Health Systems Strengthening and Conflict Transformation in Fragile States

Minimising the Policy Implementation Gap in Nigeria through reducing fragmentation

Andrew McKenzie

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Minimising the Policy Implementation Gap in Nigeria through reducing fragmentation

Purpose

- Fragmented health system reality
  - Driving forces for this reality
  - Impact of this fragmentation on health services and health indices
- Creates problems between policy and implementation
- Strategies to address the fragmentation
  - Governance/systems interface
  - Internal/external mix
  - Length of time needed
- Reason is to align policy and implementation

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- Nigerian background
- Fragmented nature of the health system
- Three examples addressing/minimising the policy implementation gap through reducing fragmentation
  - ‘Bringing PHC under one roof’
  - Enhancing access to GAVI
  - Midwives service scheme
- Theoretical framework
  - Complexity theory
  - Drivers of change/political economy framework
- Conclusion

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Nigerian Background

- Historical background
- Health is a concomitant responsibility
- Federal level, 37 states, 774 LGAs
- Roles and responsibilities unclear
- Health indices very poor
- Worse in the north
  - MMR of 1049 (95% confidence interval,1021-1136).
  - MMR of 1271 (95% CI was 1,152–1,445)
- PRRINN-MNCH programme
- Work continued from PATHS programme

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Fragmented Health System

- Initially Federal and regional governments
- Delegation (administrative decentralisation) to SHMBs
- Devolution (political decentralisation) PHC to LGAs
- Creation of NPHCDA and SPHCAs
- Reality
  - Services
  - Finance
  - Human resources

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Fragmented Health Systems

- Services
  - NPHCDA/NPI – facilities/immunisation
  - SMoH – tertiary and primary facilities
- Finance
  - Federal pots of money (MDG funds, NHIS)
  - Joint accounts
- Human Resources
  - CSC or PSC; LGSC; LGAs
- Both vertical and horizontal fragmentation

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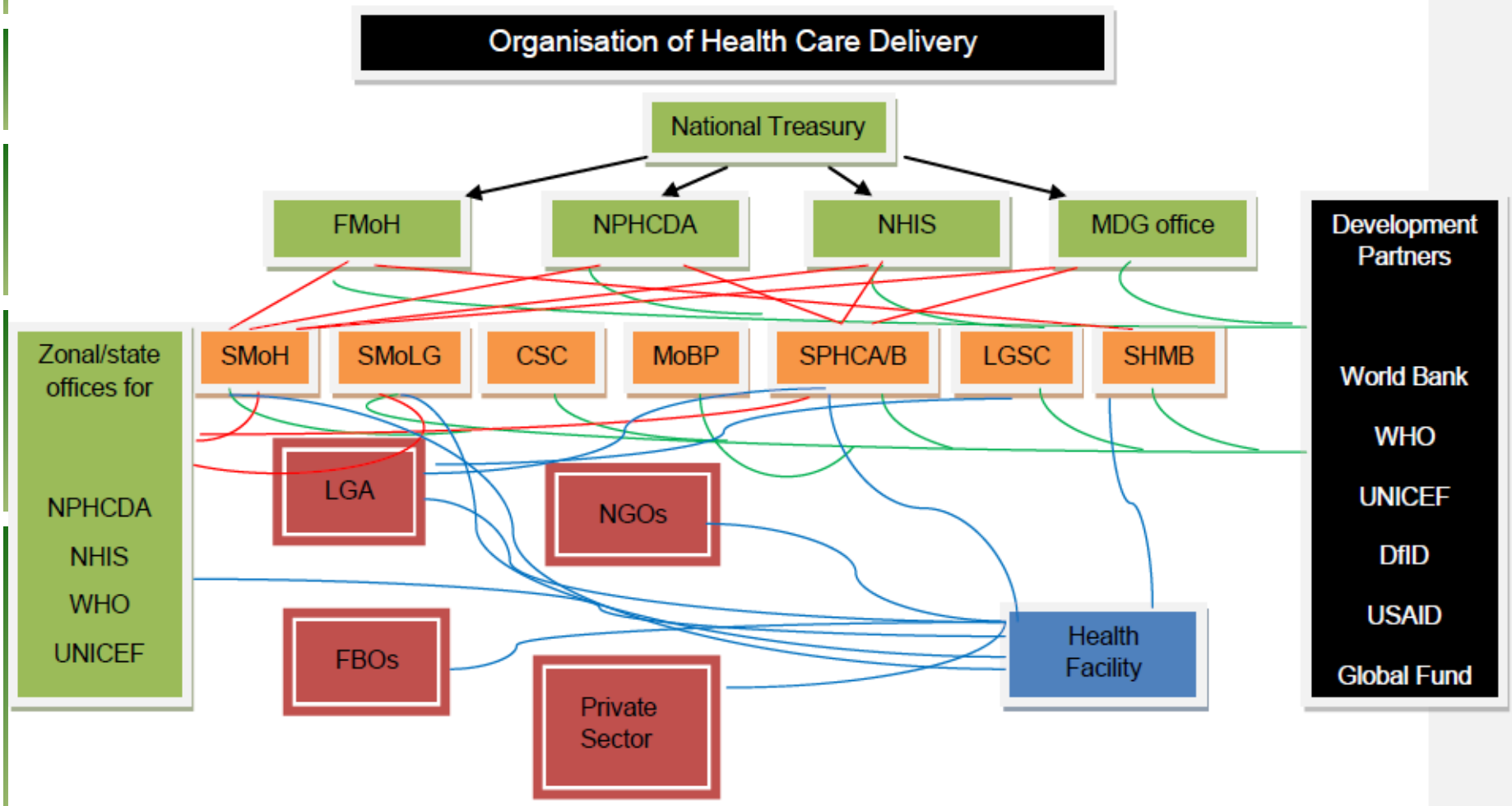

