were also moving towards a decentralised approach.

cornerstones of the reform strategy. The programme supported the evolution of three models:

- The essential healthcare package model of Ekiti - a service-driven model that started with the delivery of an essential healthcare package as the entry point
- The District Health System of Enugu – an institutional restructuring and management strengthening model that had support from the state Governor
- The Gunduma Health System of Jigawa – a similar model to Enugu but where state-health managers were re-orientated to become change agents for the district health system model.

These three states can be said to be fairly representative of the health needs and health services in Nigeria.

Developing integrated health systems for an entire state (with the associated legislation, and institutional restructuring) is nothing short of a major health sector reform initiative. Evidence from other countries suggests that a decade or more is needed for such reforms to have the desired impact. Although it is too early to expect significant results from the new models, early evidence suggests that the integrated health systems are starting to deal with some of the existing health sector problems. Jigawa and Enugu both invested time and effort to ensure the necessary legislation was in place to support the integrated health systems, and the models in these states have a better chance of being sustained than those that did not. Those states that invested very significantly in developing political support and local ownership have demonstrated even greater possibilities of being sustained. However, as developments in Ekiti have shown, much can be achieved even in the absence of the legislative framework.

This *Technical Brief* discusses the work that was done in Jigawa, Enugu and Ekiti to develop integrated health systems.

Orientation of Gunduma Directors



The Challenge

In spite of repeated efforts to improve health services in Nigeria there are still many problems. Health services are fragmented with multiple health providers (local government, state, federal, faith-based and private for profit organisations) resulting in duplication and wastage.

Nigeria is a Federation. The constitution has health as a concurrent responsibility between the three tiers of government – the federal level is responsible for tertiary services, states for secondary services, and LGAs for primary services. However, the Federal Ministry of Health (FMoH) has parastatals, for example, the National Primary Health Care Development Agency (NPHCDA) which supports PHC services. This support can include building and operating PHC facilities and implementing immunisation services. Similarly, several states operate tertiary facilities. At state level, multiple bodies are involved in health care. For example, several bodies can be involved in human resource management at PHC level: the Ministry of Local Government (MoLG), the State PHC Agency, the Local Government Service Commission and the LGA. Budget development and release is similarly fragmented. The new Health Bill which passed both Houses in May 2008 goes some way to address these issues.

The public sector has a large number of facilities, ranging from clinics to specialist hospitals, but many of these are in an advanced state of disrepair, have ill-maintained equipment, and frequent drug and medical supply stock-outs. There is no organised referral system in place. Multiple management structures co-exist and roles and responsibilities remain unclear and are often duplicated within and between the three tiers of government. There is a shortage of well-trained staff in specific disciplines (e.g. doctors, pharmacists, laboratory scientists/ technicians, accountants) and inequitable distribution of available staff, limited supervision, low staff morale and poor attitudes towards clients. At the same time there are large numbers of lower level staff leading to a poor staff mix. Funding for running the services is inadequate and unpredictable. Communities have little confidence in the services and utilisation is low.

An overview of the conceptual framework for PATHS' work on integrated health systems is derived from WHO's District Health Service model for ensuring the efficient delivery of effective health services based on primary health care principles and aimed at improving the health status of a clearly defined population within a district.



KEY FACTS

Definitions

District

An administrative unit of central government that covers a well defined geographical area and has a population of 100,000 to 250,000. It is administered by a political administrative body with representation of several central government sectors.

Health system

The people, institutions and resources that operate as a whole to provide health care and improve the health of the population it serves.*

Primary Health Care

Primary health care is "essential health care" based on practical, scientifically sound and "socially acceptable methods and technology" made "universally accessible" to individuals and families in their communities through their "full participation", and at "a cost that the community and country can afford" to maintain at every stage of their development in the spirit of self reliance and self-determination. It forms an "integral part both of the country's health system", of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of the individual, family and community with the national health system bringing health as close as possible to where people live and work, and constitutes the first element of a continuing health care process.**

* WHO, 2004. World Report on Knowledge for Better Health: Strengthening Health Systems, Geneva: World Health Organisation.

** World Health Organisation 1978 Declaration of Alma Ata.

The Response

In recognition of the diversity in Nigeria, PATHS encouraged the states to consider models and approaches that were appropriate to their own context - no single size could fit all states. Thus, three different models were developed by the states to achieve the desired outcome of a functional integrated health system. These are:

- The essential healthcare package model of Ekiti - a service-driven model that started with the delivery of an essential healthcare package as the entry point
- The District Health System of Enugu – an institutional restructuring and management strengthening model that had early support from the state Governor
- The Gunduma Health System of Jigawa – a similar model to Enugu but where state-health managers were re-orientated to become change agents for the district health model.

These three states can be said to be fairly representative of the health needs and health services in Nigeria.

The key issue is not whether one model is better than another, but rather whether each model is robust enough to address the structural weaknesses in the Nigerian health system.

Enugu, Jigawa and Ekiti states went through similar stages in the development of integrated health systems: starting with a process of stakeholder engagement; situational analysis; quick-win intervention; development of a plan; and implementation and roll out of the plan with frequent monitoring and review visits. Each programme made extensive use of consultants for technical assistance and furthermore exposed various stakeholders to examples of functioning systems in other countries.

The experiences in each state differed in terms of the duration of engagement, the type of quick-win intervention, the relative importance attached to obtaining legal backing for the reforms inherent in introducing an integrated health systems and the amount of political support available.

Ekiti's Essential Services and Systems Package (ESSP)

From 2002, PATHS worked with stakeholders in Ekiti to support their initiatives to improve the provision of basic health services that would be sustainable, functional, effective and accessible, particularly to the poor and other vulnerable groups.

In December 2005, the State Ministry of Health and its partners adopted the Essential Services and Systems Package as the strategy for the achievement of the health-related MDGs in Ekiti State.

