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Nigeria Partnership for Transforming Health Systems

Technical Brief

Developing an Essential Minimum Service Package

DFID Department for International Development

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Child Health is an Essential Component of the MSP

Developing an Essential Minimum Service Package

Summary

No country in the world can provide health services to meet all the possible needs of the population. For this reason, countries have to select which services to provide, and many have taken the approach of defining a minimum package of services. The extent of the burden of a disease or health condition, the cost effectiveness of interventions to deal with it, and lately the MDGs are important considerations in the choice of the contents of a country specific minimum essential health service package. Since its inception in 2002, PATHS has contributed immensely towards the strengthening of the health system in its focal states. This work has included developing an efficient system to deliver an integrated and accessible minimum service package (MSP). The system and the MSP should address the priority health needs of the majority of the population (especially the poor) in an equitable and cost effective way.

In Ekiti, the health service delivery system was clustered - each cluster consisted of four PHC centres, one Comprehensive Health Centre, and a General Hospital. Each level of health service provided a well-defined package of services with specific standards. The package included child health (Integrated Management of Childhood Illnesses - IMCI, prevention of mother-to-child transmission of HIV - PMTCT), safe motherhood (family planning, antenatal care, skilled supervised delivery, emergency obstetric care - EOC,

post-natal care), HAST[1] services and Malaria Control (intermittent preventive treatment - IPT, insecticide treated nets - ITN). This combination of the restructured health system and the MSP was called the Essential Services and Systems Package (ESSP) to achieve the health MDGs.

In Kaduna, a similar cluster approach was used consisting of ward health centres and general hospitals. The ESSP approach was linked to the free MCH policy. This was costed and substantial investments were made in infrastructure, equipment, drugs and supplies. In addition, packages of care were defined for each level and appropriate systems were strengthened to enable service delivery.

In Enugu, a District Health System was developed – seven districts with PHC facilities and a referral hospital. Through a consultative process and the adoption of some national and international protocols (National PHC Development Agency, WHO, UNICEF, Health Commodities Programme), Enugu developed a MSP that is MDG focused and consistent with the principles of PHC. The MSP was similar to the Ekiti ESSP but included a section on adult health - the emerging health priorities of hypertension and diabetes. In addition, packages of care (POC) and specific standards for selected priority clinical conditions were developed and service providers from both public and faith-based sectors were trained to implement these.

1 HAST is HIV/AIDS/Sexually transmitted infections/TB

In Jigawa, a Gunduma[2] Health System was developed – nine Gundumas each with PHC facilities and a referral hospital. The state also defined a MSP, set standards, and built the capacity of staff to provide the MSP.

In Jigawa, Kaduna and Ekiti the classification of health facilities was problematic in the sense that facilities performing the same function were named differently. A typology of health facilities was proposed and accepted so as to standardise nomenclature.

All states demonstrated tangible improvements in stewardship and service utilisation. Many other changes were occurring at the same time[3], so it is not clear how much of this is attributable to the development of a more efficient health delivery system and the implementation of the MSP.

But, it is significant that these states gravitated towards developing a model where a cluster of PHC facilities supported by a district referral hospital provide an integrated minimum/essential health service package.

2 Gunduma is the Hausa equivalent of district

3 For more details see other relevant PATHS Technical Briefs.

Introduction

Since the Alma Ata declaration, Primary Health Care (PHC) has been adopted and adapted by governments in most countries all over the world as a key health system strategy to ensure greater coverage and equity. Its principles of essential health care based on practical, scientifically sound, and socially accepted cost effective methods and technology, community participation, intersectoral collaboration, integration of services and programmes, health promotion, and bringing services to the door steps of communities are still relevant to countries and communities globally. PHC must address the main health problems of the target population providing promotive, preventive, curative, and rehabilitative services accordingly.

The concept of a minimum service package (MSP) or an essential service package (ESP)[4] is rooted in the need to provide a package of public health and clinical interventions that are not only cost effective, socially and economically accessible to the population (especially the poor), but also deal with the priority disease burdens of the population.

No country in the world, including Nigeria, can provide health services to meet all the possible health needs of the population. The size of the disease burden caused by a particular disease or health condition and the cost-effectiveness of the interventions to deal with it is therefore a helpful guide to countries in the choice of the content of their MSP. This principle is convergent with the core values of PHC.

Within a country or state the MSP should be universally available to ensure equity. After covering the minimum for everyone, the package may later be expanded to include other interventions relevant to the country or specific segments of its population.

Recommendations from the World Bank Report

Minimum Essential Public Health Interventions

1. Immunisation plus (Including Yellow Fever and Hepatitis B vaccines, Vitamin A and Iodine supplements, and in some cases ITN distribution)
2. School-based health services (treatment of schistosomiasis, micro-nutrient deficiencies, and de-worming)
3. Behavior change communication (benefits of breast feeding, family planning, anti smoking messages, and campaigns against alcoholism)
4. Dissemination of information on hygienic practices (and improvement in water and sanitation)
5. Check the spread of HIV/AIDS by providing information to promote change in sexual behavior, distribution of condoms, and treatment of STI – targeting high risk groups.

