



# ***SUPPORTING KADUNA'S HEALTH REFORM AGENDA***

**DFID** Department for  
International  
Development

**PATHS**  
Nigeria Partnership for Transforming Health Systems

**FINAL PROGRAMME REPORT**



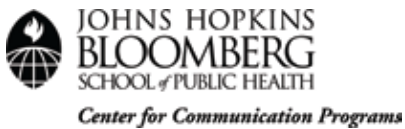
Nigeria Partnership for Transforming Health Systems

Partnership for Transforming Health Systems (PATHS)

**DFID** Department for  
International  
Development

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

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





# ***SUPPORTING KADUNA'S HEALTH REFORM AGENDA***



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“Prior to PATHS’ engagement with Kaduna State, we thought that the government was solely responsible for our needs. PATHS has made us realize our responsibilities as community members. Our involvement in the management of the clinic has made the work of the health officials easier and better. So we will remain indebted to PATHS for its timely intervention.”

*Alhaji Hamid Shafi’i  
Chairman, Community Health Committee  
PHC Tudun Wada, Zaria.*

“The gradual increase in our facility’s patient inflow is attributed to the appraisal exercise conducted through PATHS support. The community’s interest in the management of the clinic, increase in the number of staff, the serenity of the environment and government responsiveness motivated me to work harder. At least I am satisfied with what I am doing now.”

*Aisha Ahmed, Staff Nurse  
Tukur-Tukur, PHC Zaria*

# FORWARD

Delivery of health care services is one of the most important responsibilities of government, especially in developing countries. This underscores why the health sector occupies a strategic position in the overall scheme of 'delivery dividends of democracy' to the populace.

Government has invested in the rehabilitation of infrastructure and the recruitment of health personnel, all in an effort to improve the health sector. Effective delivery of health care, however, goes beyond structures and personnel, due to cultural, socio-economic and even constitutional constraints.

The arrival of PATHS in Kaduna State in 2006 provided needed intervention to ensure effective utilisation of government investment through PATHS input into policy formulation in the areas of free maternal and child care; strengthening the drug supply system; and the revitalisation of the primary health care delivery system in the State.

Perhaps the most enduring impact of the intervention is the marked improvement in the awareness of the work force in the health sector to do things the "right way" by investing time in planning, wide stakeholder consultation and monitoring of all activities.

It is our belief that the intervention by PATHS has provided the necessary impetus that would ensure a sustainable health care delivery system for the overall benefit of the people of Kaduna State.



Dr. A. B. Abubakar  
Permanent Secretary, SMoH

# Table of Contents

<b>Summary and Introduction .....</b>	<b>5</b>
<b>SECTION 1 General Overview.....</b>	<b>7</b>
<i>The Kaduna State Context.....</i>	<i>7</i>
<i>Health Status .....</i>	<i>7</i>
<i>Poverty in Kaduna State .....</i>	<i>8</i>
<i>The Health Sector .....</i>	<i>8</i>
<i>Challenges to the Delivery of Health Services .....</i>	<i>11</i>
<b>SECTION 2 Implementing the Health Sector Reform Agenda .....</b>	<b>13</b>
<i>Government Response .....</i>	<i>13</i>
<i>Supporting Government’s Health Reform Agenda - PATHS     approach.....</i>	<i>15</i>
<i>Engagement Process.....</i>	<i>15</i>
<i>Strengthening systems.....</i>	<i>17</i>
<i>Co-ordination of the Reform Process.....</i>	<i>19</i>
<i>Pro-poor Focus and Community Participation .....</i>	<i>20</i>
<b>SECTION 3 PATHS Supported Activities.....</b>	<b>21</b>
<i>Introduction .....</i>	<i>21</i>
<i>Child Health .....</i>	<i>22</i>
<i>Safe Motherhood.....</i>	<i>24</i>
<i>Improved Management through Participatory Appraisal for     Continuous Transformation (IMPACT) .....</i>	<i>27</i>
<i>Sustainable Drug Supply Systems.....</i>	<i>28</i>
<i>Leadership in State-Wide Health Planning.....</i>	<i>29</i>
<i>Consumer/Client Participation and Demand Issues.....</i>	<i>31</i>
<b>SECTION 4 Results.....</b>	<b>34</b>
<i>Key technical results.....</i>	<i>34</i>
<b>SECTION 5 Challenges and lessons Learned .....</b>	<b>40</b>
<b>Annex Resources Developed.....</b>	<b>43</b>
<b>Abbreviations and Acronyms.....</b>	<b>45</b>

# Summary and Introduction

Kaduna State government had demonstrated its commitment to reforming the health sector prior to the arrival of the PATHS programme in 2006. The State government had considered the importance of health as part of the social services to the people of the State. This commitment was reflected in the health-related targets of the Kaduna State Economic Empowerment and Development Strategy (KADSEEDS). By the end of 2007, these targets included:

- Reduce capital/recurrent spending ratio from current 90:10 to 50:50
- Reduce doctor/patient ratio from 1:67,000 to 1:50,000
- Reduce infant and maternal mortality rates
- Curb the incidence of specific diseases (malaria, typhoid, TB, measles, diarrhoea, acute respiratory infection)
- Improve the condition of PHC facilities
- Reduce HIV prevalence
- Eradicate water-borne diseases

Between 2006 and 2008, state health budgets increased rapidly, from N2 billion (£8 million) in 2006, to N10.4 billion (£41.6 million) in 2008. In 2008, this meant that the per capita government budget was about N1,500 (£6). Unlike the usual practice in Nigeria where there is a large disjuncture between budgets and releases, most of the budgeted money for health in Kaduna was released for the execution of planned activities.<sup>1</sup> For example, in 2005 80% of the health budget was released.

Additionally, the Government led the development of a number of health-related initiatives: most significantly, the decision to provide free maternal and child health services; the declaration of a 'war' on malaria; and the refurbishment of hospital facilities.

This Synthesis Report details some of the key initiatives that were led and implemented by the state; that were supported by PATHS; describes the results to date; and identifies key lessons learned from the implementation of activities.

**Section 1** provides a general overview of the state and its health sector. The challenges associated with delivering health services are explored, and the policy direction of the Government is highlighted (e.g. the eleven point agenda of the present administration). The main challenges included poor coordination between the multiple partners in health service delivery, inadequate resources and poor capacity.

**Section 2** describes the State Government's reform agenda for health. The policies and activities that aimed to strengthen health systems and ensure pro-poor service delivery are outlined. PATHS role in supporting the government reform process is described. Four areas are highlighted:

- Engagement Process
- Strengthening Systems
- Co-ordination of the Reform Process
- Pro-poor focus and community participation

<sup>1</sup> For further detail, see the PATHS Technical Brief on Planning and Budgeting.

**Section 3** describes a number of activities that provide a good overview of the process of reform. The case studies in this section, which were chosen by key stakeholders in the health sector and related institutions, highlight the five policy thrusts of Government.

Government Policy Thrusts	Initiatives
Delivery of priority health services	Child Health (Routine Immunisation) Safe Motherhood (Free MCH Policy)
Management and development of health resources	IMPACT
	Sustainable Drugs Supply System
Stewardship	Leadership in State-Wide Health Planning
Fiduciary and health management information system	
Consumer/client participation and demand issues	Ensuring Community Voice Through Facility Health Committees

**Section 4** presents key results, as far as they can be identified given the short timescale of the initiatives in Kaduna. Early results include improved systems e.g. planning and information; evidence of increased utilisation of health facilities, especially by mothers and children; better staff performance; increased focus on Quality of Care issues; and stronger community involvement in health.

**Section 5** discusses the challenges and some of the key lessons learned which included:

- Strong political commitment to health was critical.
- Effective implementation of policies led to improved service delivery.
- The role of State Government in being a catalyst for reform at Federal level.
- The importance of well-targeted capacity building.
- The importance of ensuring synchronisation between service delivery improvements and broader state level reforms.

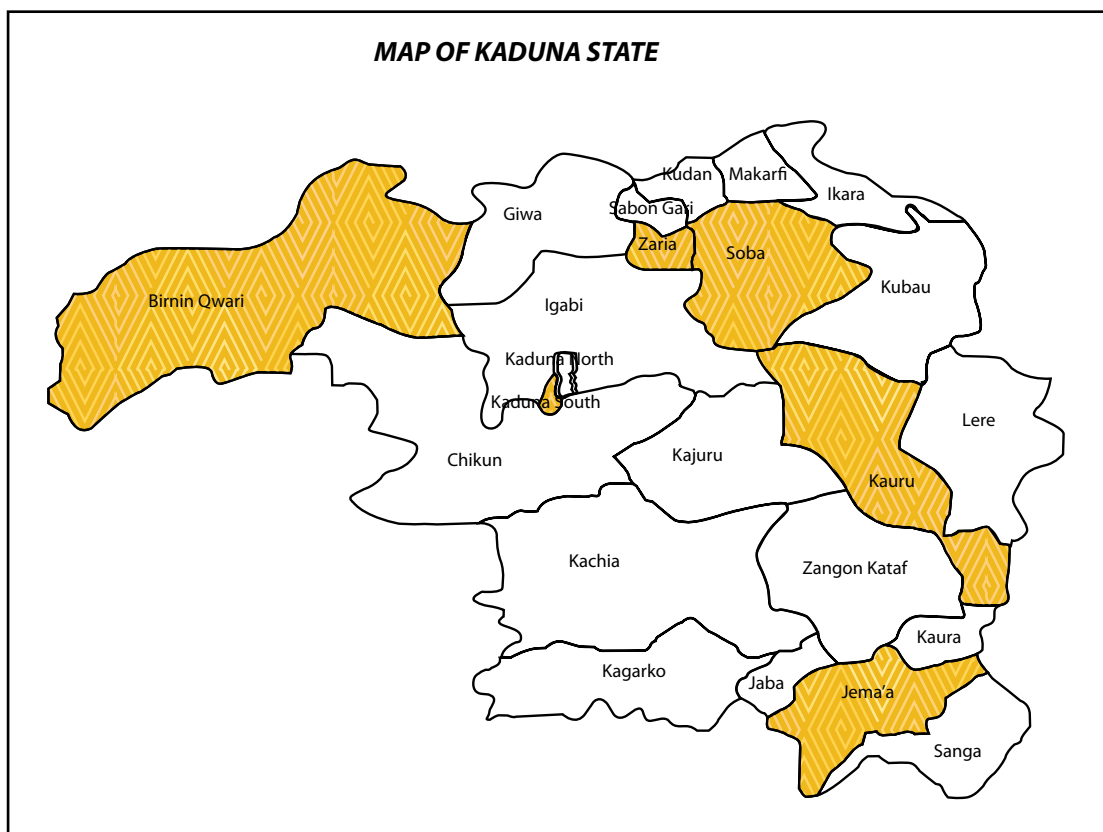
# SECTION 1

## General Overview

### *The Kaduna State Context*

Kaduna State, the third most populous state in Nigeria, is in the North West geographical zone. It is the twelfth largest State in Nigeria accounting for some 5 percent (46,000 square kilometers) of Nigeria's total land mass. It is culturally diverse and has an estimated population of 6.06 million (2006 Census) and a population density of 130 people per sq km and an annual rate of increase of around 3 percent. The State has 23 Local Government Areas (LGAs) with 255 political wards and over 1000 health facilities.

The Map of Kaduna state illustrates the six LGAs (out of a total of 23 LGAs) where PATHS efforts were mainly focussed.



### *Health Status*

Kaduna State had unacceptably high mortality rates and burden of disease profile. In 2003, the infant mortality rate (IMR) was 115 per 1,000 live births; under-five mortality rate (U5MR) was 205 per 1,000 live births and Maternal Mortality Ratio (MMR) was 980 maternal deaths per 100,000 live births. An alarming fact was that these figures represented a worsening trend over the previous five years. Corresponding figures for 1999 were 91, 191 and 950 respectively, according to the 2003 National Demographic and Health Survey (NDHS).

