Developing a District Health System in Jigawa State

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2. Context

This case study explores legislative, policy and governance changes in the health sector in Jigawa State, Nigeria and the impact of these changes on health systems, the management of health services and health service indices and outputs.

In the Nigerian constitution, health is a concomitant responsibility[2,3,4] of the three tiers of government (the Federal level, 37 states including the Federal Capital Territory and 774 Local Government Authorities [LGAs]). However, details re the specific roles and responsibilities of the three tiers of government are less clear.[5,6] Guided by national health policy and in the understanding of all the stakeholders in Nigeria, the Federal level is responsible for tertiary care, the State level for secondary care and the LGA level for primary health care. However, as will be discussed, the reality on the ground is different especially as the policy is not backed up with adequate legislation.

Following independence in 1960, Nigerian health services were the responsibility of the Federal and regional governments. As states developed, there was some delegation of power and authority (administrative decentralisation) to State Health Management Boards (SHMBs). Following Alma Ata and the emphasis on PHC, Nigeria devolved PHC services in the late 1980s to the LGA level[7] (political decentralisation). For example, the share of sub-national budget spending in the consolidated budget doubled, increasing from 23 percent in 1999 to 46 percent in 2005.[8] The National Primary Health Care Development Agency (NPHCDA) was created to support this process and in some states State Primary Health Care Agencies (SPHCAs) were established.
However, the health system was increasingly fragmented and was a mishmash of centralisation and decentralisation[9,10,11,12] The fragmentation in the public sector is both vertical and horizontal.[13]

Jigawa is a state in the north of Nigeria with a population of around 3.7 million people. Prior to policy and legislative changes, which started in 2003, the State Ministry of Health (SMOH) and the LGAs were responsible for secondary and primary health care services respectively. However, there was considerable overlap and fragmentation between the tiers of government. In addition, there was considerable (and often negative) influence by politicians on the day-to-day functioning of the health systems. For example, financial resources from the Federal level were transferred in block grants to the state and LGAs. However, both these block grants were largely controlled by the Governor through the joint account system. Money allocated to the LGAs from the joint account was again a block grant that was controlled by the LGA Chairman. The outcome was that both hospitals and primary health centres were starved of resources.

3. Brief description of the intervention

The case study will describe the process in developing the district or Gunduma system with a particular emphasis on reducing fragmentation in health service management and separating out the functions of the politicians and the health service managers. Five key areas will be discussed: legislative changes; integration of services; integration of finances and financial management systems; integration of human resources and human resource management systems; and repositioning of the structures delivering health services.

4. Brief description and reflection on the challenges encountered

Using a political economy approach, key attention was paid to the structures, institutions and agents involved in health care delivery in Jigawa and the power relations inherent in these relationships. Challenges were constantly unearthed and highlighted in what has been a

lengthy transformation process (nearly a decade) and were related to the different components (structures, institutions and agents). The case study will highlight some of these and how they were addressed.

5. Reflection on the (possible) contribution to conflict transformation
The governance and systems work in Jigawa described in this case study illustrate how a fragmented system, riven by discord between the tiers of government largely because of the lack of clarity of roles and responsibilities and weak checks and balances, especially concerning finance and human resource management, is being slowly turned around.

This has led to significant improvements in proxy indicators for health impact (e.g. increased access and coverage). In addition, the changes have clarified roles and responsibilities of all the stakeholders in the health care arena and it is hoped that this will assist in transforming the society as a whole.

6. Evidence of impact of intervention on health, health system, and/or conflict transformation
In terms of the reorganisation of the health service the following has occurred:

- Previously fragmented health services have been integrated under the Gunduma Board. Facilities are now run by the Gunduma Board and Gunduma Councils. Financial and human resources for all primary and secondary health care services are now managed by the Gunduma Board. Planning and budgeting for all these services is the Board's responsibility.
- The management and running of primary and secondary health services has been delegated to the Gunduma Board, from the SMOH, which has then deconcentrated services to the nine Gunduma Councils.
- The Gunduma Board has a Director-General as chief executive officer who reports to a governing body (the Board) and to the Commissioner for Health. The Board is made up of representatives from the different tiers of government (both political and administrative).
- The nine Gunduma councils are each headed by a Director who reports to their governing body (the Council) and to the Director-General. The Council is made up of politicians, from the different tiers of government, community members and administrative health personnel.

On examination one key change is related to integration of services and management. The other key change is the righting of the balance between the political and administrative arms of government. This has assisted in separating health service delivery from the political ambit - policy and regulatory aspects are dealt with by the SMOH and administrative/management by the Gunduma Board. This should strengthen both arms and improve health outcomes and impact

In terms of impact on services and systems the following examples will be detailed:

- Changes to the financial management system will be highlighted and improved budget performance and budget allocation will be shown. In addition, the shift in budget control from the SMOH to the Gunduma Board will be documented.
- Increases in service access, use and coverage will be illustrated showing increased immunisation coverage, increase in functional PHC units and routine immunisation service delivery points and an increase in the number of PHC visits per head of population.

7. Other relevant information
This case study will argue that the key outcomes of the health service restructuring were:

- Reduced fragmentation of the management and running of health services

- Righting of the imbalances between political and administrative imperatives and control.

The conceptual framework (or theory of change) utilises complexity theory (inclusive of an understanding of health systems as complex adaptive systems), and its links with the political economy approach and the drivers of change understanding, to analyse the changes made throughout the development of the Gunduma system in Jigawa. This will be discussed using the following components: health systems as open systems and policy developers and health system reformers needing to adopt a whole system approach; non-linearity and the notion of emergent behaviour (i.e. behaviour of a system that is not a property of any of the components of that system but a result of the interactions of the components) mean that a change in one part of the system can have unpredictable ripple effects in other parts of the system[14]; 'views' from the different levels; feedback loops (both positive and negative that influence the pace and direction of change); path dependence (processes that have similar starting points can have very dissimilar outcomes resulting from different contexts and histories and different choices at key bifurcations); scale-free networks (incorporating focal points - including key powerful people - that can dominate a structure); and phase transitions (when critical points - 'tipping points' - are reached and initiate change).[15] Lastly, the notion of structures, institutions and agents (the concepts that underpin the Drivers of Change/political economy approach) will be discussed in this context.

Complexity theory, the Drivers of Change approach and the political economy approach argue that it is important for the health system to be seen as a whole system. Developing new policy or legislation requires an understanding of the context. In effect, this means a deep and ongoing understanding of the structures, institutions and agents operating within the whole system.

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[1] PRRINN-MNCH is the Partnership for Reviving Routine Immunisation in Northern Nigeria, Maternal Newborn and Child Health programme; HPI is Health Partners International
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[3] Freinkman L. Inter-government Policy Coordination and Improvements in Service Delivery
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[7] Ibid (Khemani)
[8] Ibid (Freinkman)
[9] Ibid (Barron)
[10] Ibid (Freinkman)
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[12] Health Sector Reform Program. Strategic Thrusts; Key Performance Objectives; and Plan of Action 2004 – 2007
[13] Memorandum to the National Council for Health: 'Bringing PHC under one roof' (PHCUOR) in line with the requirements of the new national health bill
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