Minimum Essential Clinical Services

1. Services to ensure pregnancy related care (antenatal, delivery, and post partum)
2. Family Planning
3. TB control
4. Control of STIs
5. Care of common serious illnesses of young children (IMCI)

4 In this Technical Brief we will use MSP.

Estimated cost and health benefits of minimum essential health service package

Group	COST per capita per Year ($)	COST as % of income per capita	Approximate reduction of burden of disease (%)
Public Health	4.2	1.2	**8**
Essential Clinical services	7.8	2.2	**24**
Total	**12**	**3.4**	**32**

Source: World Bank Report, 1993.

A MSP of cost effective public health and clinical interventions that address the major sources of disease burden could be provided in low income countries for about $12[5] per capita (or less than 4% of income per capita) and could reduce premature mortality in children under 15 by 21 to 38 percent.[6]

The most sophisticated facility required to deliver the MSP is the District Hospital (the equivalent of a General Hospital in Nigeria). The District Hospital/ General Hospital (as a referral centre) together with a number of PHC facilities constitutes the ideal integrated system through which to deliver the MSP.

Nigeria has adopted a four-pronged approach to achieving her PHC objectives:

1. Promotion of community participation in planning, management, monitoring, and evaluation of the local government health system
2. Improved intersectoral collaboration
3. Enhancing functional integration, and
4. Strengthening of the managerial process for health development at all levels.

Consequently, a plan for Minimum District Health Package (MDHP) for all (1995-2000) was developed by the National Primary Health Care Development Agency. This was replaced by a new draft Ward Minimum Health Package (WMHP) in 2001. Although this new draft WMHP for PHC was MDG focused, it was neither costed at the time nor disseminated to stakeholders for financial reasons.

5 This was the level that influenced justifying the MSP approach. Current levels are closer to $40.

6 Bobadilla J, Cowley P, Musgrove P, Saxenian H. 1993. Design content and financing of an essential national Package of Health Services. World Bank Report. Health, Nutrition and Population Division, Human Development Department

In September 2001, a few years after the initial plan for MDHP, the Millennium Development Goals (MDGs) were published. These goals have assumed strategic importance as they are also used as a benchmark against which to assess the overall country development performance. Three of the eight MDGs are health related and are outcomes that are relevant to the development of national health policies and for tracking the performance of the health sector.

'Health Related' MDGs

Goal 4: Reducing Child Mortality

Goal 5: Improving Maternal Health

Goal 6: Combat HIV/AIDS, Malaria, and other diseases

The health system in Nigeria operates within a complex political structure, plagued by multiple hierarchies, deteriorating physical infrastructure, an inadequate and demoralised work force, and inadequate financing. It requires reforms to enable it to provide an integrated package of services that are not only consistent with the core principles of PHC but are also focused on achieving the global agenda – the MDGs.

Since its inception in July 2002, PATHS has supported some of its project states to define a MSP that fits both the core principles of PHC and also focuses on the MDGs. This technical brief documents the focus, the approach, the progress, and where possible, the outcomes of the development of a MSP in Ekiti, Enugu, Kaduna and Jigawa states.

The Response

At Federal Level, PATHS and WHO supported the NPHCDA to develop a costed Ward Minimum Health Care Package (WMHCP) with detailed activities for each intervention. This resulted from the draft Health Bill which stated "… the Federal level shall guarantee the provision of a basic minimum package of health services to all citizens". The national health system as defined in the revised national health policy of 2004 includes the ward health system.

The package included communicable diseases - especially HAST and malaria, child survival, maternal and neonatal care, nutrition, non-communicable diseases, health education and community mobilisation, essential drugs, human resources for health and health infrastructure. The implementation will require a broad engagement process. This process commenced at the technical sessions of the National Council on Health in November 2007.

In Ekiti, besides several health system strengthening interventions, service delivery improvements were first tackled vertically thus remaining supervised by programme line managers[7]. However, in 2005, an Essential Systems and Services Package (ESSP) was introduced with the support of PATHS to re-organise the health system to provide an integrated MDG-focused MSP.

> "ESSP is the definition and prioritisation of essential and the most cost effective curative, promotive, and preventive services which must be provided to ensure equitable allocation of SMoH and LGA resources, and to increase the cost effectiveness of resource utilisation"
>
> *Ekiti State Health Team retreat, December 2005*