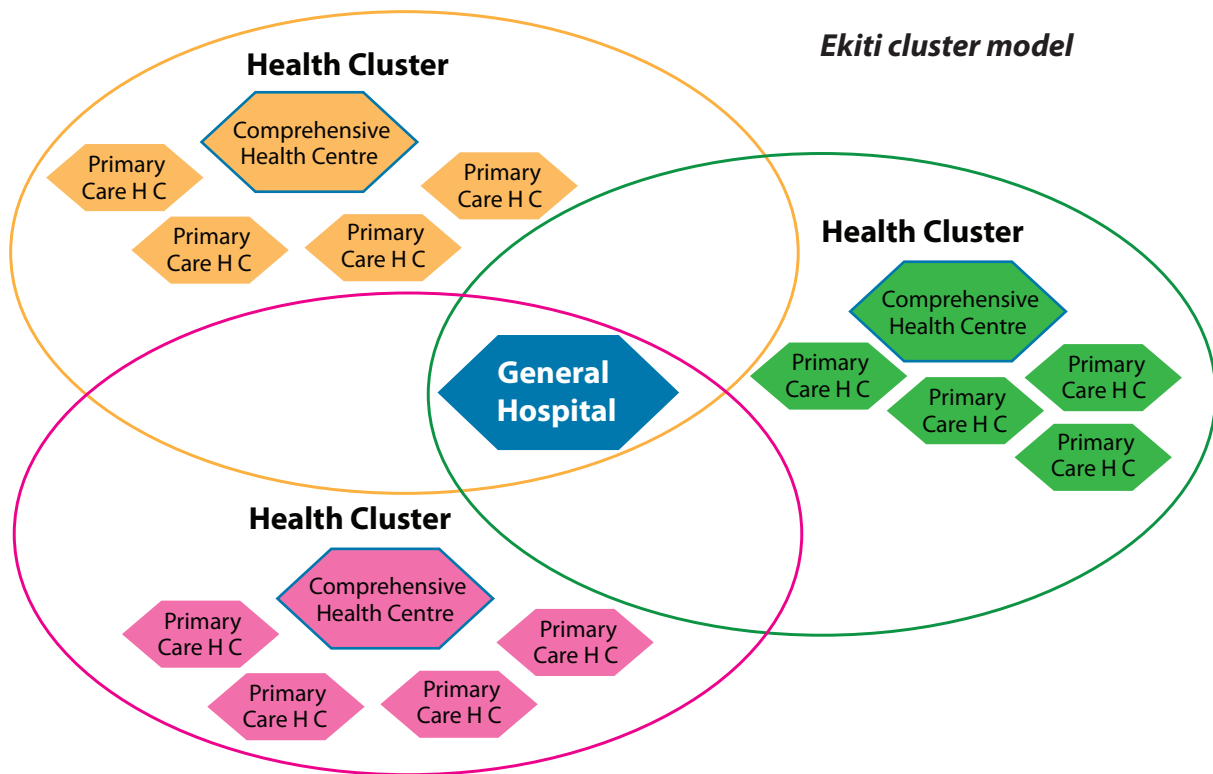
Objectives of the ESSP

“Definition and prioritisation of essential and most cost-effective curative and preventive services which must be provided to ensure equitable allocation of SMOH and LGA resources, and to increase the cost effectiveness and cost efficiency of resource allocation and use”.

Source: Essential Services and Systems Package Operational Manual, 2006

The ESSP was based on the ‘Health Cluster’ approach. The ‘cluster’ included a number of health facilities (one Community Health Centre and four PHC Clinics). Each cluster served a population of 100,000. A cluster of facilities provided integrated primary health care services, including Basic Essential Obstetric Care. These facilities referred patients needing higher level health care to a designated General Hospital and then on to the State Specialist hospital covering that health zone. One General Hospital served several clusters.

Six clusters in four LGAs namely Ijero, Gbonyin, Irepodun/Ifelodun and Ikole, were selected for the first phase of the roll-out. The resources needed for implementation of first phase ESSP clusters were determined. An operational manual for ESSP implementation was also developed. While PATHS supported the phase one clusters with technical assistance, the state government and LGAs looked at policy issues, staff rationalisation, and infrastructural/equipment improvement. A PHC unit within the Local Government Service Commission was created



and provided an excellent vehicle by which to ensure the sustainability of the initiative.

By late 2006, 23 clusters were in the process of being formed across Ekiti state. Despite a reduced level of technical support from PATHS for ESSP implementation during the latter half of 2006², progress was maintained in implementing Phase 1. A sustainability plan was developed to ensure that the 23 clusters and related activities were set up by the end of 2007. PATHS provided limited support for the first few months of 2007 to fine-tune the ESSP operational principles using lessons learned from the first phase of the roll-out process. No major alterations were made to the original plans and progress was made on establishing management systems, including monitoring and supervision for the ESSP initiative linked to an integrated supportive supervision framework.

2007 brought a new administration to govern Ekiti State. The ESSP committee overseeing the roll-out of the ESSP lobbied the new leadership to explain the benefits of the initiative. It proved successful as approval to hire 1,000 and 200 additional skilled staff at PHC and SHC levels respectively was granted. A gradual recruitment and training plan was implemented from early 2008. At the same

time discussions on how to redeploy the excess of unskilled staff were on-going, and an allowance for a rural posting was approved in 2007.

In 2007/2008, equipment was provided to over half the total 180 targeted PHC facilities and to all SHC facilities by the DfID-funded Health Commodities Project (HCP). The government was looking at equipping the balance of the facilities out of the significant provision it made in the 2008 health budget to roll-out the ESSP at PHC level - N1,625 million (£6.5 million), approximately a third of the total health budget.

Although Ekiti stakeholders realised it would be a gradual process before the full mix of resources would be in place in all the targeted facilities (especially ensuring that all skills were imparted to staff for quality service delivery and systems management), good progress was made with the first phase facilities.