Figure 1: Organisation of the Nigerian Health Service[67]

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Three examples – Bringing PHC under one roof

- Dual tracks
  - Federal level policy (2004) and legislation
  - State level: two states, broaden approach, NPHCDA Board to NCH
- Process
  - State level support (legislation, systems strengthening, repositioning)
  - NPHCDA hosted workshops
- Interaction between state and federal → introduction of a district health system

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Key Elements of the 'Bringing PHC under one roof' Policy

- A **single management body** that has **control over services and resources** (at least human and financial).
- Enabling **legislation and concomitant regulations** .
- **Decentralized authority, responsibility and accountability** with appropriate span of control.
- Principle of "three ones" (**one management, one plan and one M&E system).**
- An **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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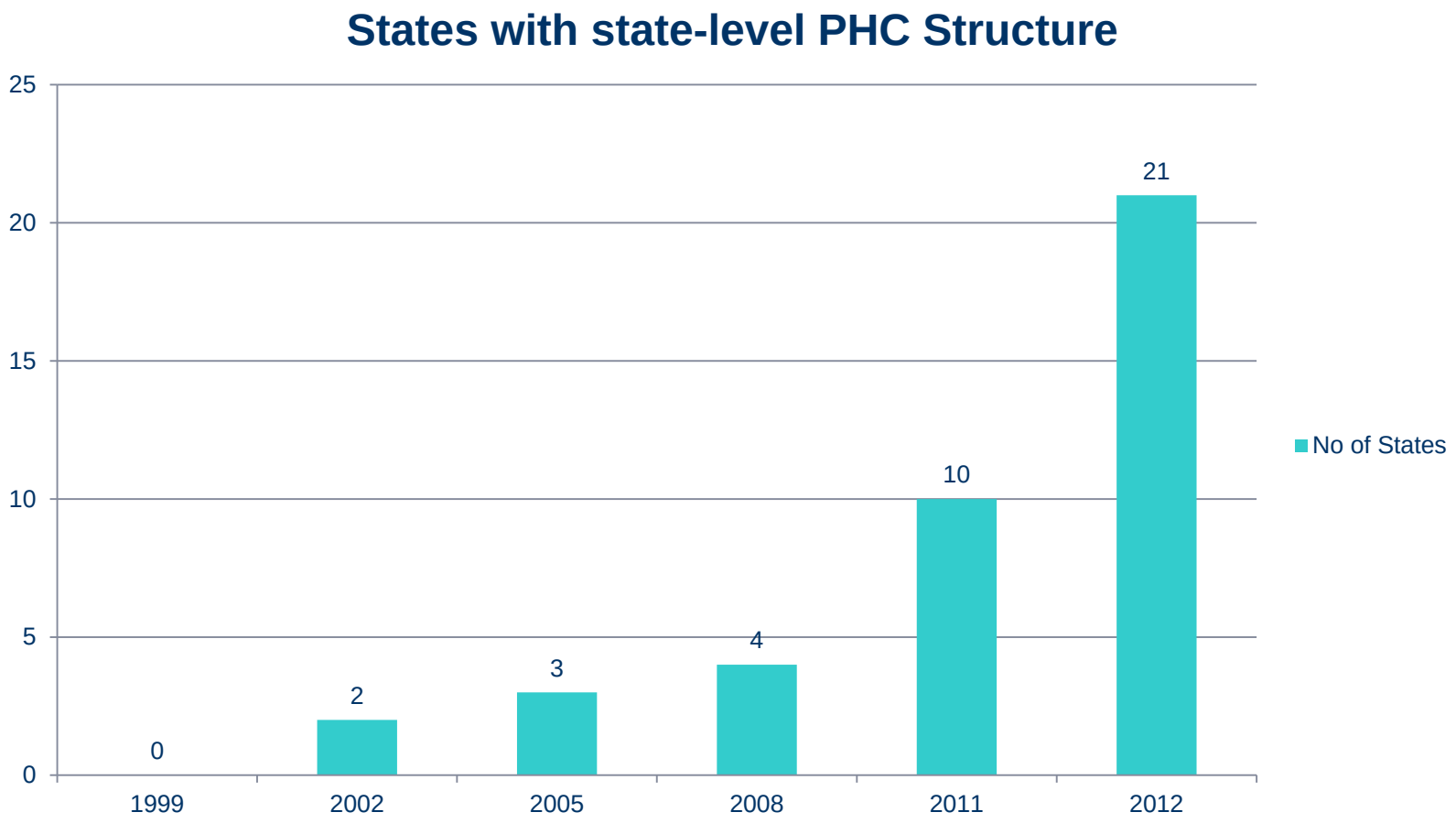