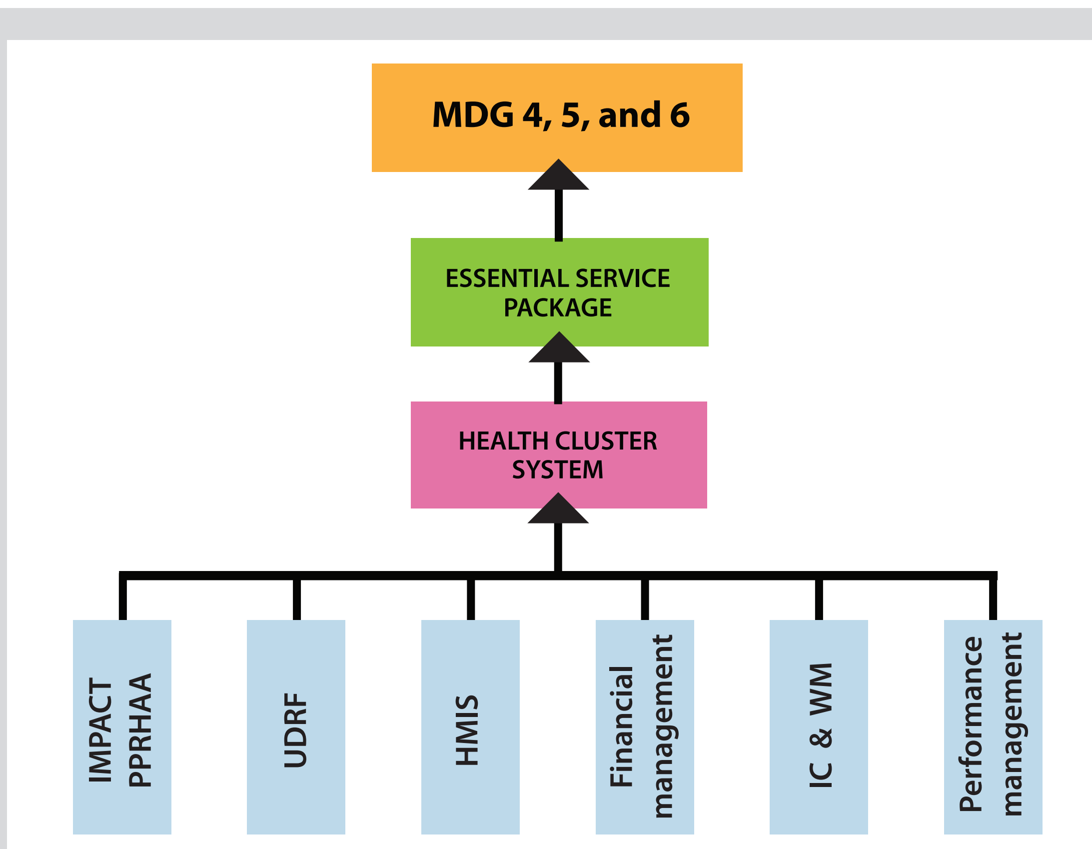
Key principles included 1) providing evidence-based, cost effective, and affordable services with a minimum health staff (with polyvalent skills), 2) fostering community participation, and 3) ensuring quality of care, within an integrated framework. The process had several components:

Setting-up of a steering committee comprising of members from different segments of the health sector and with the responsibility of driving the process and advocating in favour of an integrated approach to health care delivery in the State. Particular emphasis was given to advocacy targeting politicians to ensure they understood why rationalisation was recommended as well as their financial commitment to the roll-out process.

Rationalisation of health facility nomenclature where a facility type is defined in terms of the population covered and the scope and depth of services it provided. Thus the PHC facilities were reorganised into three functional layers :

- Primary Health Care centre – serves a population of about 15,000
- Comprehensive Health Care Centre – serves a population of about 50,000
- General Hospital that is shared by a group of Health Clusters and serves a population of 100,000 people.

7 ESSP Manual 2006. PATHS Ekiti document.



The figure illustrates a mind map of a Health Cluster supported by health system 'pillars' of institutional management (PPRHAA and IMPACT), a sustainable drug delivery system (UDRF), health information management (HMIS), financial management, Infection control and waste management system(IC & WM),and performance management which deliver an ESSP to achieve the relevant MDGs. The Health Cluster consists of a group of health facilities within a given area which will be able to provide a 'collective' and 'integrated' package of health services. It is made up of four primary health centres, one comprehensive health centre, and a General Hospital. The General Hospital may support more than one health cluster.

Definition of the package of services to be provided at each level of care within the Health Cluster system included the requisite service standards, the cadre of staff responsible for various activities, the targets to be achieved in each area of work, the indicators required in measuring tangible progress/outputs, and the human and material resources required to implement these services (ESSP Manual, 2006). The health services at the Primary Health Care centre, that are to be delivered through both static and outreach services, are focused on:

- Community IMCI, routine immunisation and prevention of mother-to-child transmission of HIV (MDG 4)
- Safe motherhood including family planning, focused antenatal care, skilled delivery, basic EOC, post abortion and post natal care (MDG 5)
- HAST services and malaria control - ITN, IPT (MDG 6)

The scope of services to be provided at the Comprehensive Health Care centre (CHC) are similar in scope to that of the Primary Health Care centre but are more comprehensive. In addition, the CHCs have admission facilities for observation and subsequent referral, if required. The minimum package of services to expect from the cluster referral centre, the General Hospital, has also been defined. It is therefore possible for clients to know what services to expect from the General Hospitals – the key referral point within the Integrated Health Cluster System.

