Bringing primary health care under one roof

Key messages: **The Nigerian heath service is characterised by poor budgeting, weak governance and limited supply of basic medicines and equipment to clinics[1]. A strong primary health care system is a prerequisite to deliver comprehensive maternal, newborn, child and routine immunisation services.[2]**

1. Bringing primary health care under one roof will enhance coordination, collaboration, effectiveness and efficiency as well as eliminating constraints, fragmentation, managerial uncertainty and wastage of resources.
2. Restructuring health systems is a time-consuming task and understanding complexity theory is key to health systems transformation.
3. Reducing fragmentation improves health indices.

The challenge: understanding fragmented PHC services using complexity theory

Burdened with some of the highest maternal mortality ratios and child mortality 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, including management of staff, funds and other resources, has been the most significant 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 and use of them is usually very low.

The Nigerian health system is underbudgeted and fragmented[1]. Only 7% of federal resources are dedicated to health. Of that, over 75% is spent on tertiary and curative care. All levels, tertiary, secondary and primary, are funded through separate channels which are not adequately budgeted, monitored or accountable to one another[2].

Efforts to improve governance and strengthen systems in Nigeria are complicated by the fragmentation of healthcare systems and resources. Vertical programming and fragmented services are anathema to those promoting an integrated approach to health care delivery.

Complexity theory has increasingly been advocated as a tool for health policy development and health systems reform[3]. In this theory, health systems are seen as open systems in which different components are interdependent and can influence each other in a non-linear fashion[4]. Non-linearity and the notion of emergent behaviour (ie behaviour that is not a property of any of the components of that system, but which results from the interactions of the components) mean that a change in one part of the system can have unpredictable 'ripple effects' in others[5].

The World Health Organisation's report *Systems Thinking For Health System Strengthening*[6], was heavily influenced by the ideas of complexity theory, and acknowledges non-linearity and interdependence in a proposed framework for health system strengthening.

Policymakers and health system reformers need to adopt a whole-system approach to ensure changes at one level will not impede changes at another. The complex adaptive systems approach reinforces concepts such as feedback loops (both positive and negative that influence the pace and direction of change); path dependence (processes with similar starting points can have very dissimilar outcomes resulting from different contexts and histories and different choices at key points); scale-free networks (incorporating focal points like key powerful people that can dominate a structure); and phase transitions (when 'tipping points' are reached and initiate change)[7].

The ideas of complexity theory are closely linked to the drivers of change (DOC) approach adopted by the Department for International Development[8] which has significantly influenced development and health system reform work in Nigeria. The DOC approach conceptualises three interacting components operating within any system and influencing change within it:

Structural features – the history of the state; natural and human resources; economic and social structures; demographic changes; regional issues; globalisation, trade and investment; urbanisation

Institutions – the informal and formal rules, such as political and public administration processes,

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that determine the realm of possible behaviour by agents

Agents – individuals and organisations pursuing particular interests: the political elite; civil servants; political parties; local government; the judiciary; the military; faith groups; trade unions; civil society groups; the media; the private sector; academics; donors

The DOC analytical approach examines the mechanisms through which power is transacted within society and the health system[10]. The DOC approach formed the basis of the political economy assessments undertaken by PRRINN-MNCH at federal and state level in Nigeria, which led to a deeper understanding of the structural features, the power relations, the institutions (particularly the informal rules) and the agents operating in the health sector[11].

Both complexity theory and the DOC approach to political economy see the health system as a whole system. Understanding the context in which potential change happens is vital for any new policy to be adopted. This requires a deep understanding of the structures, institutions and agents operating within the whole system.

However, complexity theory argues for a deeper analysis of the changes that a new policy will bring, especially a deeper appreciation of non-linearity, understanding of likely feedback loops, awareness of the key points when a theory or approach are likely to be adopted, and of the individuals who are critical to the adoption process.

PRRINN-MNCH states have adopted several strategies to address fragmentation and vertical programming. The underlying principle has been to create a unified approach so that the state can deliver healthcare services more effectively and leverage additional resources.

The response: bringing PHC under one roof

Speaking at a two-day national workshop on integrated primary health care governance in Nigeria, the Executive Director of the National PHC Development Agency (NPHCDA) said there are many challenges to running a health system in a federal government: *"The way around it is for all the authorities responsible for basic services from federal to local government levels to agree and bring their authorities 'under one roof'"*. He said primary health care under one roof would enhance coordination, collaboration, effectiveness and efficiency; eliminate constraints, fragmentation and managerial uncertainty, wastage of resources and create an enabling environment for implementation of the proposed Health Act[12].

