

Some Lessons on Health Sector Reform, from DFID Health Programmes in Nigeria¹

The Nigerian Immunization Coverage Survey (NICS) for 2010 reported major improvements across the whole country, apparently reflecting better organisation of routine immunization and vaccine availability from the National PHC Development Agency (NPHCDA). However progress was particularly good in some states where DFID has been supporting health sector reform over the last decade. One of these states, Enugu, has become the top Nigerian performer in most aspects of immunization, Another DFID-supported state, Ekiti, has also done very well, but the greatest improvement is from Jigawa – nothing short of spectacular. It has jumped from 0.1% full immunization of 1-year olds in 2003 to 76.6% in 2010, a massive increase. From being one of the worst-performing states in the country it now has the 4th highest coverage, higher than any of the other 23 Northern States.

Good immunisation coverage requires (and is an indicator of) a well-functioning primary health care system. It depends on effective routine immunization (as opposed to campaigns), which in turn needs functioning health facilities and delivery of reasonable quality accessible services, so that mothers and children are attending clinics and health centres regularly so they are getting immunized as well. It also needs a flow of recurrent funding for the different levels of the health system and good management of finance, human resources, logistics and the supply-chain (for provision of vaccines etc.). Preferably there should also be community outreach services. It is generally recognised that routine immunization in low-income countries depends on public sector health services, although private (usually non-profit) services can also play an important part. However FBOs and NGOs are thin on the ground in northern Nigeria (Jigawa) and play little role in service delivery - they are more significant in Enugu but nevertheless immunization is still largely from government services.

In the 1990's DFID's experience with its Bamako Initiative Project and the Benue Health Fund Project clearly indicated the extreme weakness of health services from Local Government Authorities (LGAs), as well the very serious impediments to changing them. This is particularly important because LGAs are responsible for delivering almost all PHC services from the public sector. It was also clear that the core problems were issues of governance, in particular:

- **fragmentation of responsibility** for staff, financing and service delivery
- **inadequate financing** of health services, especially PHC as well as very weak financial management
- **lack of LGA accountability** for delivering services or for their funding, let alone any accountability to the people they were meant to serve
- **very weak support and supervision** from the state level to LGAs and LGAs to facilities, as well as from federal to state level.

In 2001 DFID therefore recognised that the governance and management of PHC by LGAs was perhaps the most significant, intractable problem facing Nigeria's health services. It therefore decided to help a number of states and the Federal Government to tackle this problem, by launching a large, long-term, multi-faceted change-management health programme in four states (later six). In doing this, DFID and some key Nigerian stakeholders recognised that numerous attempts to fix LGA health services over the previous decade had achieved very little. Broad and substantive transformation was therefore required of health sector governance, management and service delivery – hence the name of this new programme: the "Partnership for Transforming Health Systems" (PATHS).

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It was the PATHS reform initiative that introduced the integrated district health system in Enugu and also the "Gunduma" health system in Jigawa, both of which are very far-reaching changes to the governance and organisation of health services in each state. More recently this has been taken forward by the PRRINN-MNCH Programme as "*PHC Under One Roof*" (PHCUOR) in Yobe, Zamfara as well as Jigawa States. NPHCDA is now championing PHCUOR as a national initiative and in 2011 it was adopted as Nigerian policy by the country's National Council on Health. PHCUOR is modelled on WHO's guidelines for integrated district-based service delivery and includes the following major changes in health sector governance:-

- **State legislation** establishing integrated structures, financing and staffing and management of PHC – in Jigawa 's case replacing the LGAs' role in health with "Gundumas"
- **Significantly increased budget allocations and releases** of funds for PHC, plus the establishment of much more effective financial management and reporting systems
- **Single lines of accountability** (particularly in Jigawa), integrated support and supervision from state level right down to facilities and stronger links between health services and the communities they serve
- **Extensive systems improvement** in policy, planning, management, organisation and capacity within the health sector.

These changes provide the indispensable foundation on which effective PHC service delivery is now being built. One outcome has been the spectacular increase in immunization coverage which Jigawa as well as Enugu and Ekiti have achieved, signalling an overall improvement in the delivery and uptake of health services. Another is that government is now getting increasing recognition from the public for providing better health care, which has increased political interest and commitment for the reform process. The changes have included significant reform and improvements to the functioning of state-level structures as well as extensive and wide-ranging changes at lower levels. The process of achieving this change has involved extensive engagement with and buy-in by a wide variety of stakeholders at every level in the health services.