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Pharmacy Assistant Educating Patients, Ekiti

Definition of the management systems required at all levels necessary to efficiently deliver the packages of services as follows:

- overall facility management system (using the Improved Management through Participatory Appraisal and Continuous Transformation –IMPACT- methodology)
- drug supply system in the form of drug revolving funds coupled with a protection mechanism for the poorest
- financial management system
- health management information system
- human resource management system with a great emphasis on performance management based on revised job description for all cadres
- infection control and waste management systems

Definition of the resources required to deliver the ESSP at all levels as follows:

- staffing
- supplies
- equipment
- infrastructure
- utilities
- general running and maintenance of facility and equipment

Putting in place co-ordination arrangements required to implement and institutionalise the ESSP reforms included:

- Defining the characteristics of facilities that can participate in the pilot as an ESSP cluster health facility
- Defining the constituents of a health cluster (four PHC centres and one CHC)
- Mapping referral pathways such as inter-cluster referrals in order to locate shared resources (e.g.

laboratory facilities) and the cluster-to-General Hospital referrals for secondary level care

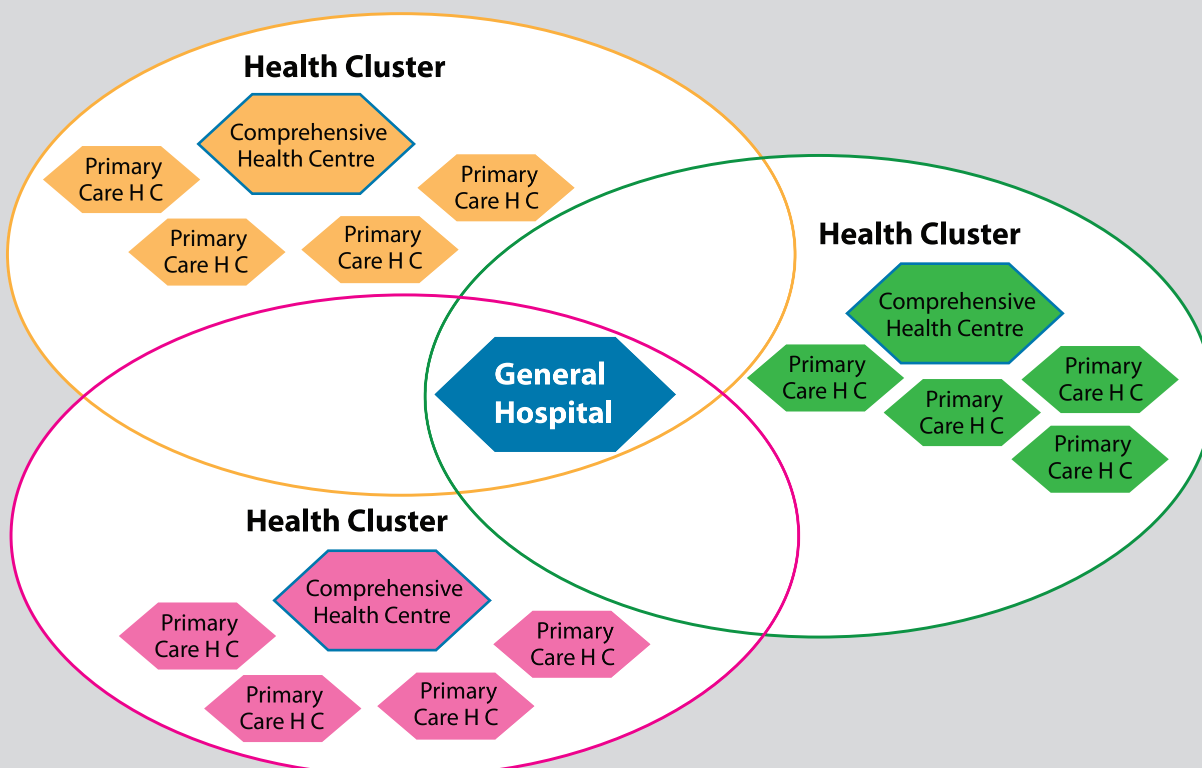
- Strengthening facility health management committees to support the health care providers and to ensure integration of the demand and supply sides. Community Resource Persons (CORPS) were also trained in sensitising the community on key areas of the ESSP and to ensure community involvement was maximised
- Establishing Local Government Authority (LGA) PHC Committees, under the chairmanship of the PHC co-ordinator, to monitor the planning, implementation and review of health programmes, and to find solutions to challenges identified
- Establishing institutional arrangements to harmonise the existing multiple hierarchies within the Cluster System (where the PHC and CHC facilities are accountable to the Ministry of Local Government – MoLG – whilst the General Hospital is accountable to the Hospital Management Board) by the creation of a new post of PHC Director Medical/Health who will liaise with the directors of PHC in the MoLG and the HMB.
- Defining how supervision is conducted at all levels and by whom and at what intervals.

In Kaduna, the process of development and implementation of an ESSP was informed by efforts at both National level (Ward Minimum Health Package of NPHCDA and Integrated Maternal Newborn and Child Health Strategy of the FMoH) and State level (Packages of Care in Enugu, ESSP in Ekiti and MSP in Jigawa). Thus, the free MCH package was expanded to become an Essential Systems Services Package for both PHC and SHC.

The State also used the opportunity to define the typology of health facilities in the state and cost the ESSP with the aim of using this information for the State medium-term plan.

Health Clusters supported by General Hospital in a LGA

The Health Cluster Model in Ekiti – The diagramme shows that one General hospital serves several health clusters. Each health cluster is made up of one comprehensive health centre and several PHC centres.