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Three examples – Bringing PHC under one roof

Outcomes

- Firstly, health services are being integrated; particularly PHC services
- Secondly, health services are being decentralised - both through devolution and deconcentration.
- Thirdly, but not uniformly, through the deconcentration to sub-state bodies (the names are different in the different states) the balance of power in the management of key resources (especially financial and human resources) is shifting from the politicians to the administrators/managers.

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Bringing PHC under one roof - Jigawa

- Fragmented services, finance and HR
- Broad-based initiative started with an institutional assessment
- Five year process to legislation in 2007
- Jigawa Integrated Health Committee drove process
- Created a new structure (Gunduma Board) and 9 Gundumas
- Key changes:
  - Integration
  - Righting the political/administrative balance

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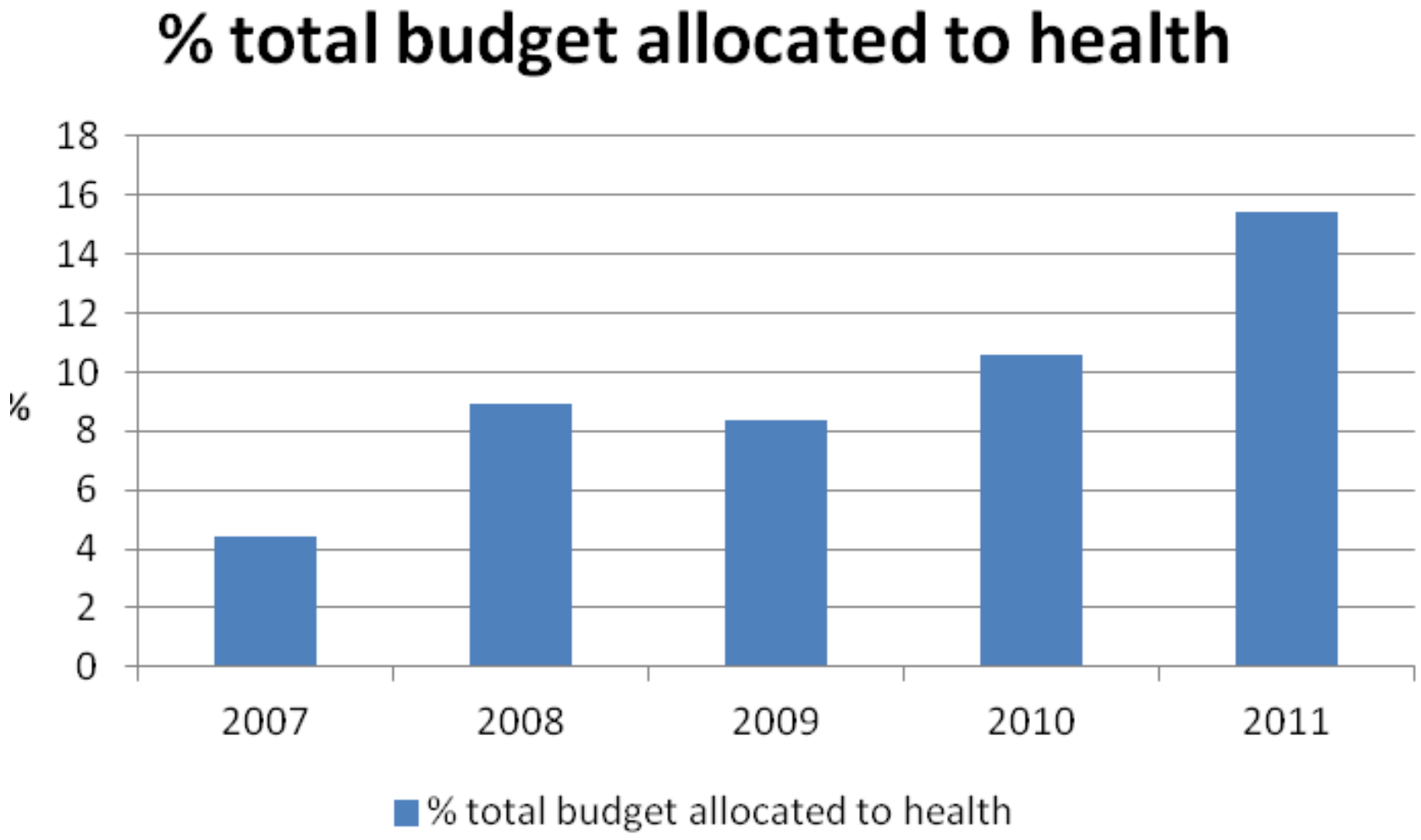