The leading causes of ill-health and death in children within the State were communicable diseases: malaria, diarrhoeal diseases, respiratory tract infections and childhood vaccine preventable diseases topped the list. Mothers died frequently from complications of pregnancy and childbirth: anaemia,

obstetric haemorrhage, obstructed labour, sepsis and other reproductive health problems. Malaria was associated with 70 percent of illnesses in pregnancy and though the use of insecticide treated nets (ITNs) was known to be an effective preventive measure, their utilisation was still low in the State. Other malaria preventive measures were not being utilised at all. Kaduna is situated in the epidemic belt of cerebro-spinal meningitis which has the highest fatality rate among the acute diseases; 84 cases of meningitis were reported in 2004. Kaduna's HIV/AIDS prevalence rate is 6 percent of the population of the State.<sup>2</sup>

## *Poverty in Kaduna State*

KADSEEDS I clearly highlighted the relationship between poverty and health in Kaduna. According to the 2006 World Bank Poverty Assessment Report<sup>3</sup> approximately 41 percent of the Kaduna population are poor<sup>4</sup>, and there is a high level of inequality in the distribution of wealth across the state. Poverty is associated with lower health status and increased vulnerability; the poor are far more likely to experience environmental and social conditions that contribute to poor health and an increase in risk of accident, injury, illness and death. For some, ill health is a direct cause of poverty, especially so when catastrophic expenditure is incurred in the event of a health emergency (e.g. such as a road traffic accident or a maternal complication).

The poor experience limited access to professional medical care, facilities and drugs. In the absence of other options, the poor tend to resort to traditional remedies or to the unregulated informal health sector when care-seeking, and are therefore prone to receiving sub-standard or ineffective care. Lack of affordability of health care is the main barrier of access to health services in many parts of Nigeria, closely followed by physical access barriers in some areas (World Bank 2006).<sup>5</sup> Although the evidence base on the relationship between poverty and health in Kaduna is weak, it is likely that the costs associated with accessing health care, especially when combined with perceptions of poor quality care, has a major negative effect on the utilisation of public sector facilities.

In Nigeria in general, local perceptions of poverty suggest a far broader understanding of what it means to be poor than income or consumption-based measures. Lacking voice on health issues – being unable to complain about poor service delivery or provider malpractice or to shape how services are managed or delivered – can be seen as one dimension of poverty. In Kaduna, as in other states, understanding among clients and communities of their rights to quality health care – and of government responsibility to deliver essential services as part of a 'social contract' with their people, was weak. On the one hand, community expectations of the public sector's capacity to deliver were very low, while health providers and their managers commonly attributed the low utilisation of public health facilities to lack of awareness or 'ignorance' among the general public. The breakdown of trust combined with weak accountability relationships between policy-makers, providers and communities meant that transformation of the 'way business is done' in the health sector was essential.

## *The Health Sector*

The World Health Organisation's report on the performance of health systems ranked the Nigerian health system 187th out of 191 Member States in 2000. Expenditure on health in Nigeria was very low at \$8 per capita (compared to an international recommendation of \$34 per capita).

KADSEEDS provided a strategic framework for reform activities within the State. The strategic framework recognized the importance of pulling together all available resources across State, private and civil society sectors in order to make progress towards achievement of the MDGs by 2015. A priority identified in KADSEEDS was that of human empowerment (economically, politically, and socially) through good health care, potable water, affordable houses, good quality education, and the availability of other basic amenities.

<sup>2</sup> Health Sector Medium Term Plan (2008-2011) for KADSEEDS II.

<sup>3</sup> World Bank, 2006, Nigeria Poverty Assessment, Washington DC: The World Bank Group, Africa Region Human Development III (draft).

<sup>4</sup> Poverty is defined as the expenditure required to meet a minimum level of calorie consumption.

<sup>5</sup> World Bank, 2006, Nigeria Poverty Assessment, Washington DC: The World Bank Group, Africa Region Human Development III (draft).

## **Kaduna State Economic Empowerment and Development Strategy (KADSEEDS)**

### ***KADSEEDS' objectives are:***

- to build trust and confidence in governance
- to reduce poverty and increase wealth
- to reorient values by elimination of negative values that are prevalent throughout Kaduna society

### ***The stated goals include:***

- reduction of poverty by 50 percent by 2015 (general goal)
- improve maternal health and decrease child mortality
- combat specific diseases (TB, HIV, Malaria)

### ***Health-related commitments***

- Reduce capital/recurrent spending ratio from 90:10 to 50:50
- Reduce doctor/patient ratio from 1:67,000 to 1: 50,000
- Reduce infant and maternal mortality rates
- Curb the incidence of specific diseases (malaria, typhoid, TB, measles, diarrhoea, acute respiratory infection)
- Improve the condition of PHC facilities
- Reduce HIV prevalence
- Eradicate water-borne diseases

### ***This will be achieved by:***

- Reforming government and institutions
- Promoting private sector growth
- Implementation of a social charter for empowering people
- Value re-orientation including civil society organisations, communication, information advocacy and participation
- Collaboration with NGOs and larger society to complement development in cooperation with the formal public sector

KADSEEDS I concluded in 2007 and the State Government worked closely with development partners to prepare the KADSEEDS II document for the period 2008-2011. Integral to the development of KADSEEDS II was the Eleven Point Agenda of the Administration; the MDGs; and the Federal Ministry of Health's revised National Health Policy (2004), which provided a framework for the delivery of health services in Nigeria.

### **The Eleven Point Agenda of the Kaduna Government covers:**

1. Security for peace and development
2. Free and compulsory Primary Education and general development of the education sector
3. Intensive agricultural development
4. Poverty alleviation
5. Youth and women empowerment
6. Infrastructural development
7. Improved health care delivery
8. Industrial regeneration (urban cottage industries)
9. Provision of housing for all, particularly low-income earners and civil servants
10. Transformation of rural areas to modern standards
11. Improved welfare package for all workers

### Key aspects of the Revised National Health Policy

- PHC remains the basic strategy for national health development
- Good quality health care is to be assured through cost-effective interventions targeted at priority health problems. Priority health conditions are identified as HIV/AIDS, malaria, tuberculosis and leprosy (TBL), reproductive health and child health (including immunisation)
- High levels of efficiency and accountability are to be maintained in the management of a national health system
- Effective partnership and collaboration between various health actors including other Ministries, NGOs and civil society
- The targets of the health policy are the same as those of the MDGs
- All governments (3 tiers) agree to co-operate among themselves in a spirit of partnership to ensure PHC for all citizens
- All governments accept to exercise political will to mobilise and use all available health resources rationally
- The Federal MoH shall ensure that there is donor coordination

(Federal Ministry of Health, September 2004)

### Health-related Millennium Development Goals and their sub-targets

**Goal 4:** Reduce child mortality

**Target 5:** Reduce by two-thirds, between 1990 and 2015, the under 5 mortality rate

**Goal 5:** Improve maternal health

**Target 6:** Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

**Goal 6:** Combat HIV/AIDS, malaria and other diseases

**Target 7:** Have halted by 2015 and begun to reverse the spread of HIV/AIDS

**Target 8:** Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

There were five themes derived from an analysis of the health situation in Kaduna State that provided the vision and long-term policy thrusts for the health sector. The health chapter of KADSEEDS II was outlined according to these themes. The themes were:

- Stewardship
- Delivery of priority health services
- Consumer/client participation and demand issues
- Management and development of health resources
- Fiduciary and health management information systems

### KADUNA STATE HEALTH SECTOR VISION STATEMENT

A STATE WHERE QUALITY HEALTH CARE SERVICES ARE AVAILABLE, ACCESSIBLE AND AFFORDABLE TO ITS CITIZENS IN AN EQUITABLE MANNER AND ON A SUSTAINABLE BASIS THROUGH ACTIVE PARTICIPATION OF ALL INDIVIDUALS AND COMMUNITIES

## Challenges to the delivery of health services

### Multiple partners in health service delivery

A number of stakeholders delivered health services in the State. Complex organisational relationships existed between some of the institutions, which resulted in fragmentation of service delivery and made coordination challenging.

#### a) Government partners

The State Ministry of Health (SMoH) and the State Ministry of Local Government (SMoLG) were largely responsible for the provision of public health services within the State. However, the Federal Ministry of Health and its agencies were responsible for some aspects of service delivery - these services were often implemented vertically. In addition, the Civil Service Board and Local Government Service Board were responsible for the employment of secondary and primary public health sector staff respectively. This not only made long-term and cohesive human resource planning difficult, but also resulted in weak accountability relationships between health providers and their managers throughout the health sector.

#### b) Private sector partners

Even though the SMoH recognised the role that the private sector played in delivering health services to the population, interaction between the public and private sector was limited. There was also little engagement with faith-based organisations involved in the health sector.

#### c) NGOs

There were several networks of NGOs working on health and health-related issues (e.g. maternal welfare, immunisation and HIV/AIDS), but in practice most worked independently, and government-civil society relationships were fragile. NGO activities were limited due to funding challenges and institutional and other capacity constraints. A structured means of engaging civil society in the delivery of health services had not been successfully secured by either the State or Local Governments.

#### d) Development Partners

The State was also supported by a number of development partners and donors, who often supported vertical community mobilisation or disease eradication and control programmes. The activities of development partners were unco-ordinated both between the partners and with government. Two exceptions were provided by immunisations and HIV/AIDS where activities were coordinated by SACI (State Action Committee on Immunisations) and KADSACA (Kaduna State Agency on Control of AIDS/HIV) respectively.

Bringing all the actors in the health sector together to ensure an integrated health service delivery system was a major challenge for the state.

### Inadequate resources

Kaduna has five tertiary hospitals, 28 secondary hospitals, over 1,000 Local Government facilities and an estimated 656 private sector facilities. During 2006, several State Government hospitals benefited from major rehabilitation work and more were expected to benefit over the following years. However, available resources were not adequate for the number of facilities in the state. This resulted in inadequate staffing of most facilities, poor maintenance of infrastructure,



### Key Challenges

- Multiple partners in health service delivery
- Inadequate resources
- Poor capacity



### Key Challenges

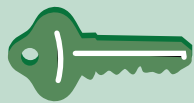
- Multiple partners in health service delivery
- Inadequate resources
- Poor capacity

inadequate services such as electricity, water supply and sewage, and inadequate supplies of equipment, drugs and consumables. However, scaling down the facilities to a manageable number had political implications for the government at both state and local government levels.

### **Poor capacity**

Staff training was another key issue as some health workers operated without the requisite knowledge and skills base, especially at PHC level. Continuous maintenance and upgrading of technical skills and expertise, as well as supervisory and managerial skills, needed to be satisfactorily carried out in an integrated and holistic way across the state.

However, despite the extremely difficult circumstances, many health workers were imaginative and creative in attempting to provide some measure of health service delivery to meet the needs of clients; while the state continued to improve its commitment to health care delivery.



### **Key Challenges**

- **Multiple partners in health service delivery**
- **Inadequate resources**
- **Poor capacity**

## SECTION 2

# Implementing the Health Sector Reform Agenda

### Government Response

Despite the challenges, the State demonstrated a strong commitment to reforming the health sector. State health budgets increased significantly, from N2 billion (£8 million) in 2006, to N10.4 billion (£41.6 million) in 2008, with most of the budgeted being released for the execution of planned activities. In 2008, this meant that the per capita government budget was about N1,500 (£6).

Additionally, the Government led the development of a number of health-related initiatives aimed at addressing some of the key challenges described above. These were linked to five key themes:

- Stewardship
- Delivery of priority health services
- Consumer/client participation and demand issues
- Management and development of health resources
- Fiduciary and health management information systems.

#### Health Reform Thrust of Kaduna State Government

- **Stewardship (Improved Health Sector Governance)**
  - o Improved and evidence-based health planning and review processes
  - o Key legislation for efficient systems strengthening e.g. creation of Primary Health Care Agency (PHCA) and Drug Management Agency (DMA)
  - o Partnership and Intersectoral Collaboration
    - Joint planning and implementation with LGAs, Ministry of Economic Planning (MOEP), Partners etc
    - Establishment of Kaduna Health Forum
    - Development of a Public Private Partnership (PPP) policy
  - o Improved Access to Health Services
    - Free treatment programme for pregnant women and children under 5
- **Delivery of priority health services**
  - o 'War' on malaria
  - o Essential Service and Systems package; especially focused on Integrated Maternal Neonatal and Child Health, HIV/AIDS and TB
  - o Community-based service delivery, including outreach
  - o Support to Sustainable Drugs Supply Systems
- **Consumer/client participation and demand issues**
  - o Inauguration of Hospital Boards and Committees and revitalisation of PHC Facility Health Committees
- **Management and development of health resources**
  - o Quality Assurance Systems including Integrated Supportive Supervision
  - o Renovation of Health Facilities
  - o Recruitment and motivation (increase in salaries) of staff
  - o Support to health training institutions
- **Fiduciary and health management information system**
  - o Improvement in Public Financial Management Systems
  - o Strengthening of Health Management Information Systems

In order to work towards achieving successful implementation of the various interventions, the State Government, supported by development partners, developed a number of integrated plans for the health sector. In addition to annual operational plans, the SMOH drafted a Health Sector Long Term Plan (2008-2017) and the KADSEEDS II workplan provided a medium term plan with prioritised health activities from 2008 to 2011.