To enhance sustainability, the SMOH will need to consider formalising the ESSP committee composition, roles and responsibilities so as to ensure proper coordination amongst the various actors for the development, running and maintenance of the clusters. Political support at all levels needs to be maintained through advocacy meetings and publicity activities. SMOH needs to work with local government to build up human resources management systems and to establish

² PATHS closed its office in Ekiti in December 2006, but maintained a small presence within the SMOH for the first six months of 2007.

cluster Management Committees as a way of bringing together the demand- and supply-side activities.

Enugu's District Health System

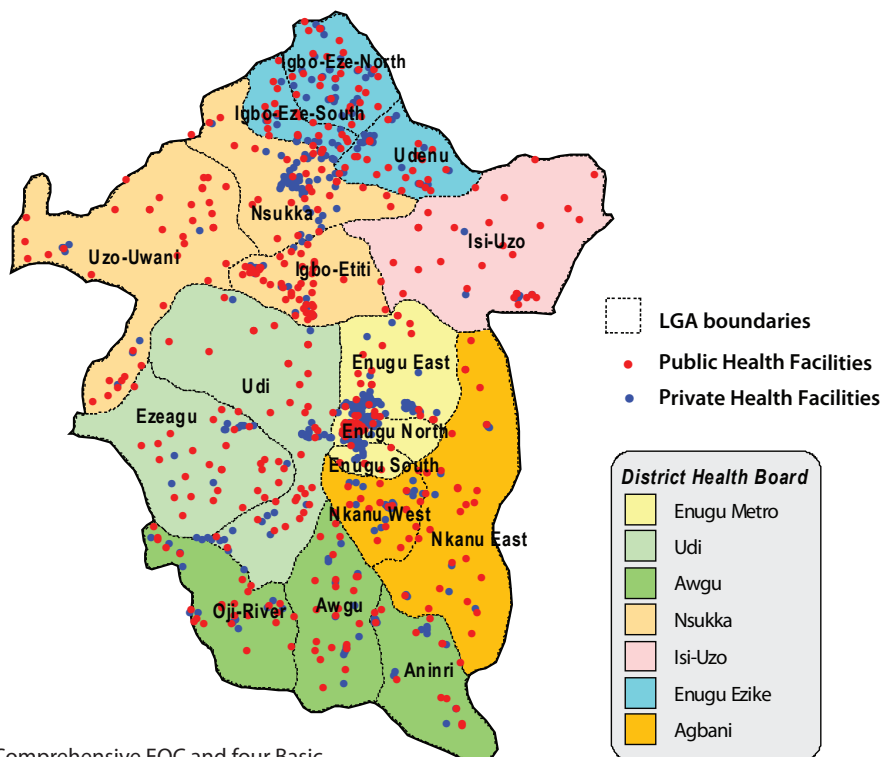
In Enugu discussions were underway in 2003 about the need for a sub-state management structure with the LGA level as the obvious building block. Local government areas were to be grouped into populations of between 250,000 to 500,000 people in line with WHO criteria for district formation and guidelines for emergency obstetric care (EOC) delivery.³

In October 2003, with the political commitment and active support of the State Governor the State Council on Health recommended that the state introduce a District Health System as its framework for health care delivery. In order to achieve this vision there was a need to move away from a centrally managed and fragmented model of health service delivery to one of integration at all levels of service delivery with a special emphasis on management at the district level.

The introduction of the District Health System required the restructuring of the Ministry of Health:

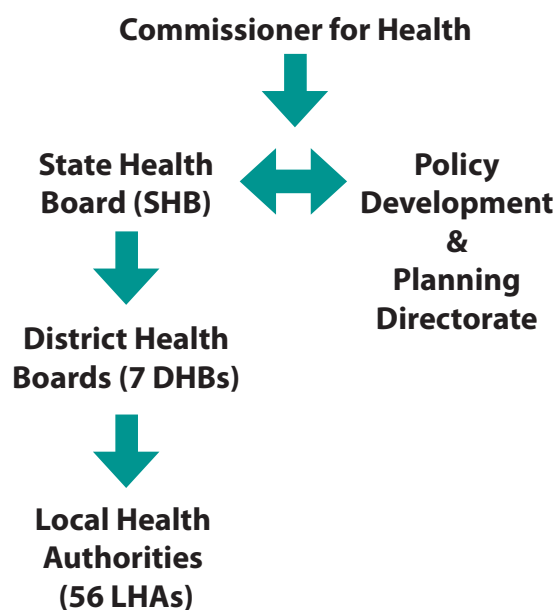
- A new Policy Development and Planning Directorate (PDPD) was created, which was responsible for strategic planning and policy development;
- The State Hospital Management Board evolved into the State Health Board (SHB); and
- Seven newly created District Health Boards (DHBs) and 56 Local Health Authorities (LHAs) were established. The Boards and Authorities were responsible for all aspects of service delivery.

Map Showing Enugu State District Health Board with Health Facilities as at February, 2006



3 For EOC services one Comprehensive EOC and four Basic EOC facilities are recommended for 500,000 people. For more details see the PATHS Technical brief on Strengthening Supply-side Components of the Safe Motherhood Programme in Nigeria

DHS Structure



The DHS promoted:

- Decentralisation of services
- Integration of primary and secondary services
- Delegated decision making as close to the patient as possible
- Increased accountability for service delivery among providers and their managers
- Greater opportunities for public private partnerships
- More effective referral systems

The DHS approach was formally adopted by the State Government in January 2004, and the resulting legislation introducing the District Health System was passed by the House of Assembly in August 2005. While the legislation was pending, the planned constituent bodies of the DHS were established in shadow form.

Once the State Executive Council had approved the introduction of the system in 2003 it became increasingly apparent that the DHS framework needed to be sufficiently in place before efforts were made to develop either the underpinning systems or to improve service delivery. A considerable amount of effort was thus invested in supporting the realisation of the State vision of a District Health System.

In the early days of DHS implementation, the commitment and drive of some key individuals helped to ensure positive progress. This included the Health Commissioner, Dr Festus Uzor, the two Health Administrators of the State Health Board, the seven Chief Executives of the District Health Boards and the 56 Executive Secretaries of Local Health Authorities. The Boards and Authorities created their own support networks in order to learn from what worked or did not work well in each district or health authority catchment area. This helped ensure that the Boards and Authorities had a united voice when advocating for changes within the DHS.