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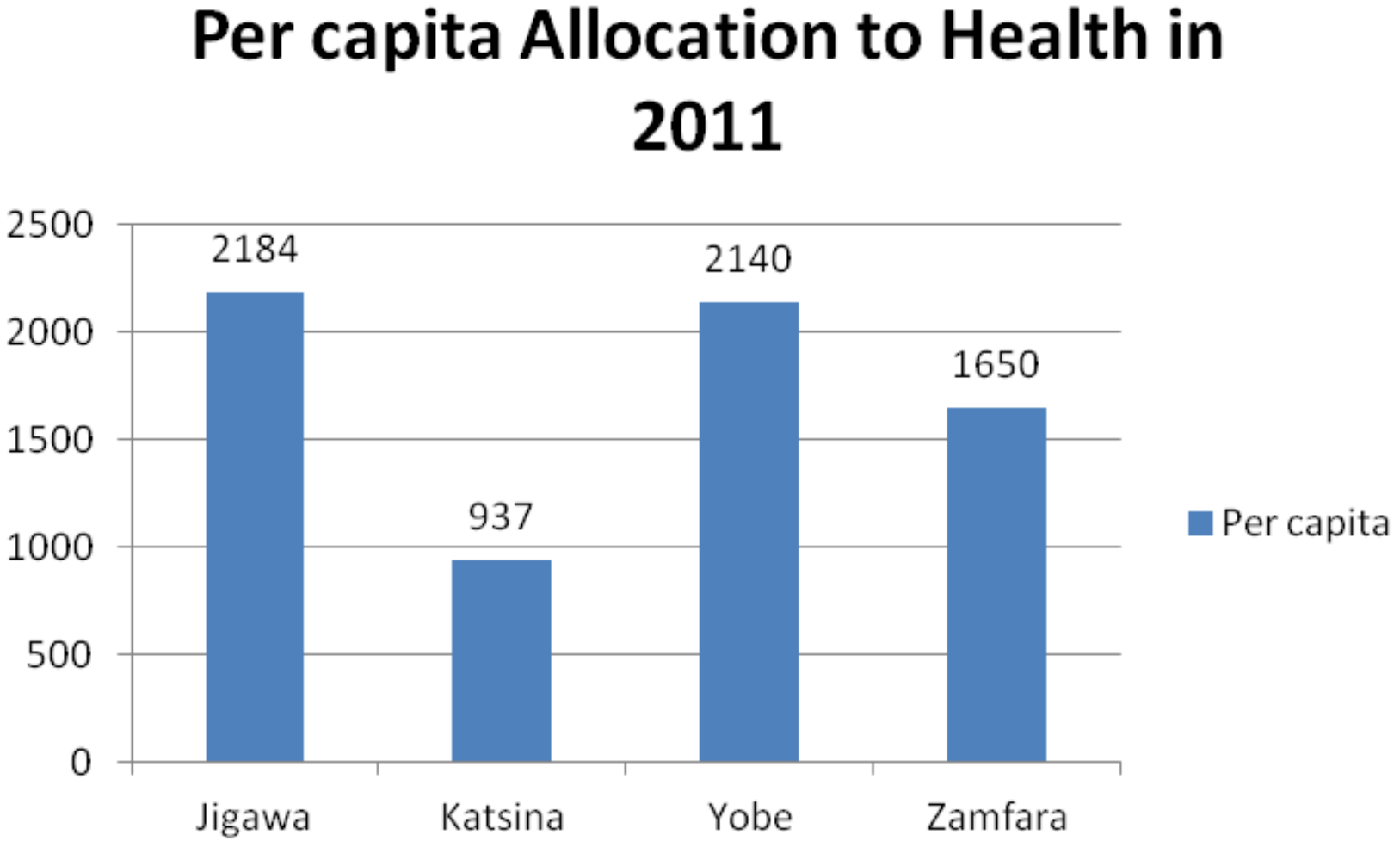