These plans were underpinned by a number of operational plans that addressed priority health issues within the State. Developed by the SMOH and stakeholders, these plans included:

1. Integrated Management of Childhood Illnesses Operational Plan 2008
2. Safe Motherhood Operational Plan 2008
3. Routine Immunisation Strategy and Operational Plan
4. Free MCH Implementation Plan

The co-ordinated development of these plans demonstrated efforts to harmonize and improve planning processes within the SMOH, with the wider aim of ensuring better use of available resources. Together, these strategic and operational plans provided a framework for SMOH reform activities.

It was hoped that 'activity based budgeting' (ABB), that was being introduced State-wide, would enhance planning capability. In addition, as part of its focus on supervision, the SMOH would pay close attention to monitoring budget implementation by individual departments and facilities in 2008.

The implementation of a Free MCH programme was another important step taken by the State Government to address a key need of poor and vulnerable groups. The scheme essentially removed one of the most important barriers of access to health care for women and their children i.e. financial barriers.

Evaluation of the early stages of implementation of the programme will provide an opportunity to determine other ways to make the programme more effective; and how to specifically address the health-related needs of other members of the community that are poor, but not pregnant or under five years in age.

Government also recently commenced efforts in co-ordinating support from all stakeholders. The aim was to gradually move towards a sector-wide approach (SWAp). Initially, the 'building blocks' of SWAp would be established. Later direct budget support would be encouraged. The building blocks included:

- A health sector plan that is informed by the health component of KADSEEDS: the sectors reflected in the plan included the state, LGAs and partners with the private and other sectors to come later. This commenced with the harmonisation of the planning processes within the SMOH to short- (1 year), medium- (4 year) and long-term (10 year) plans. The review of the annual plans was part of the quarterly integrated supportive supervision system of the State.
- Strengthened Public Financial Management System: SMOH was taking the central budgeting reform process forward by supporting the hospitals to prepare their 2008 budgets using the new CoA and by drafting a harmonised tariff system that would facilitate the realistic estimation of the expected revenue generated by the hospitals. These were in addition to the state government approving guidelines on public procurement and establishing the Budget Implementation, Monitoring and Price intelligence (Due process) offices in all Ministries, including SMOH.
- Drafting and Costing of the Essential Service and Systems Package: the determination of the health minimal package of services for the different levels of care and the systems needed to support the delivery of these services on a sustainable basis would facilitate the availability of essential quality care to all in the state. This would also ensure easier investment and tracking of such investments by potential stakeholders, especially development partners.

- Clarification of functions of key institutions in the health sector in the state: this included the existing structures (SMoH, LGAs and FMoH) and the proposed state PHC Agency and Drug Management Agency. Expansion of the PATHS steering committee to become the Kaduna health forum, could lead to it functioning as the SWAp committee.

## Supporting Government's Health Reform Agenda - PATHS approach

### PATHS Themes

#### Theme 1

Improved access to quality services

#### Theme 2

Improved access to affordable quality drugs

#### Theme 3

Improved governance through strengthened strategic and policy development

#### Theme 4

Increased demand for services

The Partnership for Transforming Health Systems programme commenced activities in Nigeria in 2002. PATHS was a process-oriented programme that aimed to improve the health status of poor people in Nigeria through improving health systems and strengthening delivery and use of effective pro-poor health services.

Implementation of the programme was characterised by a strong, clear focus on four themes. Activities were selected if they were likely to contribute to progress towards achievement of the Millennium Development Goals (MDGs), and if they demonstrated a potential for high systems impact and wide coverage of services. States had the responsibility to determine how best the themes were customised, according to their own state-specific context.

Since its inception, PATHS supported an array of initiatives and worked collaboratively with other donor-supported programmes, especially in the areas of governance and macroeconomic management.

## Engagement Process

Having commenced its programme in Kaduna State, a state Working Group was established by SMoH to function as an interim PATHS Steering Committee with responsibility for both guiding the implementation of the programme within the state and selecting initiatives to be supported. In Kaduna, PATHS approach was characterised by:

- Support for the priorities of Kaduna State, especially in the health sector;
- Utilising the lessons learnt from programme implementation in other states. This was important as it allowed for quicker rollout of initiatives;
- The relatively short implementation period. The PATHS programme started in Nigeria in 2002, while it only began in Kaduna in 2006. However, there was the possibility of continuation of DFID support to Kaduna State on conclusion of the current programme, through PATHS 2;
- Early baseline studies.

### Key Steps in the PATHS Approach

- **Engagement Process**
- Strengthening Systems
- Co-ordination of the Reform Process
- Pro-poor focus and community participation



*Working group picture*

#### **a) Support for local priorities**

Prior to the beginning of the programme, the State had developed a roadmap encompassing the KADSEEDS framework. Specifically, the State Government had started rehabilitating some public health sector facilities and had increased the health sector budget. These developments were supported by PATHS with technical assistance (TA). The emphasis of the TA was on local capacity building as a means of sustaining programme activities. The approach adopted by PATHS positioned stakeholders in the forefront of programme implementation.

#### **Initiatives supported by PATHS arranged by Health Reform Policy Thrust of Kaduna State Government**

- **Stewardship**
  - o Support to Health Sector Planning
  - o Support to Kaduna Joint Partner Health Programme
  - o Support to Establishment of Kaduna Health Forum
  - o Support to free treatment programme for pregnant women and under 5 children (design & implementation)
- **Delivery of priority health services**
  - o Support to IMCI, RI and SM, including training of health workers
  - o Support to Development and Costing of Essential Service and Systems package
  - o Training of Community Health Volunteers (CHVs)
- **Consumer/client participation and demand issues**
  - o Support to PHC Facility Health Committees
  - o Support to integrated demand creation activities
- **Management and development of health resources**
  - o Implementation of Quality Assurance (QA) systems (IMPACT & CDP)
  - o Support to Sustainable Drugs Supply System
  - o Support to State Medical Store (SMS) and transition to a Drug Management Agency (DMA)
- **Fiduciary and health management information system**
  - o Strengthening of budgeting and other public financial management systems
  - o Strengthening of HMIS

A number of initiatives under the framework provided by the state health reform policy thrust were supported. In this document these are sometimes presented as 'stand-alone' activities, but together they represent a multi-faceted approach to strengthening key systems within the health sector.

### **b) Utilising lessons learnt from other states**

The programme in Kaduna State took into account lessons learnt from four years implementation in the other PATHS-supported States. Sharing this experience helped the State Government determine the best process for engagement and understand the nature of support offered. The initiatives which benefited from experiences in other PATHS-supported states, ranged from the Drug Revolving Fund (DRF) scheme, including strengthening of Sustainable Drug Supply Systems (SDSS) and State Medical Stores (SMS), to an approach to management strengthening called Improved Management through Participatory Appraisal and Continuous Transformation (IMPACT). Where appropriate, models, systems and processes developed elsewhere were adapted for Kaduna and utilised in programme conceptualisation and implementation. This enabled the State to learn and benefit from the experiences of other States as well as expedite implementation.

### **c) Short implementation period**

Conscious of the implementation timeframe, it was agreed that a number of specific initiatives and activities would be implemented in six LGAs (covering some 30 percent of the total population), whilst initiatives to strengthen stewardship would be implemented State-wide. Two LGAs were selected from each senatorial zone; namely Zaria, Soba, Kauru, Jema'a, Kaduna South and Birnin Gwari. Local stakeholders also agreed that the programme would work with an average of one PHC facility in a political ward and one public hospital in an LGA within the selected six LGAs.

PATHS used the entry point of strategic health planning, guided by KADSEEDS, as a basis for working with the State Government. In addition, the Peer Participatory Rapid Health Appraisal for Action (PPRHAA) methodology was used as an entry point for engagement and hardware support at health facility level.

### **d) Early baseline studies**

At the commencement of the programme, the National Bureau of Statistics conducted baseline and health facility surveys in the State. The exercise was carried out in close collaboration with the officials of the Planning Departments of the State Ministries of Health and Economic Planning. The findings were utilised by the state and development partners to inform the health planning process.

## *Strengthening systems*

The approach adopted was one of strengthening systems and processes within the health sector. This ensured that any positive changes were embedded within the health workers' and institutions' structures and ways of working. The idea was that these would become the norm and would therefore be sustainable.

The diagram illustrates the wide range of initiatives needed to strengthen MCH services and thus meet one of the imperatives of the State Government, free MCH services. It also demonstrates how the four PATHS themes align with the set of initiatives needed to strengthen MCH services.



**Key Steps in the PATHS Approach**

- Engagement Process
- **Strengthening Systems**
- Co-ordination of the Reform Process
- Pro-poor focus and community participation

# STRENGTHENING MATERNAL AND CHILD HEALTH SYSTEMS IN KADUNA STATE

## IMPROVED ACCESS TO QUALITY SERVICES

### Building capacity

- Training needs assessment for Routine Immunisation systems
- Agreement of training programme for 300 health workers on RI
- Agreement for training 100 health workers on Reaching Every Ward Strategy
- Training of Trainers on IMCI case management
- Agreement for training of 250 health workers on IMCI
- Agreement of training of 140 health workers on LSS
- Training on SDSS
- Training on DHIS and national HMIS

### Community engagement

- Strengthening of Facility Health Committees through training and the development of an operational manual
- Production of materials to raise awareness of priority health conditions
- Training of 497 Community Health Volunteers
- Implementation of 'African Transformation' gender tool

### Improved monitoring and supervision

- IMPACT + Kaduna Health Forum
- Safe Motherhood Committee
- Demand Side Coordination Forum

## IMPROVED MATERNAL AND CHILD AND HEALTH

### Policy and planning

- Development of Free MCH Policy
- KADSEEDS II
- Health Sector Med Term Plan 2008 - 2011
- Health Sector Long Term Plan 2008 - 2017
- Child Health Operational Plan 2008
- Safe Motherhood Operational Plan 2008
- Strategic and Operational Plan for Routine Immunisation systems
- BCC Strategy

### Service delivery

- Rehabilitation of some facilities by LGAs
- Re-equipping of selected facilities
- Assessment of selected EOC facilities
- Monitoring of service provision and staff performance through ISS
- Development of a referral pathway model for EOC facilities
- Community Diagnostic Programme

### Sustainable drug supply systems

- Design of a SDSS
- Development of operational guidelines for SDSS and training for the In-State team
- Quantification of drugs and consumables for capitalisation
- Inclusion of EOC drugs in the SDSS list
- Training on Free MCH procedures in implementing facilities

## IMPROVED ACCESS TO AFFORDABLE QUALITY DRUGS AND SERVICES

## INCREASED DEMAND FOR SERVICES

## IMPROVED GOVERNANCE THROUGH STRENGTHENING STRATEGIC AND POLICY DEVELOPMENT

## Coordination of Reform Process

In early 2006, linkages between the various Ministries took place at Commissioner level through the Executive Council. However, there was little or no joint planning or implementation within the health sector.<sup>6</sup> To address this:

- On a strategic level, PATHS encouraged inter-ministerial communication and collaboration. This involved closer interaction between the SMoH, SMoEP, the SMoLG and the LGSB. Each Ministry responded positively and demonstrated a commitment to collaborative working, for example, in the joint activities undertaken around health planning and budgeting.
- Intergovernmental working on health-related issues was also enhanced by State and LGA collaboration on a number of initiatives; for example RI, IMCI, Safe Motherhood, PPRHAA and SDSS. Additionally, the SMoH and SMoLG had discussions on funding of health activities in the state, especially the free MCH policy, before the commencement of the LGAs' 2008 budgeting process. These were extremely positive developments that provided a solid foundation for successful implementation of wider health sector reform initiatives. Ongoing commitment to collaborative programme implementation was an important issue for sustainability.
- Stakeholders also reported increased engagement in the health reform agenda in those LGAs receiving support. Given the perception that LGAs did not see their responsibility for the health sector as a high priority, this was an important and encouraging development.

### Examples of collaboration in Kaduna State included:

- LGAs and SMoH established a joint planning process and co-funding for Free MCH services;
- Integrated Supportive Supervision (ISS) team comprised staff from LGAs and SMOH and teams visited both hospitals and PHC facilities;
- The State Reform Team (chaired by MOEP, along with representatives from Education and Rural Development) coordinated all Donor activities in the state and had health on its agenda;
- Other inter-sectoral collaboration was in the context of programme-specific areas e.g. school health, adolescent health, KADSACA (which had responsibility for HIV/AIDS programming).