Fig 1: Conceptual model for understanding drivers of change (DOC)

Three interacting components can influence change within the system.

Source: DFID (2004) [9]

Building on previous work funded by the UK government from 2003 under the Partnership for Transforming Health Systems Programme (PATHS1), 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 single, decentralised health system (variants on the district health system) – bringing PHC under one roof
- Collaborate to overcome challenges in translating this policy into practice

The results: restructuring PHC services

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 Jigawa State Gunduma Health System and the restructuring experiences of other states.

At the May 2011 National Council on Health (NCH), the apex health policy making body of Nigeria, 'bringing PHC under one roof' was approved as a policy and implementation guidelines were recommended for use by the states. A how-to manual and implementation checklist was approved by the NCH in August 2013 and in the same year a unit was established within NPHCDA to drive PHC under one roof. A national steering committee was also established to oversee implementation.

Key elements of the '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
- ☑ Decentralised 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 across the different levels of care

Bringing PHC under one roof fits the provisions of the National Health Bill, which is awaiting approval and 23 states have implemented PHC under one roof in one form or another. Three national workshops have been held over the years with a state-level audit in September 2013 by NPHCDA, with support from PRRINN-MNCH to monitor progress, as well as zonal workshops in August and December 2013. Awareness of the benefits of PHC under one roof has also increased among donors and partners (eg interest shown from GAVI, EU, WHO).

In three of the four PRRINN-MNCH states the policy has been adopted and implemented and in the fourth (Katsina) the current legislation is being reviewed to align with the policy. All four states are progressing in implementing key elements of the policy. At state level:

- All 4 PRRINN-MNCH supported states have accepted the PHC under one roof policy
- Laws and regulations have been passed in three states and review of current legislation is ongoing in Katsina in 2013
- Jigawa has integrated PHC and secondary healthcare (SHC) by establishing the Gunduma Health System
- Management structures have been established in three states (excluding Katsina) and boards inaugurated in two states (Jigawa and Yobe)
- Transfer of services and resources (human, financial, infrastructure) has been completed in Yobe and Jigawa
- Capacity building of new managers of integrated authorities has started across the four states and among the Gunduma Councils in Jigawa

The results: improving access to services in Jigawa

Jigawa's Gunduma Health System amalgamated responsibility for primary and secondary healthcare services and the resources of 27 local government areas 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 (under the PATHS1 programme) and the accompanying regulations were signed in 2010 (with support from PRRINN-MNCH and PATHS2). This has led to a transformation in health service delivery in Jigawa.

Increased efficiency and coordination of health services (reducing duplication)

The new system has enabled the Jigawa Government to progressively increase the health budget allocation to over 15% since the Gunduma Act was signed. Budget performance has reached over 90% in the same period.

Decentralisation of health services (devolution and de-concentration)

The development of enabling legislation has helped to shift the balance of power over the management of key resources (financial and human), from politicians to managers of the decentralised health system. Fig 3 shows the shift in expenditure pattern: decreasing State Ministry of Health (SMoH) budget expenditure and increasing Gunduma Health System Board (GHSB) expenditure.

Increased confidence and use of services

Over the last five years there have been significant changes in maternal and health indices.

There have been significant increases in immunisation coverage since the Gunduma system was established. This was seen in both the household survey data and the national immunisation cluster survey (NICS) data (Figs 4 and 5).

Policy implications

It's not enough to have a good idea, backed by evidence – it needs to be translated into new policies and legislation. But to do so:

- Political will and commitment are essential
- Considerable time is needed – fragmentation is quick, integration is lengthy
- Implementation is crucial – the devil is in the detail
- Working at the governance/systems interface is key

Fig 2: Amount of state budget allocated to health (%)

Jigawa's health budget has increased since the Gunduma Act of 2007.