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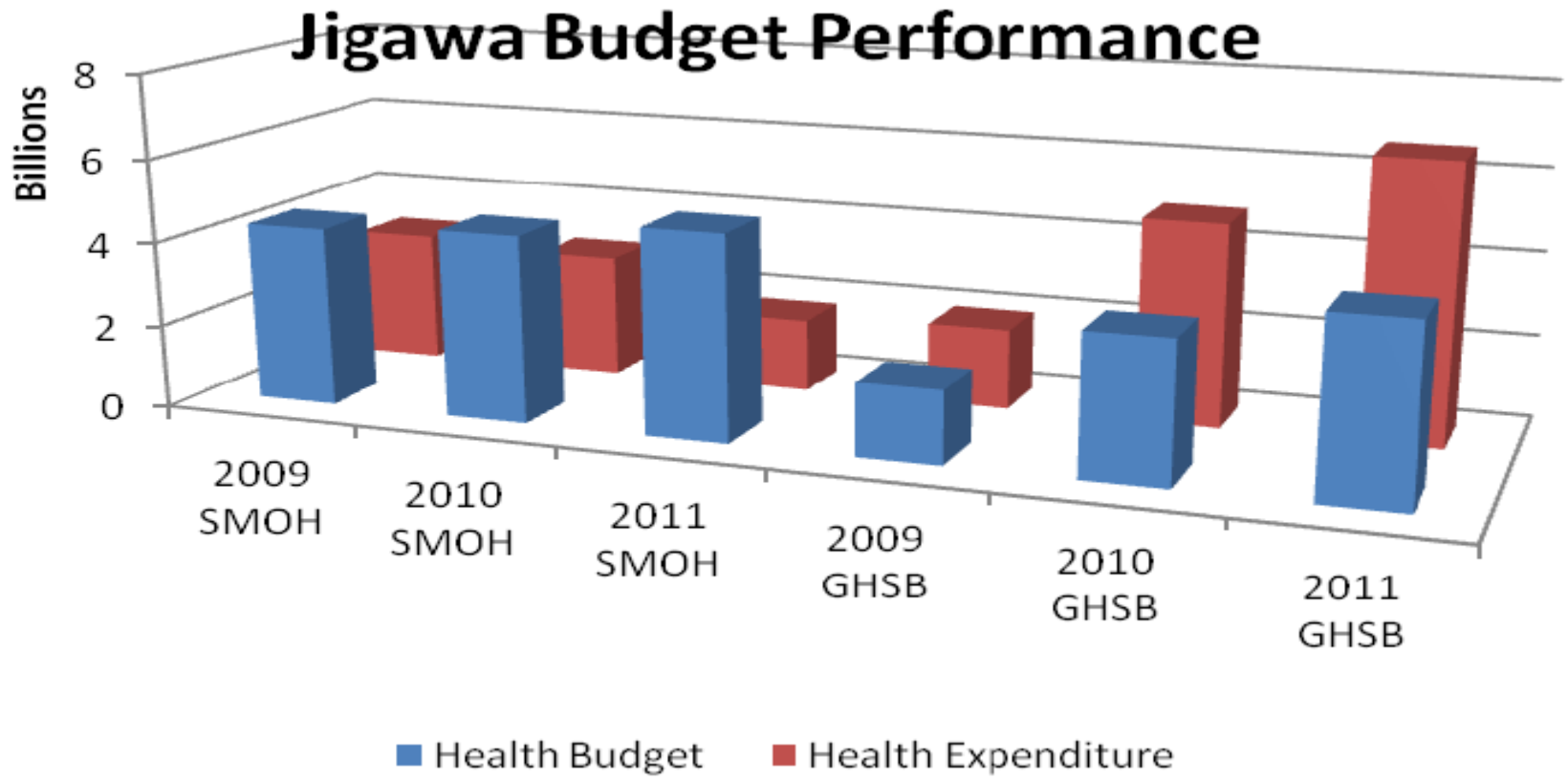
Budget Performance - Jigawa