The expansion of the PATHS Steering Committee to become the Kaduna Health Stakeholders Consultative Forum (KHF) presented a further important opportunity to improve coordination, planning and supervision of reform activities. KHF's role was to facilitate planning, co-ordination and implementation in order to maximise impact and avoid potential duplication and conflict. KHF will have a crucial role in tackling the challenges facing the health sector.



### Key Steps in the PATHS Approach

- Engagement Process
- Strengthening Systems
- **Co-ordination of the Reform Process**
- Pro-poor focus and community participation

<sup>6</sup> Compendium on Health Sector in Kaduna, May 2006.

## *Pro-poor focus and community participation*

The commitment of the State to revitalising PHC services was based on the belief that focusing service provision on an essential PHC package would tackle the common diseases of the poor. In addition, the majority of the Kaduna poor lived in rural areas and were served by PHC facilities. A further strand of the government's pro-poor health strategy was the provision of free MCH services. Although it was recognised that better-off groups were also likely to benefit from this policy, the policy was considered pro-poor for the following reasons: the high level of poverty within the state (41 percent); the danger that catastrophic expenditure on health care incurred at secondary level (such as that for emergency maternal care) would result in even better-off groups falling into poverty, or the poor becoming chronically poor; and concerns about gender equity, in that there were gender-specific barriers of access to health care which prevented many women from accessing health care, especially in a high poverty context.

By early 2008 the government had begun to examine how it could address equity issues more comprehensively within its pro-poor approach. The emphasis on health equity was based on the recognition that there were other individuals outside the categories covered by the free MCH who by virtue of their poverty were excluded from using public health services.

In 2005 the State Government passed into law a bill establishing Boards and Committees for all public hospitals in the state. As part of the implementation of the Free MCH programme in the state, these Boards and Committees, which comprised both facility staff and community representatives, were constituted and inaugurated. In addition, with PATHS support PHC Facility Health Committees were revitalised. In the latter case, committee members were trained on: involving the community in health and increasing their voice; increasing access to services and reaching the poorest; improving the health facility, and improving facility performance; and mobilising finance and other resources. Training also focused on the FHC's role in management of Sustainable Drugs Supply Systems and in ensuring the transparency and accountability of the Free MCH programme. This initiative provided opportunities for communities to engage more actively in the management, delivery and monitoring of quality health services.



### **Key Steps in the PATHS Approach**

- Engagement Process
- Strengthening Systems
- Co-ordination of the Reform Process
- **Pro-poor focus and community participation**

## SECTION 3

# PATHS Supported Activities

## Introduction

The following sections provide an overview of the different initiatives implemented in Kaduna State and are discussed under the five state government policy thrusts:

Policy Thrusts	Initiatives
Delivery of priority health services	Child Health (Routine Immunisation) and Safe Motherhood (Free MCH Policy)
Management and development of health resources	IMPACT
	Sustainable Drugs Supply System
Stewardship	Leadership in State-Wide Health Planning
Fiduciary and health management information system	
Consumer/client participation and demand issues	Ensuring Community Voice through the Facility Health Committee Support to integrated demand creation activities

The initiatives described below provide a good overview of the important work that has been undertaken in Kaduna State to date.

Free MCH was a State Government priority that provided an entry point for implementing the health reform agenda and a mechanism for accelerating progress towards health-related MDGs. Free MCH services therefore became the cornerstone of PATHS supported work in Kaduna.

Multiple initiatives supported the implementation of free MCH services. Implementation of free MCH was underpinned by the development of a strategic framework and costed operational plans. The reduction of barriers of access to services and the creation of demand for the new service were also essential. Staff were trained to deliver maternal and child health services that met minimum quality standards. Systems for monitoring and supervision were also required so that policy makers and providers would know that the services were being accessed and were of sufficient quality.

The efforts to strengthen HMIS cut across all areas of health reform. Access to quality data was essential for service delivery, for health planning and budgeting, and for determining how far the demand for services was met.

By early 2008 it was too early to see significant positive changes in health outcomes in Kaduna. This section therefore focuses on describing the processes that were used to support implementation of each initiative.

## Policy Thrust: Delivery of Priority Health Services

- Child Health
- Safe Motherhood

### Child Health

Kaduna belongs to a zone of the country (the North West) that has some of the worst child health indicators. The under 5 mortality rate is 205 per 1,000 live births.<sup>7</sup> The 2006 National Immunisation Cluster Survey indicated that the coverage rate for a fully immunized child at one year was 16.1 percent and 10.4 percent for crude (card and history) and valid (card only) coverage respectively. DPT3 coverage was 40.1 percent and 33.2 percent respectively for crude and valid coverage. As one of the cheapest and most effective strategies for reducing child mortality, the State Action Committee on Immunisation developed a strategic plan and an operational plan on Routine Immunisation. The aim was to harmonise and coordinate government and non-governmental partners involved in immunisation.

A review of the RI system undertaken by SACI which included a training needs assessment of health workers and a cold chain system appraisal identified key areas requiring support. As a result of this work, about 300 RI PHC workers were trained to organise and implement immunisation outreach services across the six LGAs.



*Child immunisation at Fadan Kagoma PHC facility*

In addition, policy makers were orientated on Integrated Management of Childhood Illness (IMCI), and PATHS supported the Training of Trainers on IMCI case management and the rollout of IMCI training to 100 health workers across the State.

<sup>7</sup> NDHS 2003.

## CASE STUDY:

### ***Routine Immunisation (RI)***

#### **Introduction**

Before the commencement of the PATHS programme, the Government established SACI which was charged with the responsibility of ensuring that polio was eradicated in the state and RI services were strengthened.

A plan of action for strengthening RI was implemented from September to December 2005, but the immunisation coverage (DPT 3) at the end of 2005 remained only 42 percent.

#### **Process**

In December 2006, a rapid assessment of the immunisation programme was conducted.

Three systemic pillars were found to be weak and constituted serious bottlenecks to improving RI. These were:

- stewardship (especially planning and financing)
- supportive supervision
- information management

Using an adapted version of the WHO Common Assessment Tool and an inventory format adapted from UNICEF, a further assessment of the immunisation system in Kaduna state was undertaken in July 2007. This generated information that was used to: make training more efficient; strengthen data quality and use of data for management; and guide the provision of cold chain equipment to LGAs.

While regular capacity building was available for service providers to implement Supplemental Immunisation Activities (SIAs) and Immunisation Plus Days (IPDs), gaps still existed in the area of service delivery (especially organising outreach services), disease surveillance (especially in relation to understanding the performance indicators and data use for decision making), and management (planning and budgeting).

In addition, not all facilities provided RI and those that did faced constant disruption because of vaccine stock-outs. Outreach services were not provided and funds were not released for immunisation activities at ward level. Although vaccine quality was adequately monitored and injection safety procedures were quite satisfactory, adverse effects following immunisation (AEFIs) were not routinely monitored. Gaps in the availability of cold chain equipment were also identified, but these gaps could have been minimised if the state had an effective preventive maintenance and repair policy in place. Moreover, information on the age of the equipment was not easily available. Problems were also identified in immunisation logistics, and cold chain management and training.

#### **Implementation**

In response, a three-year strategic plan and an operational plan for the whole state were developed. These plans were discussed with other development partners in the state such as UNICEF, Compass (USAID), and WHO. The state plan was used to guide the LGAs in producing their own annual plan for immunisation activities.

While other partners and government addressed some of the problem areas discussed above, it was agreed that PATHS would train fifty service providers in each of the six LGAs it was supporting (i.e. a total of 300 health workers). PATHS also supported the Joint Partner, State and LGA annual review of the immunisation programme. Discussions were also held with the SMOH on how to provide effective supervision of all the immunisation sites in the State.

## Results

The state immunisation operational plan fed into the 2008 SMOH budget. By early 2008, LGAs were in the process of producing individual plans for immunisation activities. The immunisation coverage (DPT 3) in the State rose from 40.5 percent in 2005 to 77 percent in 2006. However, there was a decline in 2007 from 77 percent to 55 percent, as a result of the lack of logistics at the LGA level, including irregular supply of vaccines in the second and last quarter of 2007.

**Table of immunisation Coverage 2003- 2007**

Immunisation Coverage %					
Type of Immunisation	2003	2004	2005	2006	2007
BCG coverage under 1 year %	24.9	51.4	49	41	44
OPV 3 coverage under 1 year %	14.8	48.4	38.1	36	48
DPT 3 coverage under 1 year %	22.5	46.5	40.6	77	55
Measles coverage %	29.3	48.6	15.1	124	65

Source: SMOH

## Challenges

Routine immunisation, however, still faced challenges:

- Routine Immunisation was often confused with the polio eradication campaign;
- The lack of logistics at the local government level was an ongoing problem;
- Too many rounds of IPDs, using up scarce resources and tying up the time of health providers and their managers;
- Vaccine supply was irregular;
- Non-compliance continued to be a problem. In some cases this was ascribed to religious beliefs.

Thus, a long-term strategy was required to strengthen RI services, to ensure regular vaccine supplies, to provide sustained logistic support for cold chain equipment at LGA level and to build capacity in routine immunisation data management. PATHS supported the finalisation of specifications for cold-chain equipment for the state cold store and the cold stores of the six LGAs; equipment was to be supplied by HCP. In addition, meetings of the state logistic working group to address cold chain logistics challenges in the state were supported by PATHS.

## Safe Motherhood



*Examining a pregnant woman to ensure safe delivery*

The North West Zone, where Kaduna State is situated, has the highest maternal mortality ratio (MMR) in the country. Strengthening the provision of Emergency Obstetric Care (EOC) services remains one of the most effective ways of reducing maternal mortality, hence activities focused on strengthening these services. The SMOH designated a number of facilities (including faith-based health facilities) across the State as EOC centres - 28 Comprehensive Emergency Obstetric Care Centres (CEOC) and 61 Basic Emergency Obstetric Care Centres (BEOC).

Using a tool that was based on the UN guidelines for monitoring the availability and use of obstetric services; the designated EOC facilities were assessed. Findings were used to inform the State Safe Motherhood operational plan. A multi-sectoral IMNCH (Integrated Maternal, Neonatal and Child Health) committee was established by the SMOH and had the role of co-ordinating implementation of the plan.

Strengthening EOC services targeted the third delay that prevented timely access to safe motherhood services – adequate care at the health facility (the other two delays were a delay in the decision to seek care, and a delay in actually reaching care).<sup>8</sup>

**Activities included:**

- Life Saving Skills (LSS) training
- Strengthening the referral system
- Creating clusters of health facilities
- Revising the Essential Drug List (EDL) and supplying equipment
- Introducing free MCH services

The Government trained doctors (20), midwives (40) and community health extension workers (CHEWs) (80) on life saving skills. The training was a collaborative venture between the State Government, the World Bank Health Systems Development Programme (HSDP II) and PATHS.

**A referral model for the State was agreed by the SMOH. This included:**

- Clustering of EOC facilities (CEOC & BEOC) with facilities where the majority of normal deliveries occurred;
- Clarifying roles and responsibilities for the different facilities.

## CASE STUDY:

### Free MCH Services

#### Introduction

Key health indicators (IMR, U5MR and MMR) were very poor in Kaduna. Because of these indicators, and in a national context where interest in improving MCH services, and making them more affordable, was growing, Kaduna developed a policy of free MCH services.

#### Process

In 2006, the Executive Governor of the State established a committee which was given the task of working out the modalities for



**Governor launching free MCH**

<sup>8</sup>The 'Three Delays Model' was developed by Columbia University School of Public Health. For further information, particularly on the first two delays, see PATHS Technical Brief on Increasing Access to Safe Motherhood Services. On the third delay see the PATHS Technical Brief on Strengthening Supply Side Components of the Safe Motherhood Programme in Nigeria

implementing such a free MCH programme. The key tasks for the committee were:

- To identify the resources required, including both staff and infrastructure;
- To determine the costs associated with implementation of the proposed programme.

A number of sub-committees were formed to consider other issues (e.g. advocacy). PATHS provided technical assistance to the committees in preparing the draft policy and refining the costing estimates.

### Implementation

A wide range of services was provided for under the Maternal Health package, though very few facilities could provide the full range of services from the beginning. Several interventions for children were provided free of charge. These included immunisation against major childhood infections and PMTCT. The package outlined below represents additional services that would be phased in as the free MCH services were implemented.