Revised Classification of Facilities, Kaduna

Facility type	Geographical or Population indicator
Health Clinic	Serving a community or settlement with a population of around 2,000
Primary Health Care Centre	Serving a political ward with a population of around 10 - 30,000
Rural Hospital	Serving a rural LGA with a population of around 200,000 – 300,000
General Hospital	Serving an urban or peri-urban LGA with a population of around 300,000 – 500,000
Specialist Hospital	Apex referral centre for the State.

Links to the Free MCH Policy:

In 2007, Government launched the free treatment programme for pregnant women and children that are under-five years. This included drafting a policy for the programme, renovating and equipping 255 facilities, and engaging additional human resources. The budget was 4.8 billion naira (£19.2 million). By early 2008, implementation had commenced in 112 PHC facilities and all public hospitals (26).

ESSP

Packages of services for the programme included:

For the under-five children

- Malaria
- Acute respiratory infections
- Diarrhoeal diseases
- Measles
- Worm infections
- Meningitis
- Nutrition
- HIV (mainly transmitted from infected mother)

For pregnant women

- ANC
- Treatment of severe anaemia, including malaria
- Normal delivery
- Treatment of complications during pregnancy, delivery and 6 weeks after delivery

Besides the service aspects, the ESSP included:

- Human Resource development (at facility and community level)
- Infrastructure development
- Equipment plan
- Creation of an enabling environment and systems: drugs and supplies; transport, communication and logistic systems; referral system; and Health Management Information System.

Costing

The ESSP represented a mix of interventions and diseases. These essential packages will be delivered by a health system, in addition to other functions that are not in the ESSP.

In terms of costing, a number of activities had already taken place including the costing of the medium-term plan, the free MCH policy and the ward PHC services among others. The ESSP work used these studies as useful reference materials.

The total ESSP package for the period 2008 to 2011 is about N38.9bn (£155.6 million). The per capita cost for 2008 is N1971 ($16). This investment will be expected to result in significant improvements in the MDGs 4 and 5 indicators for Kaduna.

Total Cost of ESSP 2008-11 by Year

COST CATEGORIES	2008	2009	2010	2011
DRUGS & SUPPLIES	**6,229,805,311**	**6,972,152,841**	**7,834,710,996**	**8,299,050,180**
Family Planning	51,998,144	61,901,492	73,160,234	91,363,192
ANC and Delivery Care	740,900,019	868,355,974	1,015,103,675	1,143,329,601
Obstetric Complications	351,529,692	355,847,883	382,795,344	387,110,492
Other Maternal Conditions	7,055,869	8,452,714	10,074,427	11,384,679
Newborn Interventions	691,556,162	761,199,760	845,471,186	531,556,646
STIs	41,927,210	46,660,466	50,370,186	52,591,378
Nutrition	1,992,806,180	2,253,334,117	2,547,252,100	2,844,327,885
Children>1 year	16,110,435	17,921,248	19,935,596	22,176,357
Immunisation	492,081,317	547,391,257	608,918,034	677,360,422
Malaria	1,843,840,278	2,051,087,926	2,281,630,209	2,537,849,524
SUPPORT & DELIVERY SYSTEMS	**987,486,292**	**1,066,485,195**	**1,151,804,011**	**1,243,948,331**
MAINTENANCE	**4,608,360,000**	**116,002,500**	**118,902,563**	**121,875,127**
INVESTMENT - INFRASTRUCTURE/EQUIP/ TRANSPORT	**120,956,100**	-	-	-
TOTAL	**11,946,607,703**	**8,154,640,536**	**9,105,417,569**	**9,664,873,638**

In Enugu, the focus was on establishing the District Health System. The vision was of a District Health System (DHS) that would provide a MSP that is MDG focused and addresses the priority health problems of the population. In collaboration with local stakeholders previous work done by agencies and organisations such as WHO and the National Primary Health Care Agency was reviewed in order to define Enugu's MSP. The Minimum Service Package developed was based on four elements:

- A reasonable state of infrastructure, including provision of electricity and water
- Specific services that should be offered by the facility
- Specific drugs and equipment that should be available in the facility
- Packages of care that would guide health staff in their delivery of services.

Enugu Minimum Service Package

Area of Intervention	Primary Health Level	Secondary Health Level
	Components	
Maternal Health		
	Antenatal care (from 12-40 weeks)	Primary level components plus those below:
	Safe delivery	Vasectomy and tubal ligation
	Postnatal care (up to six weeks)	
	Routine immunisation (including TT)	
	Family planning	
Child Health		
	Growth monitoring	Primary level components plus those below:
	Nutritional supplements	Intermediate surgery
	Routine immunisation	Management of tracheotomy
	Health education	
	Treatment and management of minor ailments such as diarrhea, acute respiratory infections - ARI, malaria, febrile convulsion, de-worming, male circumcision	
Adult Health		
	Minor surgery - incision and drainage of abscesses, abrasions and cuts	Primary level components plus those below:
	Treatment and management of various ailments such as diabetes screening, hypertension, malaria, arthritis, gastro-enteritis and TB	HIV/AIDS, ARI, cardiac failure, peptic ulcers, STD/STI, pelvic inflammatory diseases.