The implementation of the DHS required a fundamental shift in the roles, responsibilities, and approaches of all the constituent bodies. To facilitate these changes PATHS provided support in the following areas:

- The framing of the required legislation to introduce the District Health System;
- The establishment of the constituent bodies – i.e. the Policy Development and Planning Directorate (PDPD), the State Health Board (SHB), the seven District Health Boards (DHBs) and 56 Local Health Authorities (LHAs);
- The establishment of District Headquarters;
- Extensive capacity building for 776 members of the constituent bodies to orientate them to their revised roles and responsibilities;
- Design, development and implementation of the underpinning systems for financial management, human resource management, health management information and drug revolving funds, all adapted to reflect the new structure;
- Development of business plans and budgets for each of the constituent bodies and the working interfaces between them;
- Engagement and advocacy aimed at Local Government to improve their knowledge and understanding of the new system;
- Strengthening the new management lines of accountability to support the shift away from Local Government control of primary care;
- Encouragement of reporting channels within and between the constituent bodies;

- A study tour to learn from the Ghana District Health System.

Considerable technical assistance was provided from 2003 onwards in all the above areas. Over time, increasing responsibility for implementation of the various reform initiatives shifted to the State Health Board and the Districts. The LHAs' knowledge and understanding of their "patch" was greatly strengthened by the introduction of a quarterly review process. This commenced in 2006, and the process was chaired by the Permanent Secretary of the SMOH with support from the Ministry of Local Government and the Local Government Service Commission.

The LHA quarterly review process brings together the Permanent Secretary (PS) SMOH as Chair; PS, Ministry of Local Government; PS, Local Government Services Commission and representatives of the State Health Board as the review panel. The LHAs report against an agreed report format on all the happenings in their respective LHAs for the three-month review period. A set of indicators has been developed and each LHA is scored against the indicators. If an LHA remains at the lowest score possible on more than three occasions the LHA Executive Secretary is removed. The respective DHB members are expected to be in attendance and can also be held accountable for the poor performance of their LHAs.

Despite the positive developments, by early 2008 there was still a considerable way to go before it could be said that the District Health System was functioning in its entirety. Such wide-ranging fundamental change takes time to take root.

"How effectively can you implement a decision that you were not part of? That was our fate before the DHS. Today you met us in a meeting of the Agbani District Health Board, we review issues and exchange ideas with our bosses for the betterment of the whole system. This communication system has improved so many things that have led to better service delivery and also improved the quality of care."

Mrs Nnaji LHA Executive Secretary

* * *

"... when PATHS came, the numerous capacity building trainings they gave us opened a new page in our approach to hospital management: in terms of personnel, management of drugs, equipment and finances, client/staff relationships, general planning and resource management. In fact, DHS has given me a broader view and insight on how to manage both human and material resources."

Dr Enih CEO Agbani DHB

In summary, the DHS has:

- delegated decision making down to the level of LHAs
- strengthened accountability between the LHAs and their DHBs
- reduced duplication through the merging of up to eight primary care centres and cottage hospitals, where these were located on the same site.
- increased access to medical care, particularly primary care, through the rotation of medical staff across the districts
- enhanced management skills of the members of the SHB, DHB and LHAs
- created effective entry points for targeted action
- built effective collaborative working relationships between public and private sectors
- provided in-depth knowledge of service provision across the state
- developed an accurate data-base of public and private health facilities.

From an LHA quarterly review report relating to strengthened accountability:

“meetings held with DHB - 3

numbers of reports submitted to the DHB - 4”

As of May 2008 regulations to support the Enugu State Health Law were still required, as was a reliable flow of funds through the State Health Fund for the district health system and a comprehensive process of human resource planning including equitable distribution and management capacity development. A stronger focus on provision of effective support and supervision at all levels was also required.



District offices

Jigawa's Gunduma Health System

An institutional analysis undertaken in Jigawa in 2003 highlighted the urgent need to streamline the fragmented health system and create a unitary mechanism for health financing. In response, PATHS in Jigawa decided early in its engagement to invest substantial time and resources in identifying, supporting and working with key managers working within the health delivery system to identify the causes and results of the fragmented health system. Following this, potential solutions would be explored. The work to build a critical mass of change agents involved the Governor's office, the Commissioner for Health and State Ministry of Health, and members of the State Council on Health, among others. A number of reform-minded individuals were invited to participate in a study tour to Ghana to see first hand how the Ghanaian district health system worked, how it compared to the situation in Jigawa, and what the potential benefits might be of moving in a similar direction. This visit built knowledge of and confidence in the vision of a district health system among senior officials.

"...This (study) tour (to Ghana) converted sceptics who thought that the Gunduma Health System would not work under Nigerian conditions in Jigawa. These converts now became champions of the proposed policy change. The lessons that they had learnt were shared with other stakeholders, who were not able to participate in the study tour, at various retreats at Kaduna, Dutse and Gumel. Agreements were reached to push the Gunduma concept ahead after these retreats..."

Joseph Kumba, August 2007

A key constraint facing the reform process was the fragmented and centralised structure of the Jigawa health system which required total re-organisation to meet the goal of the strategic health plan, which was to: *Ensure an improved integrated health service with basic care accessible and accountable to all.* The Jigawa Integrated Health Committee (JIHC)

was established to produce a blueprint for the new structure.