Free Maternal Care Package	Free Child Health Care Package
<p><b>Antenatal Care</b></p> <ul style="list-style-type: none"> <li>• Treatment of anaemia</li> <li>• Treatment of malaria</li> <li>• Education on essential maternal and child care skills</li> </ul> <p><b>Normal delivery Care</b></p> <ul style="list-style-type: none"> <li>• Laboratory tests</li> <li>• Drugs</li> <li>• Consumables</li> </ul> <p><b>Emergency Obstetric Care</b></p> <ul style="list-style-type: none"> <li>• Drugs</li> <li>• Consumables, including blood bag</li> </ul> <p><b>Overhead Costs</b></p> <p>Stationery</p>	<p><b>Management of Common Childhood Illnesses</b></p> <ul style="list-style-type: none"> <li>• Drugs for malaria</li> <li>• Drugs for Acute Respiratory Infections</li> <li>• Diarrhoea drugs and ORS</li> <li>• Drugs for worms</li> <li>• Drugs for meningitis</li> </ul> <p><b>Overhead Costs</b></p> <p>Stationery</p>

The estimated cost of implementing the policy for the first three years was N18 billion (£72 million) of which N5 billion (£20 million) was required in the first year. The budget was used for community information and mobilization; provision of free drugs; improvements in staffing and infrastructure; and strengthening management systems to enable the delivery of quality services. The key sources of funding were the SMoH and LGAs.

### Results

As at early 2008, the Free MCH programme was being implemented in all public hospitals in the state and in 112 PHC facilities. State Government released an average of N75 million (£300,000) monthly for the programme since the commencement of implementation in 2007. To support further implementation,

a costed Safe Motherhood Operational Plan (2008) and a costed Child Health Operational Plan (2008) were produced.

### Challenges

The increase in utilisation of health facilities resulting from the introduction of the free MCH policy, placed a great deal of pressure

on the health system. Because free MCH services were not available in all PHC facilities (112 out of the planned 510 PHC facilities), there was evidence to suggest that clients were bypassing their nearest health facility and targeting the free MCH facilities in preference. As the programme placed significant demands on available resources, an early evaluation of impact will be essential before further roll-out.

### Lessons

The strong political support for the introduction of a free MCH service package in Kaduna presented a good model for improving access to health services for a vulnerable population. Developing the model highlighted the need for:

- Joint planning by two tiers of Government (State and LGA);
- Inter-ministerial co-ordination (SMoH, SMoLG, SMoEP, and SMoF);
- Legislation;
- Co-ordination committees for proper implementation;
- Strengthening multiple systems e.g. Central Drugs Store to ensure quality drugs and medical supplies; Sustainable Drug Supply Systems to deliver free and non-free drugs; and adequate supervision systems.

In order to embed the new initiative it will be essential that this scheme is incorporated into the regular planning and budget processes of the State Ministry of Health.

In addition, meetings of all EOC facilities in the clusters within the six LGAs were organised to encourage improved interaction between the different institutions. One CEOC served as the apex facility for each cluster.

EOC drugs were included in the State Sustainable Drug Supply System (SDSS) list, which comprises of essential drugs (EDL) and other consumables. Appropriate equipment was also provided to the EOC facilities.

One of the key causes of both the first and second delays – the delay in the decision to seek care and the delay in actually reaching care, was lack of affordability. This affected utilisation of both routine maternal care and emergency obstetric care. The Government's policy of free MCH services aimed to reduce the financial barriers of access to maternal health services.

### Policy Thrust: Management and development of health resources

- IMPACT (Improved Management through Participatory Appraisal for Continuous Transformation)
- SDSS (Sustainable Drug Supply Systems)

## *Improved Management through Participatory Appraisal for Continuous Transformation (IMPACT)*

The aim of IMPACT is to build a sustainable health system that can deliver quality services through health facilities with strong community participation. IMPACT is a broad-based management capacity building and systems strengthening initiative. It has four components – PPRHAA (Peer and Participatory Rapid Health Appraisal for Action); Systems Building; Integrated Supportive Supervision (ISS); and Quality Assessment and Recognition (QAR).<sup>9</sup> The different components are linked logically: the identification of strengths and challenges through facility appraisal leads to focused systems strengthening in key areas. Systems strengthening activities are supported by, and progress is assessed, by supportive supervisory teams. Improvements in the quality of service delivery are then publicly recognised, creating incentives for further improvement and generating additional demand for services. While PPRHAA and QAR are undertaken annually, systems strengthening and supportive supervision are on-going processes.

<sup>9</sup>For further information see the PATHS Technical Brief on IMPACT.

Facilities are appraised during PPRHAA and plans are prepared to address problem areas. In components two and three, all responsible parties strengthen the systems needed to delivery better quality health services. This involves facility staff, the community the facility serves, and an integrated supportive supervision team. The fourth component, QAR, assesses and recognises facilities that meet quality standards. Facility staff, community members and facility health committee (FHC) members are all publicly recognised.

PPRHAA was introduced to Kaduna by NPHCDA, a key federal level organisation that had been trained on the methodology by PATHS. The state conducted two rounds of PPRHAA in August 2006 and in August 2007 across a total of 110 facilities (including hospitals, PHC and faith-based facilities). With PPRHAA five key thematic areas: Patient Care Management; Internal Management and External Linkages; Client and Community Views; Finance, Accounting, Equipment and Infrastructure; and Facility Service Output in the health facilities were appraised.

In Kaduna, PPRHAA quarterly follow-up exercises were conducted after the first PPRHAA appraisal. When the ISS framework was designed and piloted in three LGAs, the quarterly review process was merged with the ISS system. Since the first ISS, key stakeholders have successfully carried out regular supervision on their own, with technical support from PATHS. In early 2008, the first facilities were assessed by the QAR teams, and facilities that reached the excellent standard of quality were recognised.

The execution of PPRHAA workplans by the facilities has had a major positive effect on the delivery of services and on client satisfaction. In addition, issues identified during the PPRHAA and ISS exercises were incorporated into the planning and budgeting processes; formed the basis for capacity building processes; and generated key concerns as well as commitments from all stakeholders, including communities. These were positive outcomes.

## *Sustainable Drug Supply Systems (SDSS<sup>10</sup>)*



**Community Members at the Handing Over of Drugs to one of the Capitalised Facilities**

<sup>10</sup>For further information see the PATHS Technical Brief on Sustainable Drug Supply Systems (SDSS).



*Perm Sec and directors discussing the functions of SMOH (30).*

Drugs and consumables are central to the delivery of quality healthcare. However, in Kaduna, while public hospitals had some drugs for their services, there was a complete absence of government drugs in any of the PHC facilities in the State in 2006. The Government commenced reform in this area by undertaking a review of the existing drug revolving fund scheme in hospitals and PHC facilities. Its aim was to revitalise the DRF scheme through ensuring more community involvement in the running of the DRF and more robust financial management systems within the facilities.

With the approval of the Free MCH policy in September 2006, a sustainable drug supply system (SDSS) was designed for the delivery of both free and fee-based drugs at facility level across the State.

Operational guidelines were developed and an in-state team of facilitators was trained to support the SDSS roll-out. After training health workers and community members (who were to have a role in managing the facility-based SDSS), facilities, which were selected based on their performance as identified by PPRHAA, were capitalised. By early 2008, five public hospitals and thirteen PHC facilities had been capitalised – in other words they received a first stock of drugs to start the drug revolving fund, and there were plans to capitalise seven hospitals and 48 PHC facilities by the end of May 2008, bringing the total of SDSS facilities up to one hospital per LGA and one PHC facility per ward.

To ensure sustainability, an assured source of affordable and quality drug supplies in the State was needed. A review of the State Medical Store (SMS) in February 2007 recommended creating an autonomous institution. This needed to be in a position to provide support in the delivery of free and fee-based drug supplies for all the public facilities in the State in the short term, and to private facilities in the future. Operational and institutional guidelines and systems were subsequently developed for the SMS; including information technology (IT) support for better accounting, drug management, and logistics. The Bill to pass the conversion of the SMS to an autonomous Drug Management Agency (DMA) was receiving favourable attention in the State House of Assembly in early 2008.

**Early challenges for the SDSS included:**

- Establishing the DMA, as described above
- Inadequate funding for capitalisation of all facilities
- Improving record keeping.

## Policy Thrusts: Stewardship and Fiduciary and Health Management Information Systems

- Leadership in State-Wide Health Planning

### *Leadership in State-Wide Health Planning*

Once the first Kaduna State Economic Empowerment and Development Strategy, the KADSEEDS, had been approved, the next step was to translate the health-related commitments into action. In May 2006, the state sought support for the development of a Health Strategic Plan, a health compendium, and a vision statement for the health sector. PATHS also provided support for the development of the Free MCH policy and other key programmes included in the KADSEEDS document e.g. SM, IMCI and RI. At the same time, facilities were developing plans during the PPRHAA exercise.

SMoH provided the leadership needed to harmonise the multitude of plans and planning processes within the health sector. Structures were established to develop and review the plans on an ongoing basis. These plans fed into the annual budgeting process of SMoH. Issues identified in the development of these plans, and lessons learnt in their implementation helped inform the development of the health component of KADSEEDS II.

It is critical that plans and policies are evidence-based. Although significant amounts of health-related data were generated in Kaduna, very little was used to inform management decision-making as it was usually of poor quality. To address this, an essential data set (EDS) based on a small set of indicators was selected by the State and comprised the initial focus of data collection, with the expectation that the EDS would expand in the future. The District Health Information System (DHIS) software was utilised to capture the data.<sup>11</sup>

A 2007 data quality audit revealed gaps in data collection. To address this situation, key health information managers in the State were trained on the DHIS and the national HMIS forms. These "State HMIS Ambassadors" were charged with the responsibility of carrying the process of strengthening the HMIS forward under the chairmanship of the SMoH Director of Health Planning and Research. To consolidate the drive, computers were provided to key offices and facilities involved in implementing the HMIS.

By early 2008, although much of the data was still of poor quality, better use was being made of the robust data that was available.



*Perm Sec and directors discussing the functions of SMOH*

<sup>11</sup>For more information see the PATHS Technical Brief on Developing an Information-based Culture: HMIS and PATHS 2003-2008.

## CASE STUDY:

### *Developing the Health Component for KADSEEDS II*

The development of KADSEEDS II offered a good opportunity to harmonise sector plans around a common planning format. The DFID-funded State and Local Government Programme (SLGP) supported government to develop KADSEEDS II. The State Ministry of Economic Planning (MoEP) provided guidance to planning processes for all Ministries. As PATHS had supported an equivalent approach in Kano, it drew on this experience in Kaduna.

To meet the SMOH's mandate of leading and coordinating health sector planning, an active Planning Forum, chaired by the Permanent Secretary, was established. To meet programme managers' expectations for technical support for planning their programmes, the capacity of the Department of Health Planning and Research in the SMOH was strengthened.

#### **Process**

There was consensus among State health officials that the current long-term plan (2007-2016) provided a good foundation for medium- and shorter-term planning and should be finalised and used for that purpose.

To ensure wider acceptance and adoption of the ten-year and medium-term planning formats, SMOH consulted further with its partners in the health-related sectors, civil society and the donor community. Stakeholders reviewed all health and health-related planning processes in the State, harmonised plans, and ensured alignment with overall state plans and with the Public Expenditure Management (PEM) framework.

This process assisted the State in developing the KADSEEDS II health component. Additionally, the SMOH developed a practical plan for strengthening organisational "planning capacity" (systems and competencies) within the Ministry.

#### **Result**

***The process resulted in the development of:***

- (a) the 2008 operational plan (and budget);
- (b) the three year medium-term plan (2008 – 2010); and
- (c) the ten year strategic health plan (2008 – 2017) for the State.

The three-year medium term plan was later revised to a four-year term to align it with KADSEEDS II which had a four year time-frame.

#### **Challenges**

Very broad estimates suggested that the combined recurrent and capital costs for fully implementing the health component of KADSEEDS II would be about 50 billion naira (£200 million) over four years. This meant a potential funding gap of up to 10 billion naira (£40 million). It was anticipated that the gaps would be covered by current and potential Partners in the State. Notwithstanding the projected large funding gap, the larger immediate concern was about improving the efficient and effective use of available resources. Efforts to strengthen State Public Expenditure Reporting and financial management systems, and to establish sub-national Health Accounts, should contribute to achieving this objective.