2007	2008	2009	2010	2011
76%	93%	81%	91%	93%



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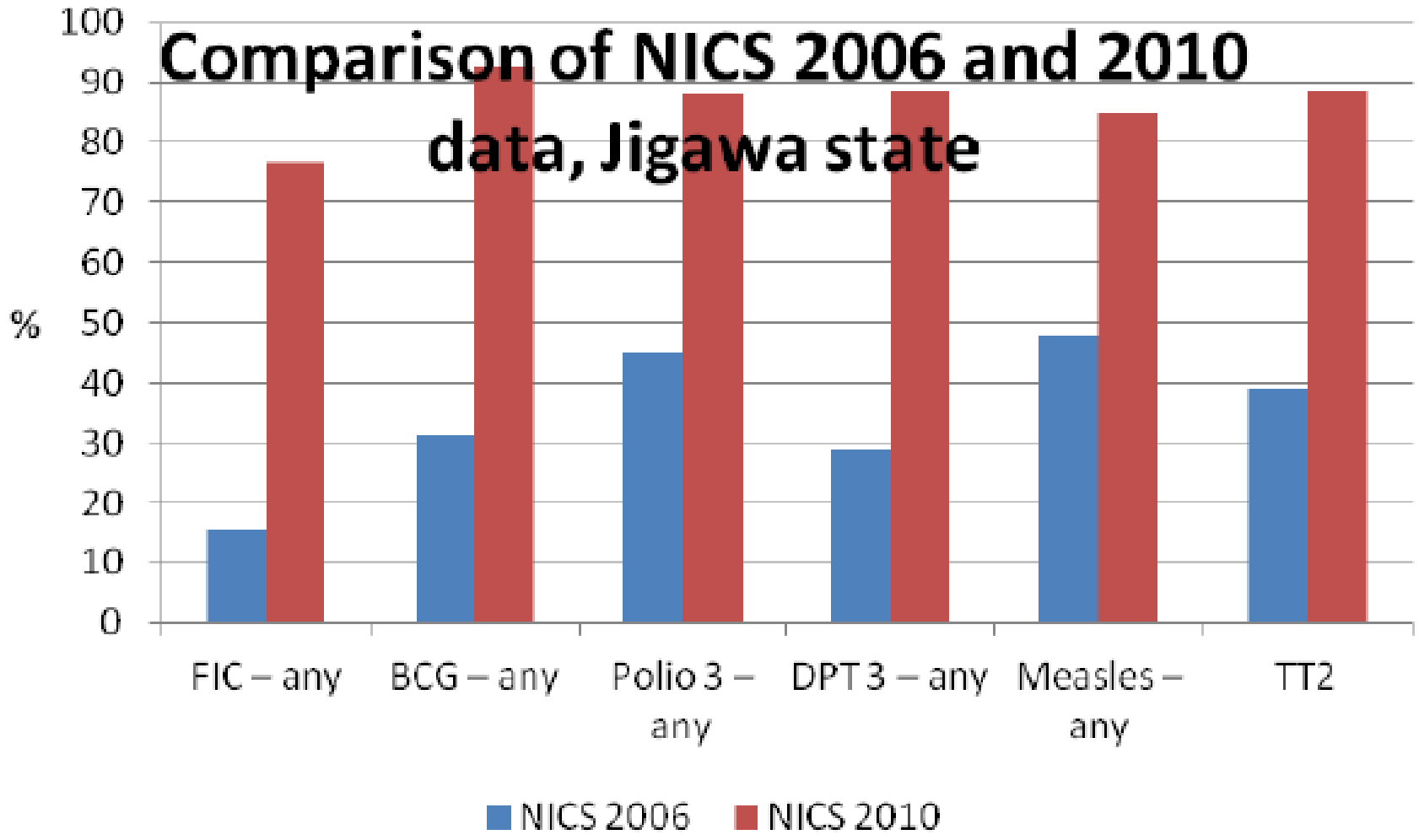

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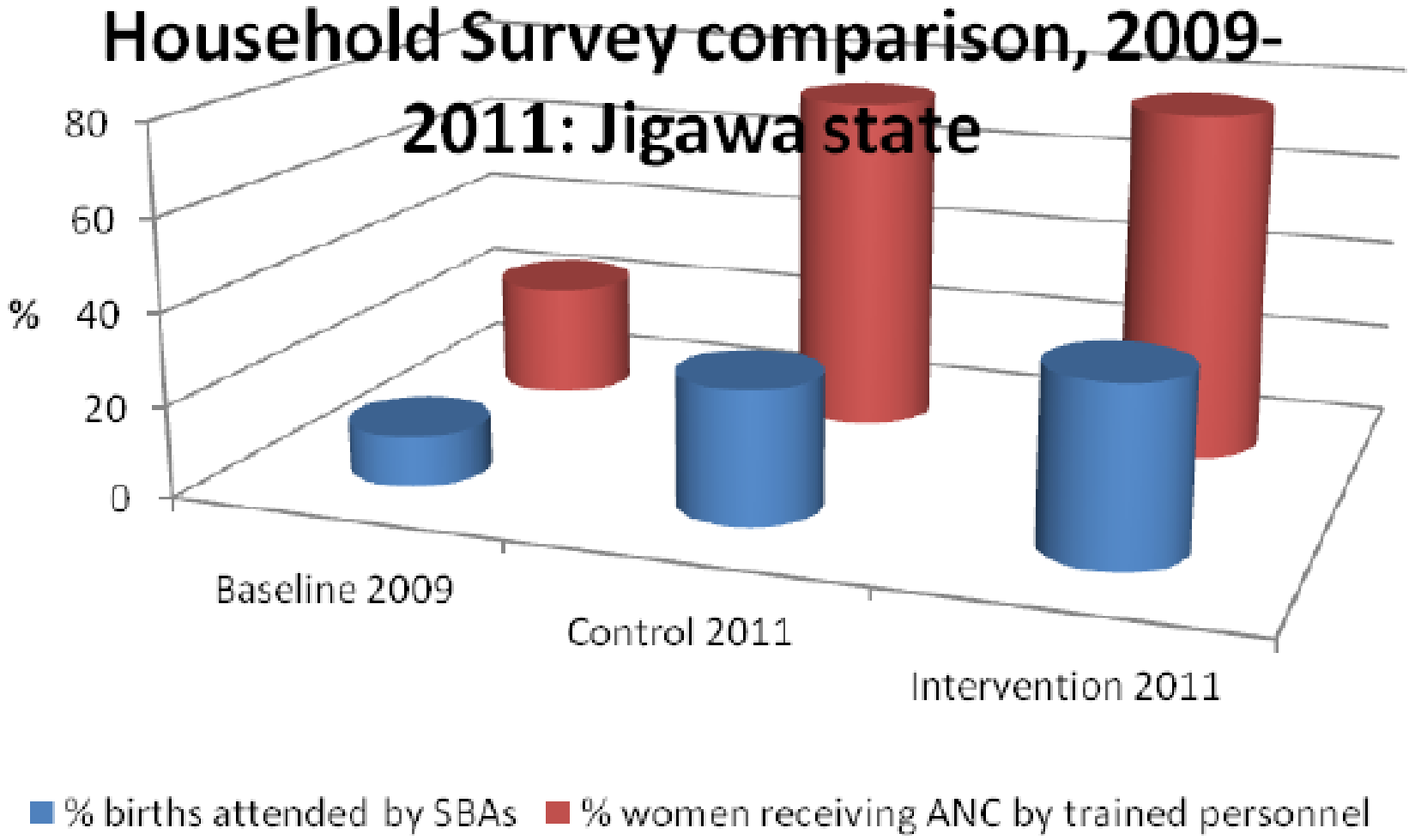