Terms of Reference for JIHC

- To explore the merits and demerits of a decentralised health structure
- To identify the structures on the ground that would support this system and the risks involved in setting up the system
- To examine the different options for a contiguous and viable geographical health unit that would satisfy the criteria established by the committee and be acceptable to all parties under a unified command structure
- To determine the funding, financial management and logistic arrangements for supporting such a structure
- To identify the legislature requirements for this structure
- To develop a performance monitoring system
- To understand the socio-political implications of the system
- To establish steps that would be required for implementation

The word "Gunduma" was chosen for the proposed health system. This is the local word for 'district'. The process of restructuring and developing the Gunduma system involved:

- Intensive and extensive consultation on all issues with a wide range of stakeholders within and outside the health sector. A team of reform-minded individuals were identified by the SMOH, PATHS, MoLG and NGOs to lead the consultative process
- Drafting the Gunduma Bill and supporting its eventual passage into law; preparation of a regulatory framework and guidelines
- Development of Gunduma systems i.e. financial management, performance management,

planning and budgeting, human resources mapping and management strategies

- Identification and rehabilitation of Gunduma offices
- Employment of key officers using internal best practices, and orientation of foundation staff
- Adaptation of the minimum service package (MSP) of care using Jigawa health facility typology
- Organisational change management for the new Gunduma teams and repositioning of the SMOH for its new role.

The new structure fused and integrated the former fragmented tiers of health services to create a common focus that promoted faster and more efficient health service delivery. The new structure:

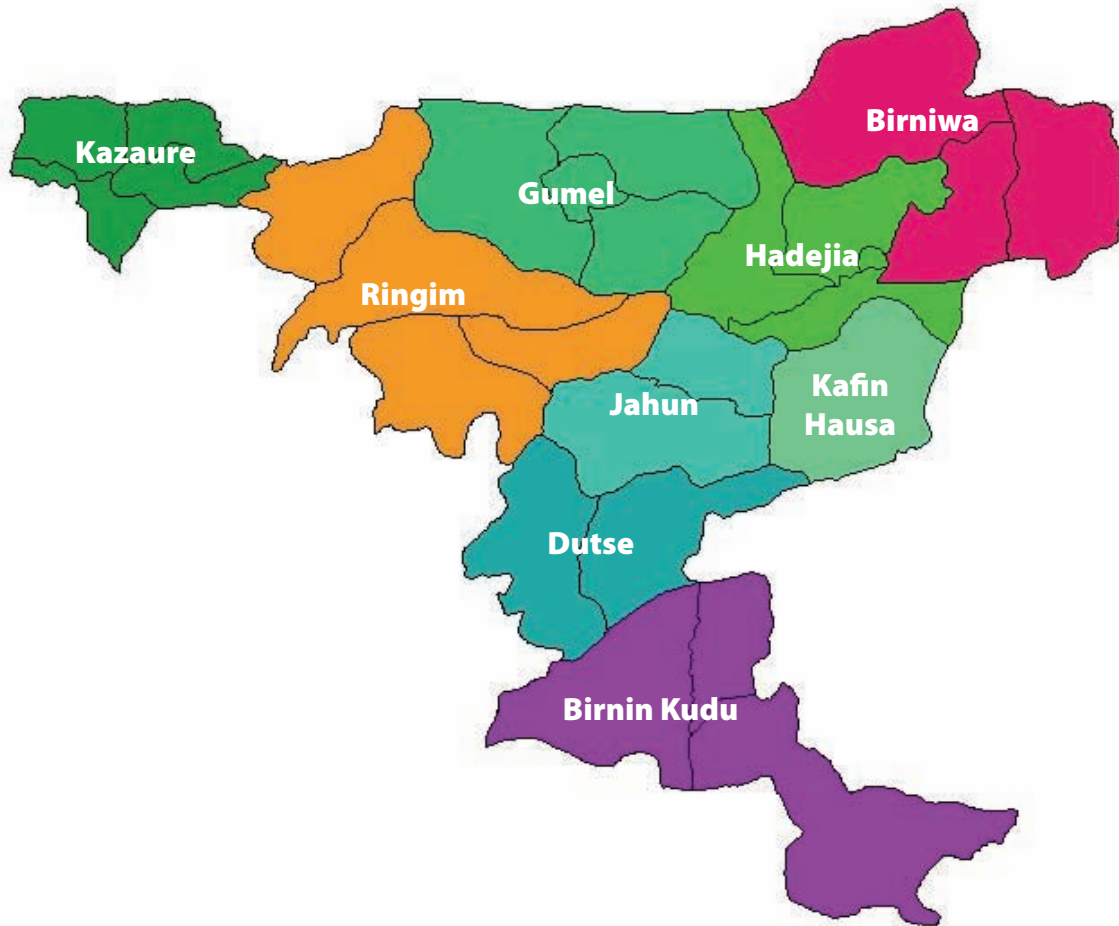
1. Established a Gunduma Board. This reported to the Commissioner for Health
2. Established nine Gundumas, each combining two to four LGAs into a viable and manageable size
3. Integrated all health services⁴ (primary, secondary; public, private) under the Gunduma
4. Created a management structure with adequate authority, decision-making powers and the resources to supervise services within the Gunduma
5. Created strong accountability systems for management.

Potential Advantages of a Decentralised Structure

- Relieves top-level managers (such as SMOH directors) of the aspects of their workload that could easily be performed by middle-level managers, leaving top-level managers time for major decisions and important work on planning, policy and development
- Provides middle-level managers with the authority to do their jobs
- Encourages initiative and responsibility at all levels
- Reduces delays in decision-making and activities
- Decentralisation and integration increases accountability by establishing single lines of authority. It is therefore clear where responsibility lies and it becomes difficult to pass blame to someone else
- Senior staff have more time to supervise
- Middle-level (or zonal managers) are able to provide direct support and supervision for the health services and facilities in their zones. Because they are located closer to the facilities they can visit regularly and are more easily accessible.

⁴ Integration is not contrary to the constitution which defines areas of responsibility for different tiers of government.