Co-ordination and integration of multiple plans was also essential to address vertical programme implementation, especially in such programmes as Free MCH services; Sustainable Drug Supply Systems; integrated supervision; and quality assurance. The planning process should incorporate these and other initiatives into a comprehensive state-wide planning and monitoring instrument.

The proliferation of other planning processes within the SMOH (e.g. driven by donors and the FMOH) posed a big challenge to the achievement of strengthening the support systems, processes and quality of planning in the SMOH.

## **Policy Thrust: Consumer/client participation and demand issues**

- Ensuring community voice through Facility Health Committees
- Support to integrated demand creation activities

### *Consumer/Client Participation and Demand Issues*

When PATHS started working in Kaduna in 2006, a wide range of health communications activities were being implemented by government, donors and civil society organisations. Many of these demand creation activities occurred during 'one-off' events, such as during immunisation campaigns. Much of the work was instructional, in other words, the emphasis was on providing information to fill perceived gaps in knowledge, which, in turn, was expected to stimulate behaviour change. These approaches did not always address the other barriers of access to utilisation of health services. Limited investment was made in social appraisal studies which would help build a better understanding of health-seeking behaviour, and inform the development of locally-appropriate intervention strategies. In addition, there was an absence of formal mechanisms that could be used to share good practice, tools and resources, or information on results from working on the 'demand-side'.

PATHS support focused on the need to ensure co-ordination and harmonisation of demand side activity across the state. The aim was to maximise and consolidate impact, and open up channels for sharing of good practice. The primary vehicle for achieving this was a Demand Side Co-ordination Forum, which was established in 2007. In addition, a number of activities were implemented with the aim of strengthening the SMOH Health Education Unit so that it could play a key role in overseeing demand-side health activities in the State.

Another key initiative of the Kaduna SMOH under this policy thrust was the Facility Health Committee (FHC) Strengthening Initiative. When PATHS started working in Kaduna in 2006 many health committees had fallen into inactivity. Working in partnership with the Ministry of Local Government, Ministry of Women's Affairs and Social Development, and Local Government Service Commission the SMOH aimed to turn this situation around. The FHC Strengthening Initiative aimed to strengthen community participation in the management of health facilities; provide a platform for community voice on health issues; and to promote accountability and sustainability of interventions such as SDSS and Free MCH services by encouraging community involvement in the governance of these schemes. The initiative focused on strengthening the capacity of FHCs by providing new ideas and tools that would allow them to work more effectively.

FHC training and operational manuals were developed with PATHS support. A core state team of FHC trainers was trained, and a first phase of training was cascaded down to 180 FHC members from 60 PHC facilities in six LGAs. In a second phase of activity, training was rolled out to a further 92 additional facilities that were implementing Free MCH services. Refresher training, of both TOTs and FHCs was also provided in order to sharpen skills and competencies in key areas such as conducting client satisfaction surveys and how to lobby and advocate effectively for improvements in health services. The training was funded by the State Government. By early 2008 there was commitment to rolling out the initiative state-wide.

By late 2007 there were some very positive signs that some FHCs were beginning to successfully challenge accountability failures, both at facility level and higher up the system.



*Members of Unguwan Fari PHC Facility Health Committee with District Head, Jema'a LGA, Kaduna*

## *Aims of the Kaduna Facility Health Committee Strengthening Initiative*

In Kaduna, the SMOH, the Ministry of Local Government, Ministry of Women's Affairs and Social Development, and Local Government Service Commission worked together to implement the Kaduna Facility Health Committee Strengthening Initiative. It was anticipated that stronger Facility Health Committees would lead to the following:

- **Communities play a more active role in ensuring 'better health for all the community'**
- **Communities feel that they have a stronger voice on how health services are managed and delivered**
- **Communities feel that health providers are more accountable to them**
- **Health services are more responsive to patient needs**
- **Health services reach the very poor and the underserved**
- **Women's views and perspectives on health issues are better represented**

The FHC strengthening work aimed to broaden the FHCs' vision of how they could operate. Historically, their primary focus had been on supporting improvements in facility infrastructure or in the wider facility environment, either through the supply of labour or via fund-raising. Although these activities were laudable, there was scope for building their capacity and confidence to work on a broader range of issues, such as: monitoring facility performance; involving the community in health and finding ways to increase community voice on health issues; working with the community to increase access to specific services where barriers of access were complex (e.g. emergency maternal health care); and identifying strategies to ensure that health services reached the poorest.

## *Support to integrated demand creation activities*

Another initiative was the development of a Behaviour Change Communication (BCC) strategy. Materials were designed and developed on priority health issues, as identified by the State. These included routine immunisation, integrated management of childhood illness, and safe motherhood. Just under 500 Community Health Volunteers (CHVs) were trained to act as a link between the facility and the community and to work closely with FHC members. The CHVs played an important role in the community in raising awareness about priority health conditions, as well as about rights and entitlements to quality health care.

A gender tool, called Africa Transformation was also piloted in Kaduna. The tool aimed to promote dialogue between men and women on gender issues at community level, and thereby address some of the gender-specific barriers of access to key health services. A local NGO, ABANTU, co-ordinated implementation in communities around EOC facilities in three LGAs.

## SECTION 4

# RESULTS

### Key technical results

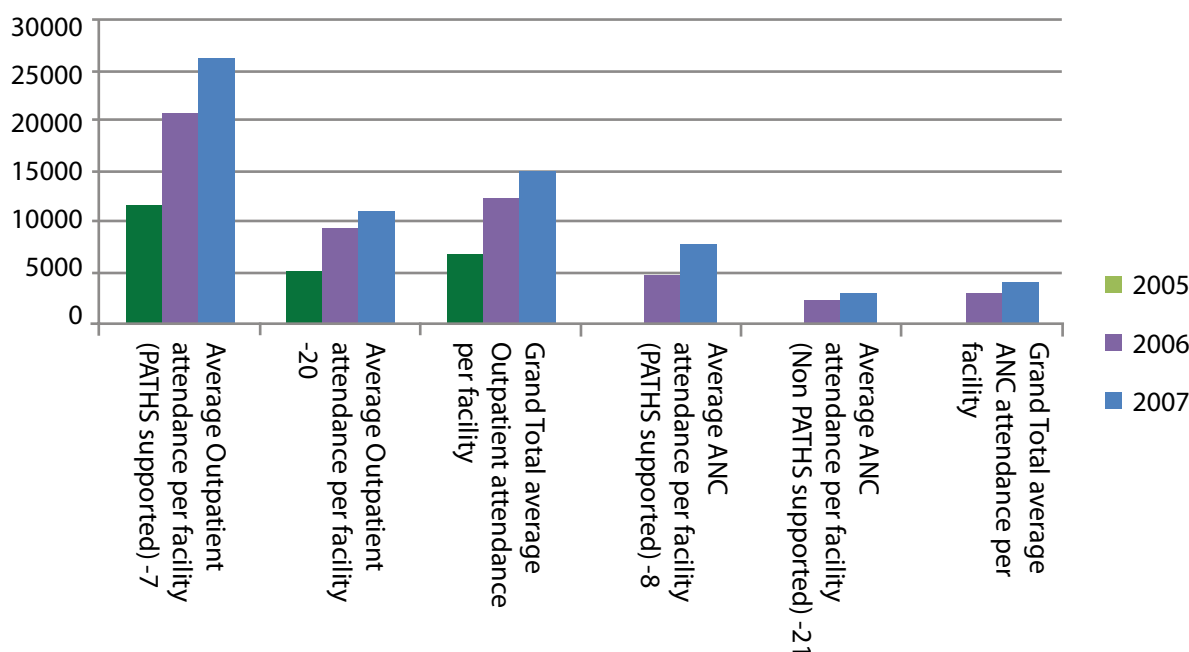
Some early results from implementation were evident by March 2008, although given the relatively short timescale for implementation evidence of long-term impact was not yet available. Since implementation across almost all policy thrusts, with the active participation of relevant stakeholders, remained at an early stage, the emphasis was on learning key lessons to inform future replication activities across the state.

By early 2008 stakeholders had reported many important results and achievements, a number of which are presented in this report. However, it is important to recognise that many of these results remain anecdotal. As the HMIS improves and more data becomes available the evidence base will improve.

#### a) More patients attending public health facilities

Increased attendance in all facilities that were involved in systems and service delivery strengthening was reported by stakeholders. For example, the graph shows outpatient and ANC trends at public hospitals over the period 2005-2007. The graph shows that the outpatient numbers had more than doubled but there was a smaller increase in ANC attendance. The PATHS-supported facilities were busier and the rate of increase was slightly faster. However, it was difficult to attribute these increases to PATHS support alone, in the absence of further information.

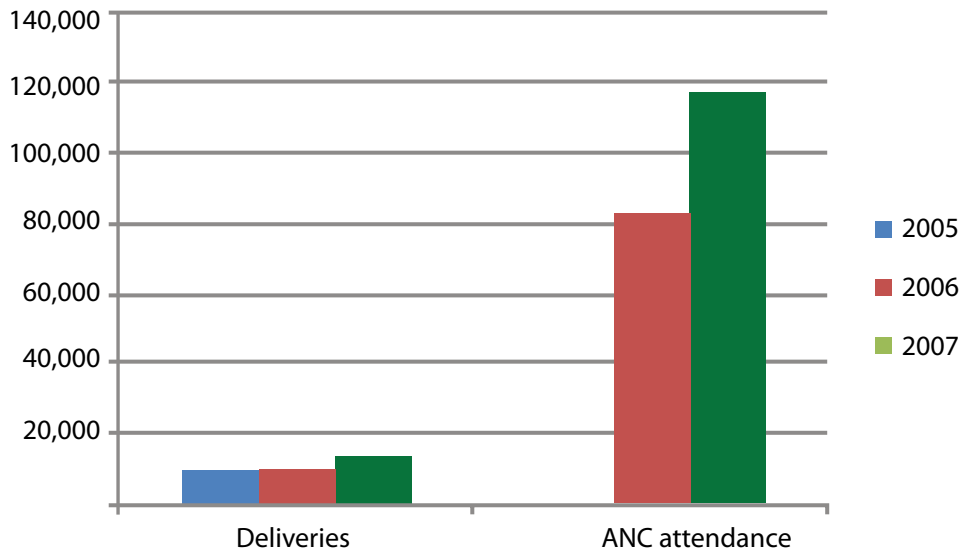
**The Differences in Attendance (2005 – 2007) between PATHS-supported and other Facilities in Kaduna State**



### b) More women accessing Free MCH services

More women were reported to be accessing health services since the introduction of Free MCH services. Although by early 2008 the Free MCH Policy was still being rolled-out and was not yet available in all health facilities, an increase in antenatal coverage was evident (from just over 80,000 clients in 2006 to just under 120,000 clients in 2007). Although, without further information, care needs to be taken on attribution.

**The Total ANC Attendance & Deliveries (2005 - 2007)  
in all Public Hospitals in Kaduna State**



### c) More community involvement

A marked increase in community engagement with the State's health sector reform agenda was also reported. Stakeholders, including community representatives themselves, reported this as a key achievement. Heads of LGA Health Departments described the training for FHC members as a 'catalyst' for the community. In some LGAs, community representatives had begun to meet with staff from local facilities on a regular basis, and there was evidence that some FHCs were beginning to challenge accountability failures at both facility and LGA levels. LGA heads of health attributed this to the various training and mobilisation activities of the State Government. Key activities included inauguration of the State Hospitals' Management Boards and Committees; reinvigoration of the FHCs that operated at PHC level; and community level mobilisation activities undertaken as part of the roll-out of the Free MCH programme.

"Every day a member of the FHC comes to see what is happening with the free MCH drugs. They see how we give the patients the drugs. It is helpful that they watch the dispensing. We are only getting about 50 percent of the drugs we need. We therefore need to ask clients to buy outside, and this leads to suspicion of us providers. The FHC is very helpful in explaining the role of free MCH to communities since there is a great deal of confusion among clients."

*Health provider, Ung Mu'Azu PHC Facility, Kaduna*

"The FHC has been able to influence local government decisions. We have a good relationship with local government. We call the local councillor – he's part of our community - and let him know what we want."

*Chairman, Makera PHC, Kaduna*

“The FHC holds meetings at the health facility the first week of the month. The community representatives on the committee wish to be aware of the activities of the health facility so that they can feed back to the community. The FHC dug a well for the facility and put up a very nice sign board explaining what services are available and when. They also made a suggestion box. The Chair of the FHC can often be found at the health facility for supervision. He likes to see the flow of clients and see how the providers relate to community members. The Chairman lives very close to the facility. The women’s leader is always here too. If there are any problems, then both of these individuals help us deal with them. They can quickly contact the community and help sort out any issues.”