Finally, the big question: what were the essential ingredients in achieving these substantive health sector reforms? As implementers in these donor-assisted programmes we identified ten key ingredients. However we also believe these key ingredients are potentially very pertinent to the work and roles of the NPHCDA and the Federal and State Ministries of Health.

1. Very careful attention to engagement with stakeholders at many levels affected by reforms, who must lead and implement the reform process. This engagement is at the heart of governance reforms, but it is not automatic nor simple to execute. It requires understanding the political economy in each state, very careful planning and methods of engagement, as well as constant attention.
2. Multi-faceted health system change initiatives. Too often interventions address a small corner of the health system so their results tend to be short-lived, because different elements of the system are integrally inter-connected and inter-dependent so narrow changes are difficult to sustain. PATHS and PRRINN-MNCH have had the ability to work widely across the health system, addressing issues of governance, finance, institutional management, demand and accountability, service delivery, etc., – frequently at the same time. Comprehensive reforms such as these require large-scale interventions, "flexible" resources (as compared to rigid aid or usually inflexible government funding) and continuity over a significant period - preferably 10 to 15 years.
3. Capacity to respond flexibly to local conditions and grasp opportunities when they come up for addressing core elements of health system functionality, while still maintaining consistency and persistence.

4. A sectoral approach to governance reform. Our experience suggests the struggle for reform may be easier within a sector such as health, rather than across the whole of government. We have found that key players have been prepared to give ground on a limited portion of their finance, staff, structure, systems, etc., in the expectation of fairly tangible, popular benefits (e.g. better health care or education services). Changes of this nature right across government would pose a far greater challenge to entrenched interests - although there are a few indications that change in one sector can start to spread to others.
5. A "systems approach" to developing organisational and institutional management. It has proved extremely important to get basic systems up and running for financial management, support and supervision, patient care management, logistics, drug supplies and so on. These are indispensable and their effect in improving health service delivery is direct and extensive.
6. Linking up governance reforms with systems strengthening. This link is seldom made and there are usually different people working on improving management systems to those working on governance issues. All the critical issues in managing health services (e.g. budget allocations and disbursement, staff management, drug procurement and capital investment) have massive governance implications and requirements as well. These need to be understood and then strategies adopted to improve systems *in the context* of the prevailing governance milieu and where necessary with support for governance reforms.
7. Strengthening management capacity, especially through a work-based, problem-based, mentoring approach (not enough of this has yet been done in Nigeria).
8. Attention to coverage and scale-up from the beginning. Time and again pilot projects targeting a few LGAs have not proved feasible to expand more widely. DFID's whole-state approach from 2001 onwards has been vital for realistic, real change and replicability.
9. Appropriate technical support. Health managers battling on their own can't find the time, energy and resources to carry forward major reforms or to identify and assess the best options to pursue. Access to capable, supportive assistance and shared experience from similar situations can therefore be very valuable. Getting the right type of technical support is difficult however, because often it is inappropriate for local conditions, amateurish and unskilled, undermining of local initiative, self-serving and self-perpetuating. Donor projects have been the main source of such support, but it is a more appropriate role for Federal agencies, such as the FMOH or NPHCDA, if they had the resources and willingness to change their functions radically, focusing on a supportive role to the states with plenty of time in the field.
10. Hard sustained work. Many people believe that they can come in, spend some time, wave the wand and all things will miraculously improve. This is delusional. Our experience is that you need senior, experienced support over a long time to make a difference. Stakeholders on the ground won't trust you, let alone listen to you, until you have served some time, paid careful attention to those directly facing the problems every day, understood the complexity of the issues, etc, etc. Turning systems around needs the kind of sustained input that often is not allowed for. It is also important to realise that important systemic changes will suffer setbacks. There are good reasons why the existing system works the way it does and we want to change this. Thus, while on the surface it makes sense to improve and make a better functioning, more efficient health delivery system, this is not necessarily what the power-brokers want (although they would never admit this). So substantial reforms inevitably require a sustained struggle with very careful strategizing, some inevitable setbacks and above all persistence.