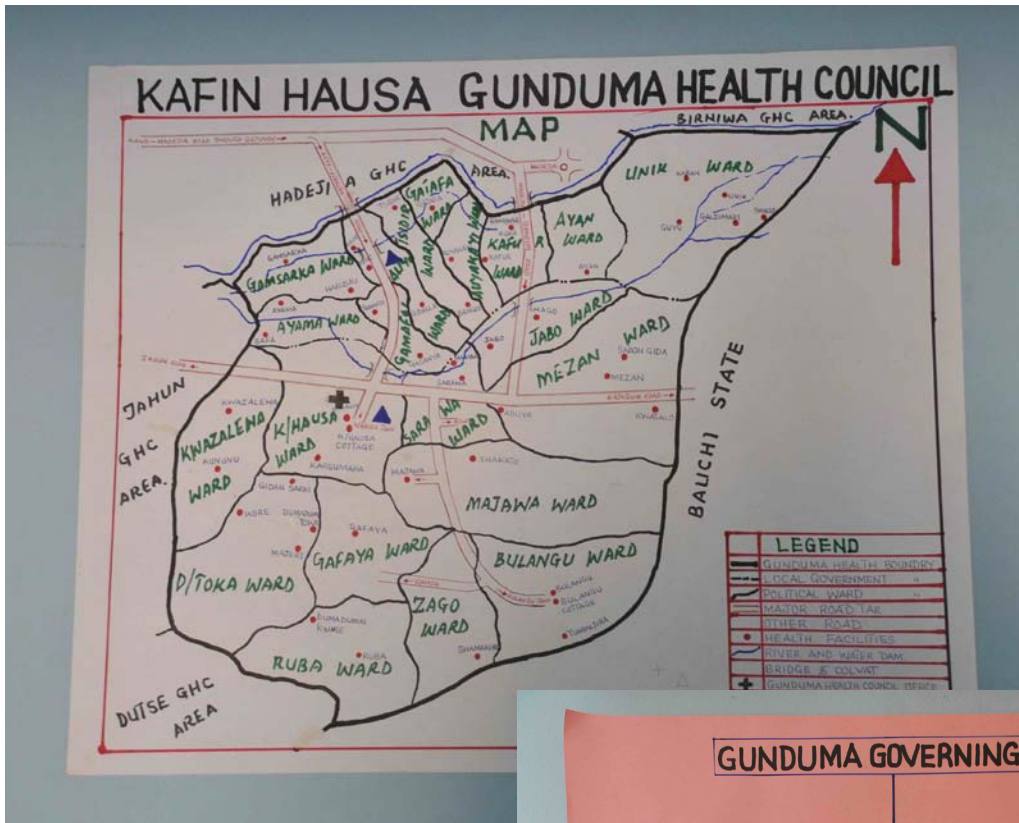
Gunduma Map showing the Nine Gundumas



It was important not to rush the restructuring and to allow sufficient time for consultation on sensitive issues (e.g. boundaries, roles and responsibilities) since radical changes need to be locally owned and locally driven. Because individuals and teams within the health sector initially felt threatened by the discussions that were underway there was initial resistance to any change and this required protracted discussions on the advantages and disadvantages of the system. The change agents were the best people to handle these discussions. Capacity and mechanisms to manage the change process therefore need to be robust and with consistent messages relayed by all key partners. The process was also helped by commitment from the top political leadership.

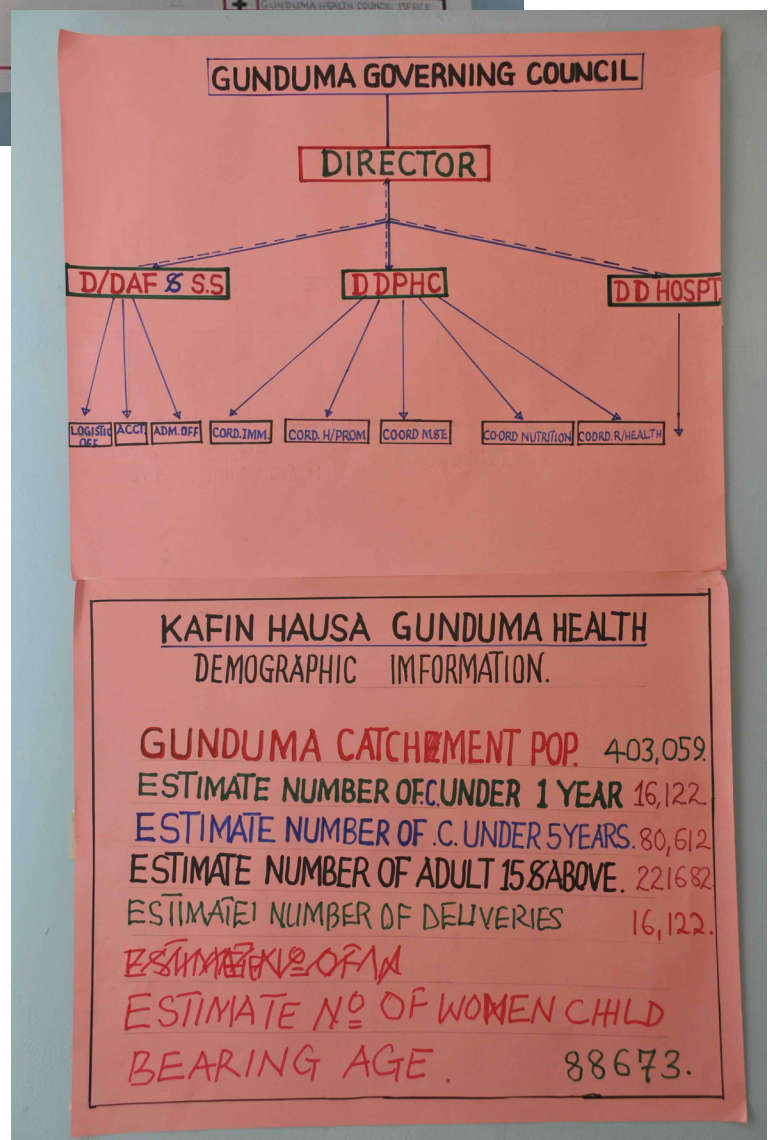
The preparation of a law to back the proposed changes slowed during and immediately after the 2007 national elections as other activities took precedence. In October 2007 the law was passed; managers were appointed to the positions created in the new system and were given the mandate to lead the implementation of the law, policies and strategic plans that had evolved during the four-year period of engagement.