*Officer in Charge, Barnawa PHC, Kaduna*

“Our local health facility lost some land when a dual carriageway was constructed. The state government planned to compensate local government for the loss. We lobbied the state government and asked to be paid the compensation directly. We wanted to avoid local government getting the cheque because there would be long bureaucratic delays in moving ahead with the building... The funds were released in September 2007. By early December 2007 we had renovated large parts of the health facility, built a new delivery ward, fenced the facility, installed a new water tank, and dug a pit latrine for patients. The new ward is bigger and better than what was originally in place. It was not easy to make the argument. We had to use impressive people for this... The Local Government PHC Co-ordinator assisted a lot. Everybody knew that if we got the money we could do a lot for the clinic. We submitted an expenditure report to local government in early December 2007 and have arranged for the Local Government Chairman to come and inspect the building work.”

*Babban Dodo PHC Facility Health Committee, Kaduna*

#### **d) Better staff performance**

Another major result reported by stakeholders was improved staff performance and motivation. This was attributed to increased supervision at facility level. As before, in the absence of evidence, it is not possible to directly attribute this improvement in performance to the initiatives supported by PATHS. Nevertheless, it was interesting to note that stakeholders ‘felt’ that there had been a significant improvement, even if this could not be accurately measured. Such a perception was an important factor in motivating staff and engaging them in the process of improving quality of health services on an ongoing basis. Similarly, a perception amongst the community that things were changing was important to secure their engagement and build their confidence in the State’s health reform agenda.

***“Before now I didn’t come to this clinic because the health workers are arrogant, they shout at you any time you come for treatment. But suddenly they have changed; they are now very friendly and caring. So I feel very free to come to this clinic with my children.”***

*Mallama Zainab Ibrahim, Resident of Tudun Wada community, Zaria LGA, Kaduna.*

Another aspect of improved staff performance reported by the heads of LGA Health Departments was improved staff attendance at their place of work in those facilities that had benefited from PATHS support.

The State Government made a commitment to increased remuneration of health sector staff. Senior

officers reported that this would have a significant impact on staff motivation within the health sector, such that it would have positive implications for successful implementation and sustainability of programme initiatives.

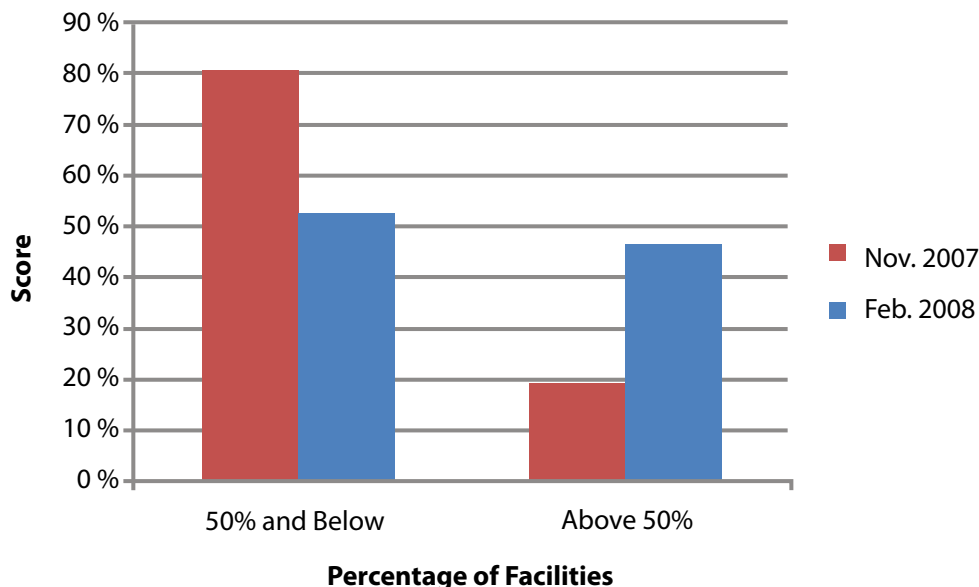
**e) Improved Quality of Care**

Data collected by Integrated Supportive Supervision teams, which started functioning in 2007, provided information on different aspects of quality of care in the following thematic areas:

- Patient Care Management
- Internal General Management and External Linkages
- Finance, Accounting, Equipment and Infrastructure
- Output data
- Community and Client Views

Analysis of this data shows that as at February 2008, there had been almost 100 percent increase in the number of facilities whose performance was above 50 percent when compared to November 2007.

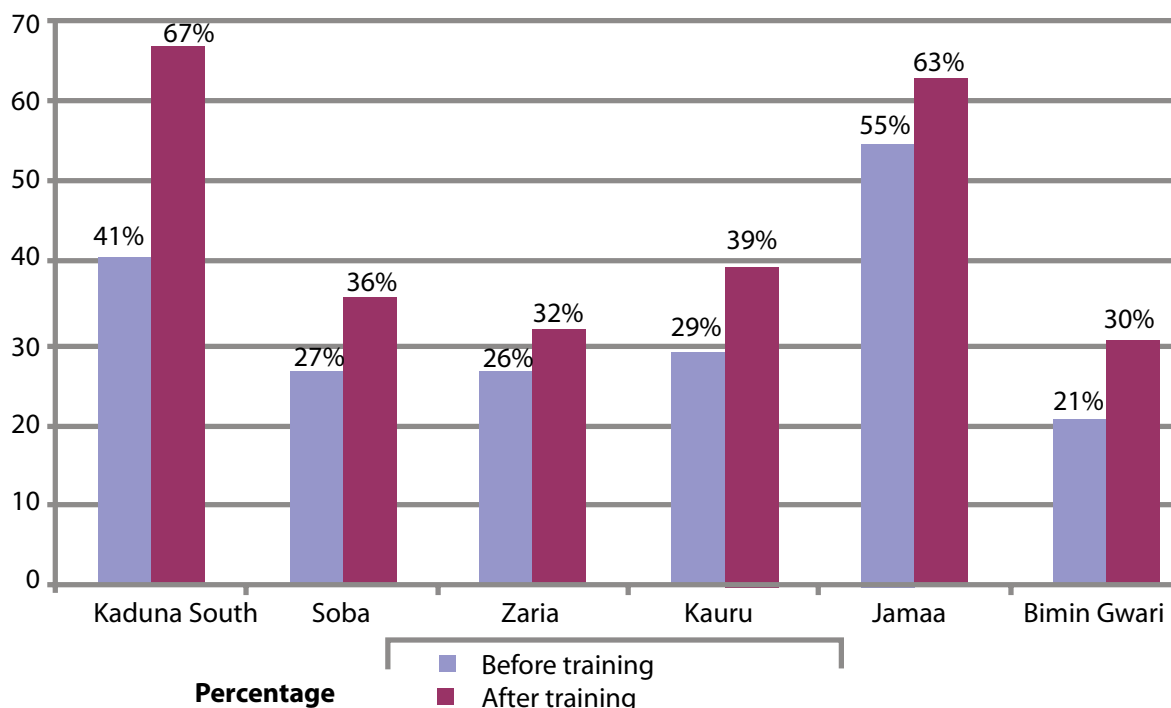
**Integrated Supportive Supervision - facility performance scores**



**f) Better information**

Good quality information is essential for effective management of health services. Staff reported that HMIS training had resulted in some improvement to the quality and completeness of data being collected at facility level. LGA Health Departments reported this as a positive impact of Integrated Supportive Supervision (ISS) activities.

## GRAPH SHOWING IMPROVEMENTS IN COMPLETENESS OF DATA SUBMISSION



The graph shows improvement in the monthly submission rates. For example, in Kaduna South LGA monthly submission rates had improved from 40 percent before training to 66 percent after training.

### g) Better planning

By early 2008 the SMOH was in the process of building a robust health-planning framework that demonstrated clear linkages between strategic, operational and financial planning. This was a crucial early step in demonstrating effective governance and improving performance. A number of strategic and operational plans had been developed by the SMOH and these were used to inform the 2008 State budgeting process, and guided the LGA planning process and other reform processes in the State e.g. KADSEEDS II. Although gaps remained in terms of the funds available to implement the plans, the process of budgeting within a planning framework was an important development, and one which could be consolidated in the next planning round.

Besides PATHS, the SMOH worked collaboratively with a number of other donor programmes within the State in order to strengthen the overall impact of health reform activities. In particular, there was a close partnership between the SMOH and the DfID-funded State and Local Government (SLGP) programme. Activities included a review of the budget format and budgeting process. Following the review, a draft Chart of Accounts for the State was developed. SLGP also supported the government to introduce activity based budgeting (ABB). PATHS supported this initiative by working with the SMOH to introduce ABB in all public hospitals within the State.

The MoEP, supported by SLGP, coordinated the production of KADSEEDS II. PATHS provided support to the SMOH to prepare the health component of the strategy. It was anticipated that the State Government would finalise the document by May 2008. Other health planning activities were undertaken in collaboration with partner agencies; for example, the Health Sector Medium Term Plan (2008-2011) and the state multi-year plan on RI.

## *Summary*

SMoH developed systems, processes and tools that were transferable across the health sector and could be implemented by LGAs that were not in receipt of direct support from PATHS. Examples included the health facility assessment tool developed for EOC, and the various training programmes that were developed (e.g. FHC training programme and manuals). Although the entry point to the reform process was the public sector, preliminary steps were taken towards engaging more fully with the faith-based sector. For example, a number of faith-based organisations were involved in PPRHAA. It was anticipated that any follow-on programme of support to the health sector would provide an opportunity for engaging the wider private-for-profit sector in the State's reform agenda.

## SECTION 5

# CHALLENGES and LESSONS LEARNT



## Challenges

The key challenge was to maintain the momentum of these early successes and the high level of motivation amongst stakeholders. By early 2008 feedback from stakeholders was extremely positive and complimentary. In a context where historically appraisal and supervision were associated with criticism and reprimand, constructive criticism was beginning to be seen as a positive tool for improvement, and an opportunity for individuals and organisations to learn from their shared experiences. Nevertheless, there is still some way to go before 'critical analysis' of successes and challenges becomes the norm.

**Health Financing** - The State Government demonstrated an important commitment to the health sector by increasing the annual health sector budget. Nevertheless, the SMOH and other institutions need to ensure that the available budget is utilised efficiently and effectively to build public and government confidence in public financial management within the health sector. Support provided so far for the development of planning, budgeting and public financial management within the health sector will assist the Government in meeting this challenge, but many challenges remain and strong political will is needed to ensure transparency and accountability in the management of public finances.

**Intersectoral Collaboration** - As well as a high level of commitment from the SMOH, successful implementation of activities was dependent on ongoing support from MoLG and LGAs. As well as financial support, these institutions provided authorisation for training and were responsible for subsequent roll-out of any supported initiatives. It was evident that a high level of support was available. However, this has to continue. By early 2008 the State had committed to mobilising resources so that non-PATHS supported facilities could be involved in key reform activities. However, the process for this, and the scale of the roll-out have yet to be determined.

**Human Resource Development** - Numerous training activities were implemented with PATHS support, with agreed plans for further inputs. There was strong consensus amongst stakeholders that the training was beneficial and that it must continue as planned. However, some stakeholders pointed out that these inputs were not enough and that more staff should be trained on an ongoing basis in order to ensure sustainable capacity. The future financing of training programmes, is likely to present a challenge for Government if it continues at the same rate. More work needs to be done to develop costed training plans against which the government can continue to draw down financial support from development partners.

**Logistical Challenges** - The successful roll-out of a number of reform initiatives, either by the State, by LGAs or by future donor-supported programmes, is likely to present logistical challenges that need to be taken into consideration. These include, among others, geographical challenges presented by terrain – how to access hard to reach areas.

**Provider Mindset** - Some senior officers described an increase in the workload of their staff as a result of their commitment to implementing the supported activities; particularly given

that a large number of activities were implemented within a relatively short timescale. On a positive note, where there was increased activity, staff responded positively and this did not appear to have been a problem. However, a challenge will be to ensure that any new systems and processes that replace existing ones become 'the way things are done' rather than 'extra' activities.