Having agreed on the components of the package, steps were taken in collaboration with the Health Commodities Project (a DfID-funded project), to determine the resources (supplies and equipment) that were required to provide this service package at the primary and secondary levels of care. A preliminary assessment revealed that the health centres and hospitals lacked even the most basic equipment to provide services in the areas of maternal and child health. Furthermore, there was a shortage of anti-malarial drugs, infrastructure for the storage and security of the supplies was inadequate, and systems for the control and management of logistics were not in place. Therefore, PATHS worked with the stakeholders to rehabilitate the infrastructure and strengthen the relevant systems such as Drug Revolving Funds, Financial Management systems, Inter-Personal Communication and Counseling (IPCC), and Health Management Information System (HMIS).

Although the MSP specified the key areas of intervention, the package did not describe in detail, for each component, the key activities that should be undertaken at the various levels of care, who undertakes these activities, and indications for referral to next hierarchical level of care.

Thus, Enugu went a step further and developed, for each component of the MSP, a more detailed description of activities – the Packages of Care (POC). These POC guided service providers, supervisors, and managers on the scope, depth, and quality of services that should be provided at primary and secondary levels of care. The POC also developed specific standards for each component.

The process of developing the POC was participatory and involved health service providers and managers. The clients or service users were also consulted through a series of focus group discussions. The involvement of the key stakeholders - service providers, health service managers, and clients - ensured stakeholder ownership and provided an opportunity to tap the vast pool of expertise within the health service. The POC documents were produced and disseminated to the health facilities. Training guidelines were developed and service providers were trained on how to use these standards. In September 2005, 36 master trainers were trained, of whom 18 were given responsibility for overseeing the roll-out to facilities. The medical packages of care were introduced in 2005 and the surgical packages in 2006. By early 2008, 1,040 people had been trained in their use. In addition a total of six faith-based hospitals, and seven faith-based PHC facilities were included in this initiative and use the POC.

Drugs and Equipment being Received at a PHC Facility, Enugu

© Sanctus Okereke

A package of care was defined as:

"a protocol to be observed by ALL health care providers, which includes where health care will be provided, by whom, and to what basic and specific standards."

and included:

Medical: acute respiratory tract infection, common worm infestation, gastro-enteritis, HIV/AIDS, hypertension, malaria, maternal health, measles, osteoarthritis, diabetes, IMCI, TB

Surgical: Basic surgery, Gynaecology, Obstetrics, Trauma/Orthopaedics

General Package of Care describes for each health condition what activities are to be undertaken at each level under the preventive, promotion, curative, and rehabilitative dimensions of care and by whom.

Specific Standards of care set management objectives and required standards of care.

For example, at the PHC level a presumptive diagnosis of malaria is based on a standard case definition or diagnostic algorithm

Factors needed	Process	Outcome
Health Care Provider Essential Drugs for treatment of uncomplicated malaria Equipment to observe vital signs Patient records	Take clinical history to confirm fever for two days or less and exclude other common causes of fever such as septic lesions, cough, ear discharge Examine client to confirm fever and exclude other common causes of fever Take and record temperature Use diagnostic algorithm if available	Early diagnosis of malaria Exclusion of other common causes of fever.

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Stakeholder meeting in Enugu on POC

In Jigawa when PATHS started, the PHC facilities were not categorised by clearly defined criteria. It was therefore difficult to know what range and quality of services to expect from each type of health facility listed by a rather complex nomenclature. In addition, referral pathways were not clearly defined. PHC coverage was only 10-15 percent and there was no uniform service package at facility level. The Jigawa MSP, developed in consultation with stakeholders such as the LGA/PHC co-ordinators, senior level management and directors of the SMoH, included:

Rationalisation of health facility nomenclature to align with the National Health Policy and strategy 1988. The levels of care were categorised as:

- Basic health Clinic
- Primary Health Clinic
- Comprehensive Health Clinic
- General Hospital
- Specialist Hospital

Classification criteria included a) size of the population to be served, b) number of beds, c) category and number of staff, d) services provided, e) referral relationships with other institutions, and f) equipment available.

Jigawa MSP Components

- Reproductive health
- Malaria
- Childhood illnesses, and routine immunisation
- Malnutrition
- HAST

"Many facilities are called by different names but are performing the same function, On the other hand some facilities are performing functions different from what they are originally designed for."

Remi Sogunro, consultant

Adoption of a MSP, which was defined as "the smallest collection of health intervention that will be needed to improve the health of a large majority of the people of Jigawa." The following factors were considered in the selection of the priority areas for the MSP:

- The vulnerable population in Jigawa
- The disease burden of the majority of the population
- Cost effectiveness of the interventions
- Proportion of the population or community that can afford to pay for such services
- The tier of services that can best provide these services

To address the five MSP components specific standards/protocols were developed or adapted from national guidelines for IMCI, common EOC conditions, IPT, laboratory quality standard operating procedures, and TB DOTS. Staff have also been trained on the use of these protocols.