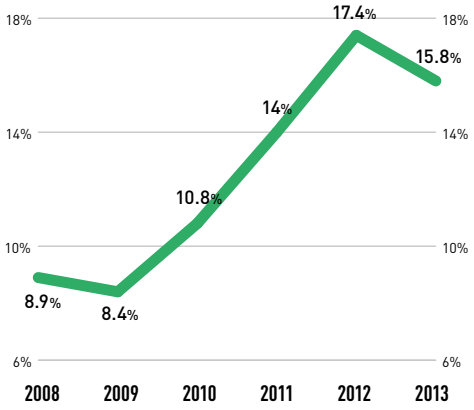


Fig 3A: Jigawa expenditure shifts

SMoH budget expenditure has declined

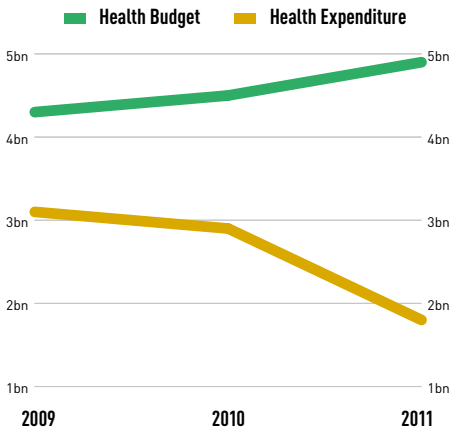


Fig 3B: Jigawa expenditure shifts

GHSB expenditure has increased

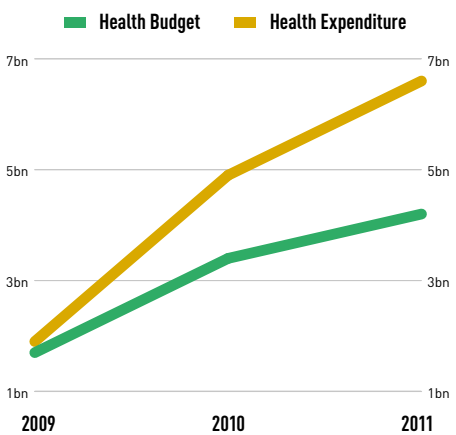
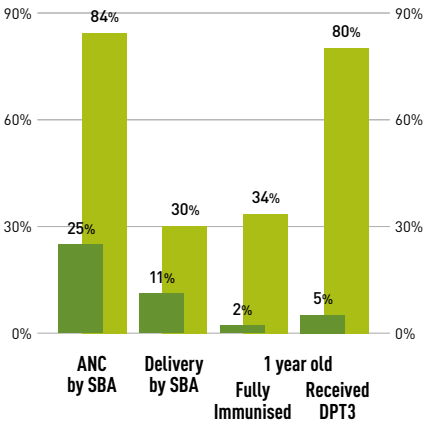


Fig 4: Changes in service provision from the PRRINN-MNCH household surveys (HHS)

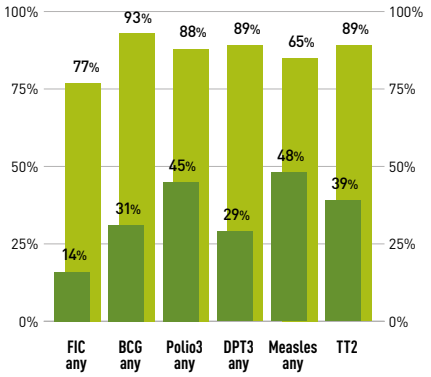
Maternal care and immunisation have improved considerably.



Baseline HHS 2009 Endline HHS 2013

Fig 5: Comparison of NICS data in Jigawa state 2006 and 2010

Immunisation coverage has improved considerably.



Baseline NICS 2006 Endline NICS 2010

Identifying and leveraging power and economic interests

Laying the foundations for the development of the PHC under one roof policy was time consuming and the advocacy approaches used were multi-pronged. Enormous, careful and sustained efforts were made to include all stakeholders at 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 to review policy choices and to illustrate advantages in certain policy choices.

Putting policy into practice through institutional restructuring

Practical issues such as the rationalisation of government management structures are complex in any setting, even more so when stakeholders have minimal experience of unitary and decentralised health systems. Multiple issues needed to be dealt with in an ongoing manner. The emphasis was on transferring services and responsibility from one tier of government to another. This involved the reorganisation of human and financial resources as well as the reorganisation of state ministries of health and local government area structures to play new roles.

Conclusions

Reducing the fragmentation of PHC service management is a key step in improving Nigerian health care indicators. However, this is a journey that takes considerable time and a deep understanding of the political economy of the Nigerian health sector. In addition, flexibility and perseverance are needed to see the journey through to completion.

But despite progress, some of the issues with healthcare delivery in Nigeria stem from the country's fractured federal system of governance. Much time is spent developing strategies for the entire nation, but when it comes to implementing them, the politics of federalism grind progress to a halt.

But with the primary healthcare under one roof initiative, *"we have the whole primary healthcare delivery on one platform – that is, the state's own primary healthcare development agency,"* says Dr Ado Jimada Gana Muhammad (executive director of the NPHCDA). *"The staff of the primary healthcare department in the local government departments and areas will now be absorbed into [that] agency. And we are beginning to see it work."*[13]

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

The PRRINN-MNCH programme works with federal, state and local governments and local communities to improve the quality and availability of maternal, newborn and child health services.

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