As part of a review of the process of change, managers of the Gunduma Board identified the following lessons: it was important to have the support of the Governor at every stage of the process; to challenge the top political levels to support a change that was far-reaching; and to communicate clearly and often to individuals and teams likely to be affected by the change; and to be transparent at all times and diplomatic, especially when dealing with opposition.



Map of Gunduma

Gunduma structure and Demographics



Results

Expected benefits of a functioning district health system include:

- Allowing efficient health service delivery through better supervision, co-ordination and inter-sectoral collaboration
- Enabling better integration of primary health centres and hospitals
- Improving levels and timeliness of funding as state and donors would respond favourably to a better planned service with proven effectiveness
- Improving access to health care, especially for rural populations
- Lowering the cost of services as services are brought nearer to remote communities
- Making services more cost-effective
- Increased access to limited medical services
- Improving technical performance and quality of service delivery, thus increasing utilisation of health services
- Improving distribution and mix of human resources
- Enabling supervision and support to be nearer to health facilities and service delivery points
- Improving the effectiveness and efficiency of monitoring by the State Ministry of Health, Ministry of Local Government and Primary Health Care Agency through shared responsibility
- Improving health indicators and ultimately facilitating the attainment of the Millennium Development Goal targets.

To what extent have the three states realised these benefits?

Improvements in the functioning of health systems in the three states have arisen as a result of a variety of governance and systems strengthening interventions. Most managers

directly involved in developing district health systems insisted that the changes represented a very significant improvement on what was in place before PATHS started working in the three states.

By 2008, all districts had the skills to prepare feasible plans with budgets and expected to receive funds to implement these plans. In Jigawa, budget lines were created for the Gunduma Councils and Boards and money was released for the Gundumas to begin operation. The commitment of the current Ekiti administration has been promising in terms of resource allocation. In contrast, Enugu was less successful at leveraging funds to support the reforms.

Supervision by state and district teams had become a more regular feature. In Enugu, targets and indicators were set and review sessions to determine progress were being held. Likewise, in Jigawa key performance indicators for the different parts of the Gunduma have been agreed.

By 2008 the Federal level was studying the models with a view to encouraging other states to adopt similar reforms. In November 2007, the National Health Council invited Enugu and Jigawa to make presentations on the district health system models in their states and subsequently drafted recommendations for consideration by the FMOH.

However, some areas remained unresolved. Many technical programmes were still being designed and implemented vertically with little evidence of the desired integration. In addition, the vertical and piecemeal funding for district health services meant that much progress still needed to be made towards streamlined financing for the sector.

The focus in all states was primarily on the public sector with limited involvement of private sector health services. Enugu provided an exception. By 2008, there was representation at Boards and Authority level and the PPP EOC plus initiative where faith-based hospitals provided EOC services for public sector patients in the Enugu Metropolitan District, was implemented.⁵ It was perhaps inevitable that reform efforts would focus first on 'putting the public sector house in order' before broadening the focus to include other key

5 For more details see the PATHS Technical brief on A Pilot Public Private Partnership Scheme In Enugu – Emergency Obstetric Care Plus

players, although all three states did involve public and civil society sectors in reform consultations. Nevertheless, to get the full benefit of reform, a district or state needs to define clear roles for both the private and civil society sectors. It is the responsibility of the district and state health management teams to create the forums and opportunities for these sectors to play their part in improving access, and providing more options for better health services to communities. The state also has the obligation and mandate to regulate the private sector on behalf of the federal government.

Selected features in the development of decentralised health system in three PATHS-supported states

Characteristic/ Issue	Ekiti	Enugu	Jigawa
Essential features	After incremental improvements in management systems and quality of care through vertical entry-points, stakeholders realised the need for an integrated approach through a minimum services and systems package	State Governor support led to early rollout and progressive changes based on business plans	Change agents facilitated a process of awareness creation and introduced change as beneficiaries caught on and demonstrated appetite for further change
Period of PATHS engagement	September 2002- December 2006	July 2002 – June 2008	July 2002 - June 2008
Entry point	Essential services and systems package	Policy change – advocated by the Governor and State Council for Health	Policy change – led by state health officials
Coverage	At the time of PATHS closure, four out of 16 LGAs were involved in ESSP implementation but the package is now being rolled-out across the state with State and LGA resources	Whole state	Whole state
Management body established for sub-state structure	ESSP Committee	District Health Boards and Local Health Authorities (LHAs) – established by law	Gunduma Health Councils - established by law
Specific legal backing for new structures & functions	No	Yes (2005)	Yes (2007)
Budget line created within state budget for new structures	Yes and substantial funds released after PATHS left the state	Yes, but limited funds only released to date	Yes
Clarification of roles and functions of different levels of stewardship and management.	SMOH chairs the ESSP committee which coordinates implementation - through LGSC PHC Unit and HMB	Yes	Yes
Organisational re-structuring in place to incorporate reforms	No	PDPD, SHB, DHBs, and LHAs all created	Gunduma Boards created. SMOH reorganisation mapped out, but not yet executed. Organisational development on-going
Horizontal integration of programmes	Good start and commitment to integration maintained after PATHS exit at end of 2006	Integrated supportive supervision strong. DHBs played a key role in managing services within their districts	Active discussions on-going in context of ISS and PPRHAA
Community involvement in service re-organisation	High level of concern with demand-supply side integration	High community representation particularly at LHA level	Role for community representatives on Gunduma Councils, DRF committees and on Integrated Supportive Supervisory teams.
Community perspective on recent performance of public sector health services	Not assessed	Not assessed	Not assessed
Level of political support from Governor Commissioner State Assembly Local Government Chairmen	High-level advocacy to LGA Chairmen raised profile and commitment for the integrated approach. Current Commissioner and Governor very much in favour.	Governor originated the idea very early and then actively supported the Commissioner for Health in its realisation. LGA level was much slower. The new Commissioner needed orientation	Needed substantial discussion until all committed. The new Commissioner appointed in 2007 needed orientation but is supportive

Sustainability

Will the district health system remain functional when PATHS' support is withdrawn?