The initial plan was to implement the MSP in phases, starting with facilities in three to six LGAs and later extending it to cover the rest of the state. This plan did not come to fruition because of the lower than anticipated political commitment, some lack of understanding by health managers, and human resource constraints. As a compromise only some of the packages of care were provided together with system strengthening interventions.

System strengthening interventions facilitated effective delivery of the MSP and included the Drug Revolving Fund (DRF) scheme, HMIS, rehabilitation of key service areas, equipment inventory and the supply of basic equipment to health facilities, improving the skills and competencies of service providers, formation and training of health facility committees, improving planning and budgeting processes, and advocating for effective accountability within the health system. In addition, the establishment of the Gunduma Health System - a district health system approach that integrates both primary and secondary health levels of care – provided the institutional framework for effective MSP delivery.

© PATHS Photographer

Rehabilitating Infrastructure, Jahun Hospital Jigawa

Development of clinical standards and norms that focused on OPD, ward admissions, and operating theatre. The OPD standards focused on the provision of adequate information to clients or their relatives, accurate diagnosis and appropriate treatment, and ensuring patient safety by reducing or mitigating the risk to the patient of adverse effects from treatment. The three operating theatre standards were the prevention of infection and cross infection, ensuring a safe working environment, and the prevention of pre-, peri- and post-operative complications. The ward admission standards focused on nursing procedures and responsibilities. A series of training workshops were conducted to provide the staff with the skill and competencies required to apply the standards and norms to improve the quality of care.

RESULTS

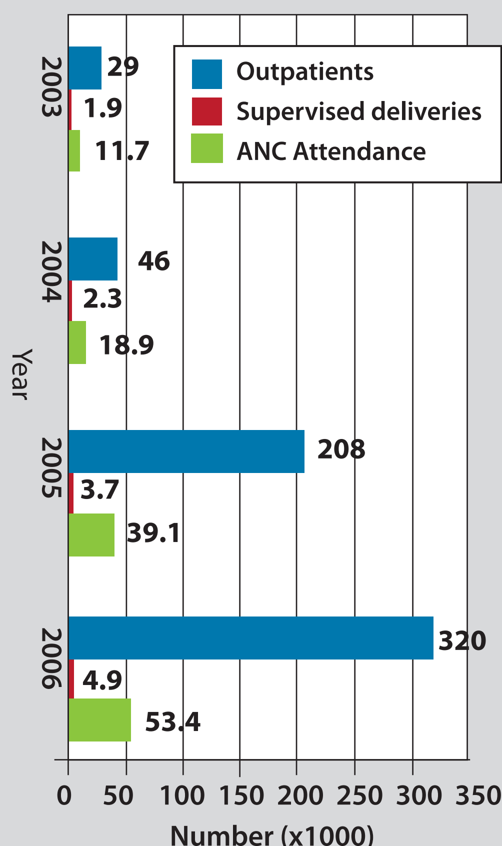
In Enugu, there have been significant changes in service utilisation. Outpatient attendance has more than doubled in two years while supervised deliveries have increased by 80 percent. The immunisation data reflects the usual differences (for Nigeria) between survey and administrative data. The development of the MSP and the POC would have contributed but direct attribution is difficult, because alongside the introduction of MSP there were other changes e.g. more funding, more regular drugs. Also, It is not possible to tell from the data available how equitably distributed these gains are.

In Jigawa, in spite of initial foot dragging by the political authorities and health managers, the revised facility nomenclature has been adapted as a tool to organise, deliver, and monitor health services. By early 2008, a number of PHC and secondary facilities were providing selected components of the MSP but there was no universal delivery of the MSP in all five components. EOC and RI are some of the packages being implemented.

Service utilisation has improved – outpatient attendance has increased tenfold, supervised deliveries have more than doubled and ANC attendance has increased fourfold. As before direct attribution is difficult.

The number of facilities providing RI/IMCI services has increased by over 60 percent between 2005 and

Service Utilisation Trends in Jigawa



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Selected Outcomes of Health System Reforms in Enugu

Indicator	Pre-MSP/POC (2004)	Post MSP Implementation (2006)
OPD Attendance	135,725 (PHC-105,098)	353,244 (PHC-257,869)
Supervised delivery	2,375	4,276
Measles Coverage (Administrative records)	30%	79%
DPT3 Coverage (valid Card+History @52wks)	NICS 2003 – 48.5%	NICS 2006 – 53.6

Source : Chukwani CM, Olugboji A, Akutto EE, Odebunmi A, Ezeilo E, Ugbene E, 2006. The Primary Health Care System in Enugu state- Baseline audit. Health Policy 2006 Jul 77(2) 182-201

June 2007. Similarly, facilities providing EOC services have increased from six in 2004 to seventeen in June 2007 and over 80 percent of them are providing 70 percent of all EOC signal functions that they are suppose to provide for their level of care. Outpatient consultations and supervised deliveries have increased.

In Ekiti, implementation of ESSP commenced with 25 PHC facilities in four LGAs and four Public Hospitals in 2006. This was further rolled-out to 92 PHC facilities and all public hospitals (21) in the State a year later[8]. In 2008, the state planned to expand to 180 PHC facilities.

