EXECUTIVE SUMMARY **April 2010**

Workshop on '*Bringing PHC under one roof*'

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With Kwame Adogboda, Carole Baekey and Bryan Haddon

Many reports describing the Nigerian health system have identified the PHC/LGA level as the area of most concern and weakness. The major limitations are linked to fragmentation and lack of accountability. Over the years, there have been several initiatives focused on addressing these areas of weakness. Most create unitary, integrated and decentralised management bodies and structures.

A workshop on bringing "*PHC under one roof*" was hosted by NPHCDA in October 2009.[1] The current report describes the follow up workshop in March 2010, hosted by NPHCDA (with PRRINN-MNCH and PATHS2 support) in which the draft implementation guidelines and policy document were reviewed.

The Mid-level Managers Training programme (MLMT) was discussed and experiences from across the country in bringing "*PHC under one roof*" were shared. Participants came from across Nigeria.

Key outcomes included a deepened understanding of "*PHC under one roof*", agreement on the policy document and implementation guidelines (with some minor changes) and interest and support expressed for the MLMT.

Key presentations included those from NPHCDA (on the state of PHC in Nigeria and on the MLMT initiative), and from PATHS2 (Creating an enabling environment for better health outcomes), NHIS (NHIS Community Health Insurance Scheme) and PRRINN-MNCH (on lessons on training midlevel managers in other African countries).

In addition, many more (approximately 25) states were present (in relation to those present at the October workshop) and new states shared progress in bringing "*PHC under one roof*". This included presentations from Lagos, Bauchi and Ekiti states.

In going forward it was agreed that:

a. NPHCDA would ensure approval and adoption of the Policy Brief and *PHCUOR* Implementation Guidelines by the NPHCDA Board and then present the two documents to the National Council for Health for approval.

b. NPHCDA would link support for bringing "*PHC under one roof*" with the MLMT and the NHIS.

c. States would similarly present the documents for adoption at the States Councils for Health and utilise them in implementing "*PHC under one roof*"

d. Development partners would support the NPHCDA and states in finalising and implementing the above tasks.

The workshop ended with a commitment to get together before the end of 2010 to review progress.

For the full report, please email info@prrinn-mnch.org.

[1] See report 'Workshop on bringing PHC under one roof by Andrew McKenzie and Nana Enyimayew, October 2009'.

PRRINN-MNCH is funded and supported by the UK Government's Department for International Development (DFID) and the State Department of the Norwegian Government

PRRINN-MNCH

Partnership for Reviving Routine Immunisation in Northern Nigeria; Maternal Newborn and Child Health Initiative

PRIMARY HEALTH CARE UNDER ONE ROOF

Policy to integrate management of Nigeria's Primary Health Care

Reflections from our experience in Jigawa state, Northern Nigeria

by Dr Emmanuel Sokpo and Dr Andrew McKenzie

OVERVIEW

Burdened with some of the highest maternal mortality and child morbidity rates in the world, northern Nigeria's efforts to improve health services are continually undermined by structural and institutional weaknesses. Fragmentation of the health sector, inclusive of management of staff, funds and other resources, has been the most significant intractable problem facing the country's primary health care (PHC) services. Accountability mechanisms are weak and the quality of health services suffer. Communities have little confidence in services provided and utilisation is usually very low.

Under the Partnership to Revive Routine Immunisation in Northern Nigeria/Maternal Newborn and Child Health (PRRINN-MNCH) programme [1], a range of activities were undertaken over the last decade to address these issues. Building on previous work funded by the UK government from 2003, PRRINN-MNCH supported stakeholders to:

- Use evidence to advocate for policy choices at state and federal levels
- Translate policy choices into appropriate legislation and regulations
- Develop and use enabling legislation to establish a unitary and decentralised health system (Gunduma, or district, health system)
- Collaborate to overcome challenges and issues experienced in translating policy into implementation

THE POLICY

In 2011, Nigeria instituted a national policy, 'Bringing PHC under one roof' to integrate management of PHC and end fragmentation in the health sector. The policy built on the experience of the Gunduma system which amalgamated responsibility for services and resources of 27 local government authorities under nine Gunduma Councils which are now accountable to a single Gunduma Health System Board. In Jigawa, the Gunduma legislation was signed into law in 2007.