The answer is a clear yes for the Jigawa and Enugu models which are backed by law and have clear ownership by state health managers and top political stakeholders. However in 2008, the changes were still new and fragile and needed ongoing support to embed the new systems. In Ekiti, after PATHS withdrew in 2006, substantial progress and commitment was shown by the government. The Ekiti experience shows that although legislation is preferable, where there is ownership, political commitment and a drive to improve the health system much progress can be made.

In all three states PATHS made significant investments in building the capacity of a wide range of health workers through training and up-grading of managerial and technical skills. All management teams have the competence to prepare feasible plans for their districts and programmes and to supervise implementation of those plans. Government, PATHS and other donors like the World Bank have invested in the rehabilitation of infrastructure and provision of equipment and supplies and have thus contributed significantly to the development of the new integrated system for service delivery.

Challenges

One of the key considerations facing the states was the size of the districts. Enugu with a population of 3.9 million (2006 census) and Jigawa with a population of 4.3 million (2006 census), formed seven and nine districts respectively. This meant districts of 550,000 people in Enugu and 525,000 people in Jigawa, both larger than recommended by WHO. It could be argued that the LGA was a more appropriate size. However, the key challenge was to integrate services. Under the constitution PHC services were the responsibility of the LGA and Secondary Health Care services the responsibility of the state. To integrate services a structure between the state and the LGA was considered the best option. It was argued that using LGAs would not work for the following reasons:

- The system was very fragmented with multiple bodies responsible for human resource and finance functions. Rather than trying to reform in a piecemeal fashion it was felt that radical reform (in line with international best practice – the district) would stand a better chance of success.
- A new body needed to be created so that neither the PHC system (LGAs) nor the SHC system (SMoH) would be seen to be dominant.
- The span of control between state and LGA was unwieldy. In Jigawa, there are 27 LGAs and in Enugu there are 17 LGAs. This meant managing 27 or 17 LGA managers through one line structure. This was far from ideal.

With the passage of the Health Bill in May 2008 the strengthening of PHC services was seen as critical. The Bill provides for the establishment of a substantial National Primary Health Care Development Fund, which is to be used to strengthen PHC services. The fund will consist of money from the Federal Government, donors, counterpart funding from state and LGAs and any other sources (e.g. debt relief monies). The fund will be administered by the NPHCDA who will disburse the money through State Primary Health Care Boards. As of May 2008 guidelines for the Fund had not been developed.

In anticipation of the Bill passing into law several states formed State PHC Agencies⁶ (SPHCAs) e.g. in Katsina and in 2008 in Kaduna. One of the constraints of the SPHCA model was the lack of integration of PHC and SHC services. While SPHCAs can strengthen PHC services by consolidating human resource and financial controls in one body and creating one line through which PHC services are managed, it is unlikely that this approach will be sustainable without the integration of PHC and SHC services. It also does not address the span of control issue. As it introduces the SPHCA Kaduna is already looking into the feasibility of a zonal integrated model.

The legislation in both Enugu and Jigawa allows for the creation of a State Health Fund. This needs to be aligned with the guidelines that the NPHCDA will draft for the National Primary Health Care Development Fund.

6 Earlier drafts of the Health Bill specified the creation of SPHCAs. However, this was later dropped.

Lessons Learned

1. The basic model of the WHO District Health System (based on the key principles of improving integration, decentralisation, co-ordination, access and effective health services) can be adapted to suit state-specific situations in Nigeria.
2. Though health service problems are similar in all states of Nigeria, there is no one-size-fits-all model of an integrated health system for a country with such diversity and with a federal form of government that provides for local initiative to deal with local problems.
3. Exposure to successful examples early in the process of health sector reform is essential for building a critical mass of converts to carry the process of change forward, for convincing opponents and the undecided of its feasibility, and for reassuring those who are willing to commit to change. In Jigawa, a visit of state legislators to Ghana in early 2007 brought about a better understanding of feasibility of the Gunduma health system and this understanding facilitated the passage of the Gunduma Health System law later that year. In Enugu, a five day visit to Ghana in January 2008 convinced the team led by the Health Commissioner to make a strong case for release of funding to the District Health Boards.
4. Though managerial and administrative initiative can result in clear progress towards achieving the goals of a decentralised health system, formal legislation to back its existence provides an essential environment for sustained implementation of reform efforts by local managers. Ekiti achieved much by way of improving access to an essential health package using well-tried management systems, but the absence of a legal framework for decentralised health services may have made it more difficult for local managers to push forward after PATHS withdrew. By 2008 in Enugu and Jigawa it was very evident that state and district level managers were confident in using their respective laws as a basis for negotiating for state funds and for other improvements. The law also provided management the authority to challenge any serious attempts to undermine its existence.

Recommendations

1. Building an effective integrated and decentralised health system is a long-term activity – it took 15 years in Ghana and South Africa has been grappling with it for over a decade. It has only just begun in Nigeria. Persistence and patience will be the key to success. Early withdrawal of partner support can undermine or kill an initiative with a long build-up phase like an integrated decentralised health system. Thus ongoing support will be needed.
2. The states need to build on the interest shown by the federal level through intensified advocacy and packaging achievements for specific audiences including the political level. Advocacy towards top politicians as well as communities should be an ongoing activity if support is to be maintained through the early years of developing integrated and decentralised health systems.
3. The private and civil society sectors are major players in the health system and must be provided the opportunity to participate fully in the development of integrated, decentralised health systems in the state if the full benefits of the reforms are to be realised.
4. At national level, forums need to be created for states and partners to share their experiences of developing integrated decentralised health systems. No single option should be promoted. Rather each state should be encouraged to develop a model that addresses the institutional weaknesses of the health system in their own context. These models need to be supported by the allocation of sufficient resources.

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