**Redistribution of Staff** - Human resource challenges within the health sector, both in terms of staff numbers and staff capacity, are likely to present a significant challenge to the successful implementation of the State's reform agenda. Options for the most effective deployment of staff need to be fully explored and enacted, where appropriate. Human resources management presented a significant challenge for institutions across the public sector and this issue will require ongoing close collaboration between SMOH, SMO LG, LGAs and LGSB.

**Data Quality** - The scarcity and poor quality of health-related data across the state was widely acknowledged. Health managers often had inadequate data on which to base their planning and decision-making. Additionally, the lack of data made it more difficult to determine the impact of any of the State Government's interventions and reform activities. With support, data collection began to show some improvement. Further capacity building and HMIS strengthening will be needed to ensure that there is data available to measure results and impact.

**Sustainability** - Over the period 2006-2008 the State Government introduced a number of important changes within the health sector. These new developments need to be embedded within the health system for sustainability. Institutionalisation of change takes time, and was unlikely to have been completed over the timeframe of PATHS. However, the health sector reform measures were initiated in Kaduna in anticipation that donor partners would continue to provide support over the medium- to long-term. It is essential that any subsequent donor support builds on what has already been achieved, and that all development partners work collaboratively to ensure that reforms are institutionalised and sustainable.



## Lessons learned

*Despite the short implementation period of the reforms there were some valuable lessons. These included:*

### **1. The strong political commitment to health was critical**

The Kaduna State Government demonstrated its commitment to reducing the burden of poverty of its people by prioritising the improvement of social services in the state. The increase in the State Health Budget was extremely important evidence of this commitment, and a move that was critical to the success and sustainability of the state's reform agenda. Anecdotal evidence, based on client feedback and facility data suggests that the removal of fees for some key health services reduced consumers' expenditure on health and improved utilisation of public facilities. More work needs to be undertaken to evaluate the impact of the free MCH policy on out of pocket expenditure on health and on citizens' perceptions of the affordability of health services.

## **2. Effective implementation of policies led to improved service delivery**

It was not enough for the Government to commit funding to the health sector; there was a need for the managers to interpret the policy, consult widely and plan with stakeholders before implementation. These were the processes that characterised the planning of the free MCH programme. In addition, the consultation process strengthened planning by the SMOH at inter-ministerial (e.g. between Ministry of Finance, Ministry of Economic Planning), inter-tier (e.g. between Ministry of Local Government and Local Government Service Board, and representatives from the Tertiary Health Institutions) and donor/development partner levels (e.g. UNICEF, WHO).

## **3. State Government could be a key catalyst for reform at Federal level**

The conceptualisation and implementation of State health reforms was guided by federal health policies; but the decision to remove user fees was that of the State and Local Governments in Kaduna. Efforts at the federal level to improve maternal and child health through strengthening of the IMNCH policy, benefitted when the federal team visited Kaduna to learn from and advise the State on the implementation of the Free MCH policy.

## **4. Capacity building was vital**

Building capacity to implement health reforms was carefully managed. Prior work in other PATHS-supported states was reviewed with stakeholders and carefully adapted to suit the Kaduna context. For example, the ISS format was adapted specifically for Kaduna and the DRF was designed to accommodate both the free MCH and non-free drugs and consumables. Stakeholders were integrally involved in the adaptation processes to ensure that approaches and tools were fully owned. Tools to aid implementation were also developed and widely disseminated by government (e.g. operational manuals, training manuals, training curricula, job aids, technical documents and demand creation materials). The actual training of staff was usually phased, with a major emphasis on building training capacity within the state and then cascading training down through the health system. The refurbishment and equipping of facilities took place in parallel with the capacity building – one without the other would not have had the desired impact.

## **5. Service delivery improvements must be synchronised with state level reforms**

While the reforms to improve service delivery were happening, there were several complementary state-level activities which included legislation for creating the PHCA and DMA. These changes were necessary to ensure that service level improvements were supported. In addition, the availability of key frameworks and materials, such as strategic and operational plans, policy briefs, training materials, operational guidelines, would enhance roll-out of the reform.

## **6. Managing community expectations is important**

As implementation of the different aspects of the health reform process proceeded, it was important to manage the expectation of communities who understandably were in a hurry to see improvements in the quality and affordability of service delivery. The role of FHCs in managing expectations, particularly in relation to implementation of the free MCH policy, was particularly important.

In addition to the results and key lessons described above there were a number of less tangible but equally important outcomes that were critical to success. These included the confidence of, and effective working relationships with, key stakeholders across the State; renewed engagement of the community in the state's reform agenda; and progress in collaborative working across Ministries and especially between SMOH and the LGAs. As with the reforms described in this report, it is of critical importance that these less tangible outcomes become institutionalised and strengthened in order to ensure the future sustainability and success of the health reform agenda in Kaduna.

# Annex Resources Developed

Category of material	Name of material, model or document	Comments
<b>BCC Materials</b>	BCC leaflets on SM	Kaduna Specific
	QAR - Leaflets	Kaduna Specific
	QAR - Calendrum, etc	Kaduna Specific
	BCC Posters on V & A	Kaduna Specific
	Immunization (Go five times) - English	Kaduna Specific
	Immunization (Go five times) - Hausa	Kaduna Specific
	QAR - Posters	Kaduna Specific
	BCC poster on danger signs translated	Kaduna Specific
	BCC poster on birth plans Poster	Kaduna Specific
	BCC Radio Spots	Kaduna Specific
	QAR - Radio Spots	Kaduna Specific
<b>Field Guide</b>	Integrated Supportive Supervision Format	Kaduna Specific
	Quality Assessment and Recognition Field Guide	Kaduna Specific
<b>Form</b>	IMCI Recording Forms aged 2 months to 5 years	Similar for all States
	IMCI Recording Forms – Sick Child aged 1 week to 2 months	Similar for all States
	Supervision Form – Recording of IMCI trained health worker	Similar for all States
	IMCI Supervision Form – Recording of Child 2 months up to 5 years	Similar for all States
	IMCI Supervision Form – Exit interview of Mothers	Similar for all States
	IMCI Supervision Form – Health Facility Assessment	Similar for all States
	IMCI Supervision Form – Summary form for Health Facility and LGA	Similar for all States
	Integrated Demand Side Monitoring Checklist	Kaduna Specific
<b>Job aid</b>	EOC protocols	Similar for all States
	Job Aid TB treatment	Similar for all States
	Obstetric Case Note	Kaduna Specific
<b>Operational Manual</b>	Facility Health Committee Operational Guideline	Kaduna Specific
<b>Technical Document</b>	Essential Service & Systems Package Document	Kaduna Specific
<b>Policy &amp; Plan</b>	Kaduna Under 5 & Pregnant Free Treatment Policy	Kaduna Specific
<b>Training Curriculum</b>	Modified LSS for CHEWS	Similar for all States
	SDSS Guideline - PHC Training Curriculum	Kaduna Specific
	SDSS Guideline - SHC Training Curriculum	Kaduna Specific
	SDSS Guideline - LGA Stores Training Curriculum	Kaduna Specific
	Free MCH Training Curriculum	Kaduna Specific

<b>Training / Implementation Guideline</b>	AT Facilitators Guide	Similar for all States
	AT Modules & Profiles	Similar for all States
	CHV Training Guideline	Kaduna Specific
	Free MCH Guideline	Kaduna Specific
	SDSS Guideline - PHC	Kaduna Specific
	SDSS Guideline - SHC	Kaduna Specific
	SDSS Guideline - LGA Stores	Kaduna Specific
	SDSS Implementation Guideline - PHC	Kaduna Specific
	SDSS Implementation Guideline - SHC	Kaduna Specific
	SDSS Implementation Guideline - LGA Store	Kaduna Specific
	Free MCH Implementation Guideline - PHC	Kaduna Specific
	Free MCH Implementation Guideline - SHC	Kaduna Specific
	State Medical Store Guideline	Kaduna Specific
<b>Training Manual</b>	CHV / CBO Manuals	Kaduna Specific
	IPCC Training Curriculum for HODs/OICs/Providers	Kaduna Specific
	IPCC Training Curriculum for Trainers	Kaduna Specific
	HMIS Trainers Guide	Kaduna Specific
	HMIS Trainers Notes	Kaduna Specific
	HMIS Trainers Workbook	Kaduna Specific
	HMIS Trainee's Notes	Kaduna Specific
	HMIS Trainee's Workbook	Kaduna Specific
	HMIS Training Pre test	Kaduna Specific
	HMIS Training Post test	Kaduna Specific
	Facility Health Committees Training Manual	Kaduna Specific
	IMCI Supervisor's Guide	Similar for all States
	IMCI Facilitator's Guide	Similar for all States
	IMCI Course Director's Guide	Similar for all States
	IMI Photograph Booklet	Similar for all States
	IMCI Assess and Classify the sick child age 2 mnths – 5yrs	Similar for all States
	IMCI Assess and Classify the sick child age 2 mnths – 5yrs Ex. Booklet	Similar for all States
	IMCI Counsel the Mother	Similar for all States
	IMI Counsel the Mother Ex. Booklet	Similar for all States
	IMCI Follow-up	Similar for all States
	IMCI Follow-up Ex. Booklet	Similar for all States
	IMCI Management of the Sick Young infant aged 1 wk – 2 months	Similar for all States
	IMCI Management of Sick Young Infant Ex. Booklet	Similar for all States
	IMCI Identify Treatment and Treat the Child	Similar for all States
	IMCI Identify Treatment and Treat the Child Ex. Booklet	Similar for all States
	IMCI Guide for Practical in the In-patient Ward	Similar for all States
	IMCI Facilitators Guide for Modules	Similar for all States
	IMCI Facilitators Guide for Out Patient Clinical Practice	Similar for all States
	How to Conduct an Annual PPRHAA for Hospitals	Similar for all States
	How to Conduct an Annual PPRHAA for PHC facilities	Similar for all States
	LSS Training Manual on EOC for Doctors	Similar for all States
	Modified LSS for CHEWS	Similar for all States
LSS Training Manual for Nurses and Midwives	Similar for all States	
LSS Facilitators' Guide Manual	Similar for all States	
LSS Participants' Handbook for Nurses and Midwives	Similar for all States	

# Abbreviations and Acronyms

ABB	Activity Based Budgeting
AIDS	Acquired Immune Deficiency Syndrome
AT	African Transformation
BCC	Behaviour Change Communication
CHEWs	Community Health Extension Workers
CHVs	Community Health Volunteers
DfID	Department for International Development
DHIS	District Health Information System
DMA	Drug Management Agency
DOTS	Directly Observed Treatment Short Course
DRF	Drug Revolving Fund
ECWA	Evangelical Church of West Africa
EDL	Essential Drug List
EDS	Essential Dataset
EOC	Emergency Obstetrics Care
FHC	Facility Health Committee
FMOH	Federal Ministry of Health
FOMWAN	Federation of Muslim Women Association of Nigeria
HIV	Human Immunodeficiency Virus
HMB/C	Hospitals Management Boards / Committees
HMIS	Health Management Information System
IMCI	Integrated Management of Childhood Illnesses
IMPACT	Improved Management through Participatory Appraisal for Continuous Transformation
IMR	Infant Mortality Rate
IPCC	Inter-Personal Communication and Counselling
ISS	Integrated Supportive Supervision
KADSEEDS	Kaduna State Economic Empowerment and Development Strategy
KHF	Kaduna Health Stakeholder Consultative Forum
LGA	Local Government Area

LGSB	Local Government Service Board
LSS	Life Saving Skills
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MLSS	Modified Life Saving Skills
MoEP	Ministry of Economic Planning
MoLG	Ministry of Local Government
NEEDS	National Economic Empowerment and Development Strategy
NGO	Non-Governmental Organisation
NHMIS	National Health Management Information System
NICS	National Immunisation Cluster Survey
NPHCDA	National Primary Health Care Development Agency
PATHS	Partnership for Transforming Health Systems
PHC	Primary Health Care
PHCA	Primary Health Care Agency
PMTCT	Prevention of Mother to Child Transmission
PPRHAA	Peer Participatory Rapid Health Appraisal for Action
QAR	Quality Assessment and Recognition
REW	Reaching Every Ward
RH	Reproductive Health
RI	Routine Immunisation
SACI	State Action Committee on Immunisation
SDSS	Sustainable Drug Supply System
SEEDS	State Economic Empowerment and Development Strategy
SLGP	State and Local Government Programme
SMoH	State Ministry of Health
SMoLG	State Ministry of Local Government
TB	Tuberculosis
ToT	Training of Trainers
U5MR	Under-Five Mortality Rate
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organisation
WG	Working Group for PATHS