In Kaduna, the ESSP plan would be implemented in phases:

Phase I: A PHC centre (Ward Health Centre) would be selected from each ward. This WHC would have the basic equipment, drugs, manpower to provide the services required of it. All the 255 Wards will be operational. Rural/General hospitals covering 30% of the LGAs will implement the ESSP.

Phase II: There will be an expansion within the ward to an additional 30-50 percent of the facilities. Expansion to Rural/General hospitals covering 60% of the LGAs.

Phase III: It is anticipated that all health facilities in all wards will provide ESSP. All Rural/General hospitals throughout the State will be implementing the ESSP.

Because LGAs vary in how they are able to mobilise resources, the duration of the phases may vary but should not be more than 2 years.

8 Note that PATHS closed in Ekiti at the end of 2006

Challenges

Financial resources needed for sustainability

What will it cost to deliver a MSP? Some work has been done with PATHS support at the federal level to determine the cost of delivering a Ward MSP. This estimate however excludes the cost of secondary level care that is vital for complementing primary level care in a 'district health system' model. In Kaduna, substantial work was completed on costing the free MCH services and the ESSP. This information has been used for budgeting purposes. Good progress in terms of costing was also recorded for the State specific packages in Enugu and Ekiti. In Enugu, the MSP is a key factor for developing the 2009 State budget. However, more work needs to be done on the costing of the implementation of the full complement of the MSP as this will assist all stakeholders in determining what is feasible in cost and scope and inform negotiations on adequately funding health services in Nigeria. Where donors, like DFID through HCP, agree to provide basic equipment and seed stocks of drugs for the roll-out of MSP implementation, it is important these elements remain an integral part of the costing process. This provides a comprehensive picture to governments of how much it costs holistically to provide a MSP (i.e. start-up, running and maintenance cost).

In addition, inadequate levels of staffing, and poorly equipped facilities without basic essential facilities like water, lights and sanitation pose a serious challenge to the successful universal delivery of the MSP. While there has been some work in strengthening these areas, much remains to be done.

Thus a key obstacle to the sustainability and roll-out of the MSP is financing. The scale up will be expensive and its implementation will also require constant monitoring.

The Health Bill which was passed in May 2008 might provide some answers for the financing constraints. The Bill provides for the establishment of a substantial National Primary Health Care Development Fund which is to be used to strengthen PHC services

Accepting new facility nomenclature

The facility typology, though approved by the state, was not fully understood and accepted by some political and community stakeholders. These stakeholders or opinion leaders felt that the restructuring would involve what they perceived as 'down grading' of their local facilities from 'hospitals' to 'mere clinics' thus reducing government allocation of funds to such community facilities.

Lack of harmonisation of donor support

This has led to several donor-funded vertical programmes that do not cover the full spectrum of the MSP. Without a state owned integrated health plan designed to deliver a priority-based and cost-driven MSP to the majority of the population, donors have no compelling reason to buy into state owned plans or harmonise their support. This challenge must be addressed to ensure there is tangible harmonisation of donor support.

Lessons Learnt

When carefully defined and costed, a MSP enables health managers to ration scarce public funds for maximum health gain. The package also defines for the clients or community what services and standards of care to expect from the health service. When adequately financed and universally implemented, it is expected to increase service utilisation and reduce morbidity and mortality as it addresses priority health conditions in an equitable manner.

It is interesting to observe that all states gravitated towards putting in place a district health system-like model where a cluster of primary health care facilities supported by a district referral hospital provides an integrated minimum/essential health service package. In developing this integrated system, all states were however confronted with the challenge of multiple hierarchies and the complexities of the management arrangements of the health sector in Nigeria - the PHC facilities fall under Local governments, or State Ministries of Local Government, or state Primary Health Care Agencies and the General Hospitals (the district referral centres) are under the State Health Management Board or the State Ministry of Health. In a sense, developing a MSP stimulates managers and policy makers to consider institutional arrangements. In addition, systems strengthening also becomes imperative.

It was also seen as important to consult widely in developing the MSP and associated POC. This increased ownership and allowed the development teams to draw widely on experience and expertise resident in the different states. Not surprisingly, the states developed very similar MSP with limited geographic variations.

Conclusion

What are the possible policy implications? What model could be most effective as a vehicle to deliver a MSP that is consistent with the PHC objectives and focused on the health MDGs? If it is a 'district health system model', should this be built around the wards or the local government areas? The wards are an extension of the political structure but may not have secondary level facilities - an essential component of the district health system model. The restructuring being undertaken in all the states (DHS in Enugu, Health Cluster system in Ekiti and Kaduna, or the Gunduma system in Jigawa) does cut across wards. This has necessitated legislative backup, amongst other steps taken, to legalise and institutionalise the reforms. The quest for an effective integrated system to equitably deliver a minimum package of essential services should remain in focus in any future health systems reform programme.

The content of the MSP developed in the states cover the priority health conditions and are convergent with national policy in Nigeria. By early 2008, the coverage of the implementation of the full MSP was far from universal. But already there are significant improvements in utilisation.

Thus, although the journey to deliver widespread access to a MSP has started, there is still a long way to go. Key factors for future success will include the development of a robust institutional framework and sufficient resources to implement a MSP.

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