Key Elements of Bringing PHC Under One Roof Policy

- Principle of "three ones" (**one management body, one plan** and **one monitoring and evaluation system**).
- **Single management body** with control over services and resources (human and financial)
- Enabling **legislative framework**
- **Decentralized authority, responsibility and accountability** with appropriate span of control.
- **Integrated supportive supervisory system** managed from a single source.
- **Integration** of all PHC services under one authority.
- **Effective referral system** between/across the different levels of care.

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1 The programme is funded and supported by UK aid from the UK Government and the State Department of the Norwegian Government.

CHALLENGES

Identifying power-economic interests and leveraging them for aspired change.

Laying the foundations for the development of the policy was time consuming and the advocacy approaches used, multi-pronged. Enormous, careful and sustained effort was made to include all stakeholders in all stages of policy development – from politicians to senior government officials, service providers, progressive institutions and community leaders. Evidence of malfunctioning health services and successes from other African countries was used to urge politicians into reviewing policy choices and to illustrate advantages in certain policy choices.

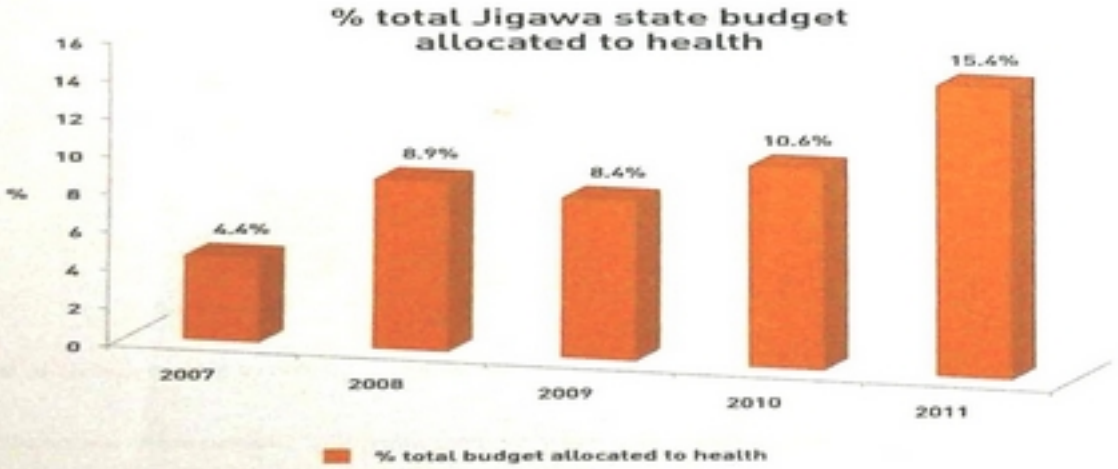
Implementing policy into practice through institutional restructuring

Practical issues such as the rationalisation of government management structures are complex in any setting, even more so as stakeholders had minimal exposure to or experience of unitary and decentralised health systems. Emphasis was on transferring services and responsibility from one tier of government to another, human and financial resource reorganisation and the reorganisation of State Ministries of Health and Local Government and Local Government Authority structures to play new roles.

OUTCOMES

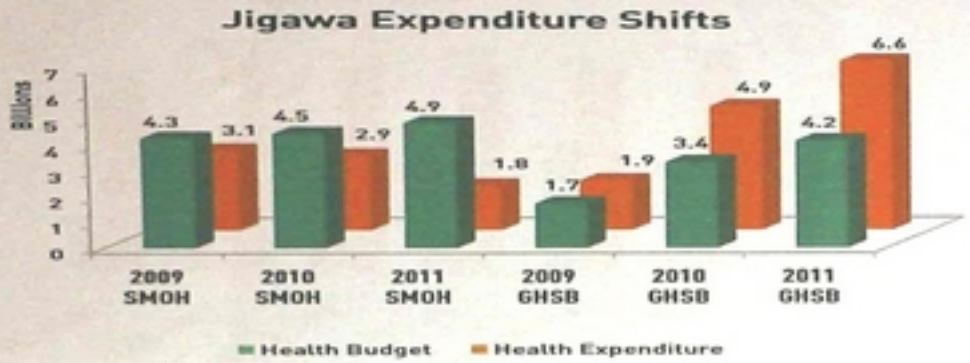
1. Increased efficiency and coordination of health services (reduction in duplication)