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Three examples – Enhancing access to GAVI

- GAVI funds available for supporting immunisation
- Northern states – one tranche states
- Dual track approach to addressing problem
  - States: systems/capacity to access and retire
  - Federal: systems to manage system
- All PRRINN-MNCH supported states now access and retire GAVI funds

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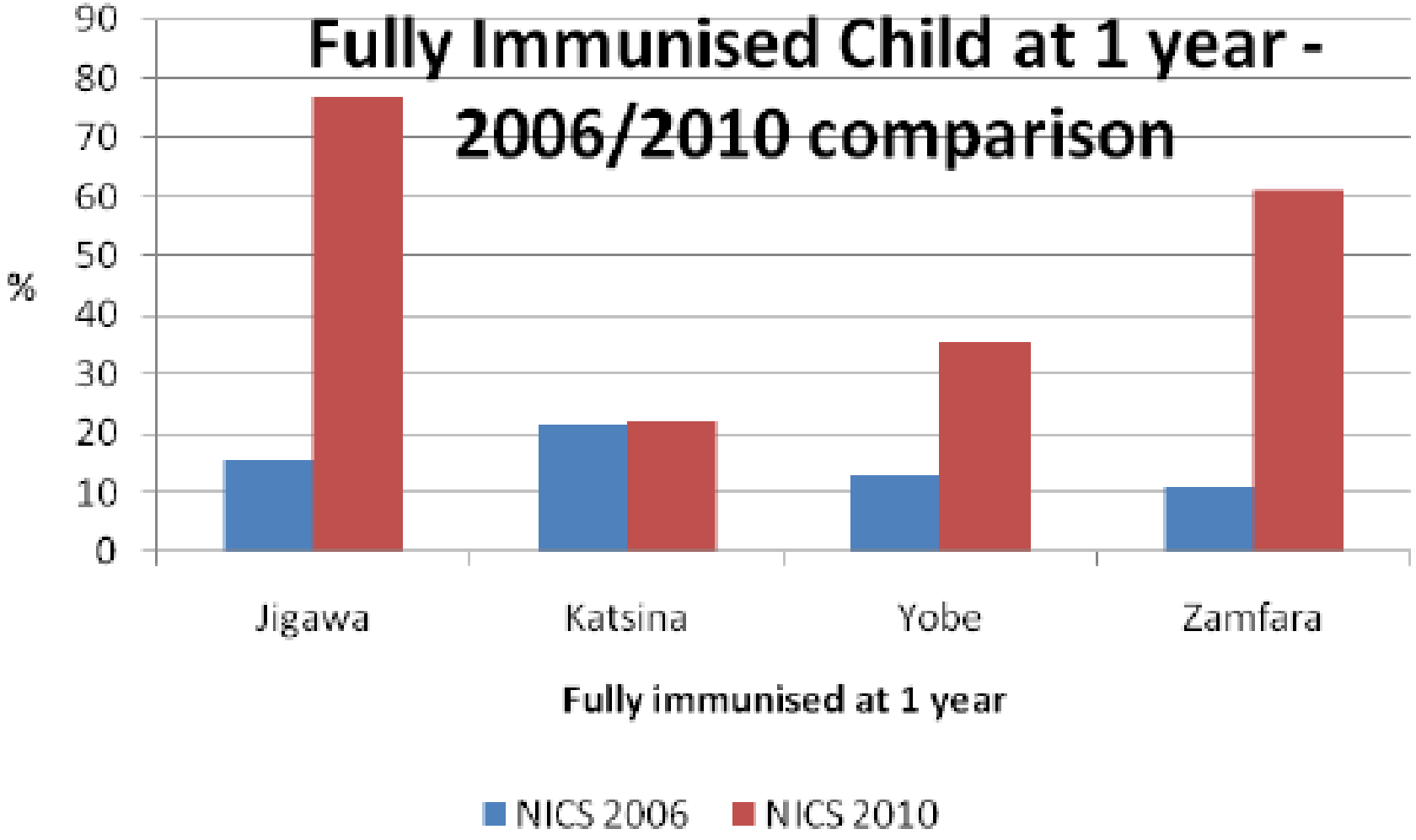