This has enabled the Jigawa Government to progressively increase health budget allocation to over 15% since the Gunduma Act was signed. (Budget performance is over 90%)



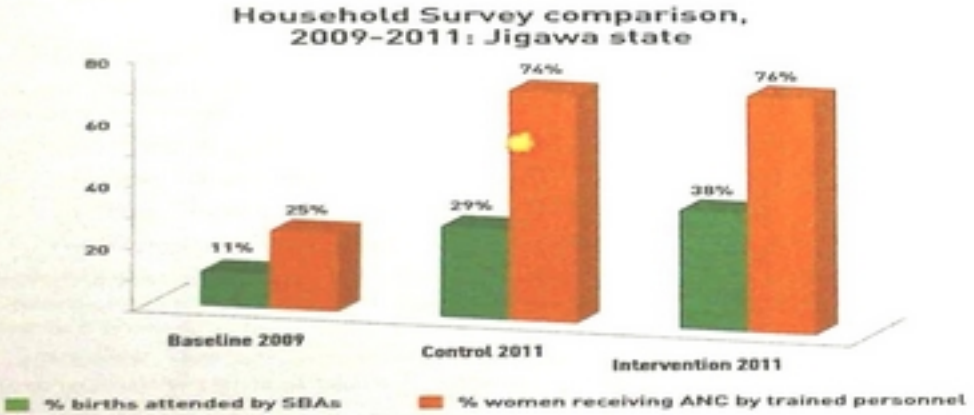
2. Decentralisation of health services (devolution and de-concentration)

The development of enabling legislation has helped to shift the balance of power over management of key resources (financial and human) from politicians to managers for a decentralised health system. The graph below shows the shift in expenditure pattern; decreasing State Ministry of Health (SMOH) budget expenditure and increasing Gunduma Health System Board (GHSB) expenditure.



3. Increased confidence in and utilisation of services

Over the last 5 years there have been significant changes in maternal and health indices[2].



Data from Household Surveys: Intervention are cluster sites, control are non-cluster sites

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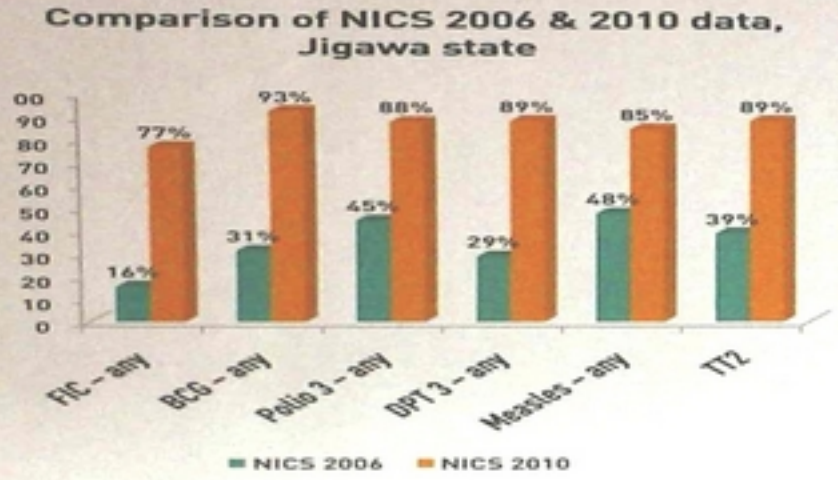
2. Documented from a variety of sources including: National surveys (e.g. National Immunisation Coverage Surveys, District Health Surveys, Routine Health Management Information systems, PRRINN-MNCH programme surveys and monitoring and evaluation systems

Significant increase in immunization coverage over the period the District (Gunduma) system was established.



Data from two National Immunisation Cluster Surveys

LEARNING

It is not enough to have a 'good idea', backed by evidence. It is not enough to translate this into new policies and legislation.

- Political will and commitment is essential
- Considerable time is needed - fragmentation is quick, integration is lengthy
- The devil is in the detail of implementation
- Working at the governance/ systems interface is key

Implementation is the interface where researchers, policymakers, service providers and programme implementers need to overlap and share learning to ensure that evidence-based best practice is enabled to flourish.

The PRRINN-MNCH programme has integrated a deep knowledge of the political economy of Northern Nigeria with technical health system solutions to transform the health service.

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