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Three examples – Midwives Service Scheme

- NPHCDA initiative using MDG funds
- Retired and unemployed midwives
- Needed state and federal level participation
- Dual track approach:
  - State level: negotiations, induction, inservice training
  - Federal level: developing tools – baseline, supervision; joint planning and assessment
- States documented improvements in services

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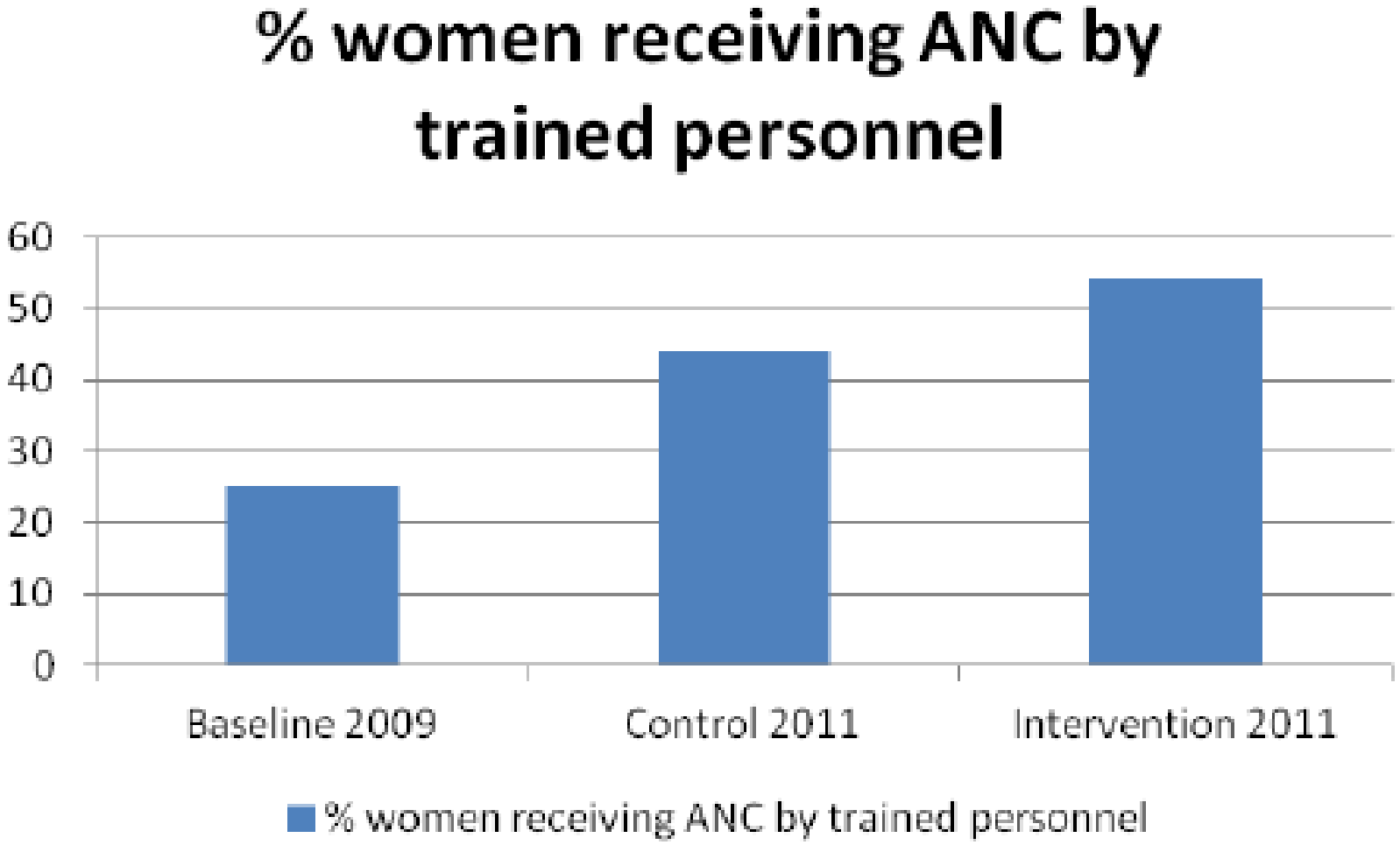

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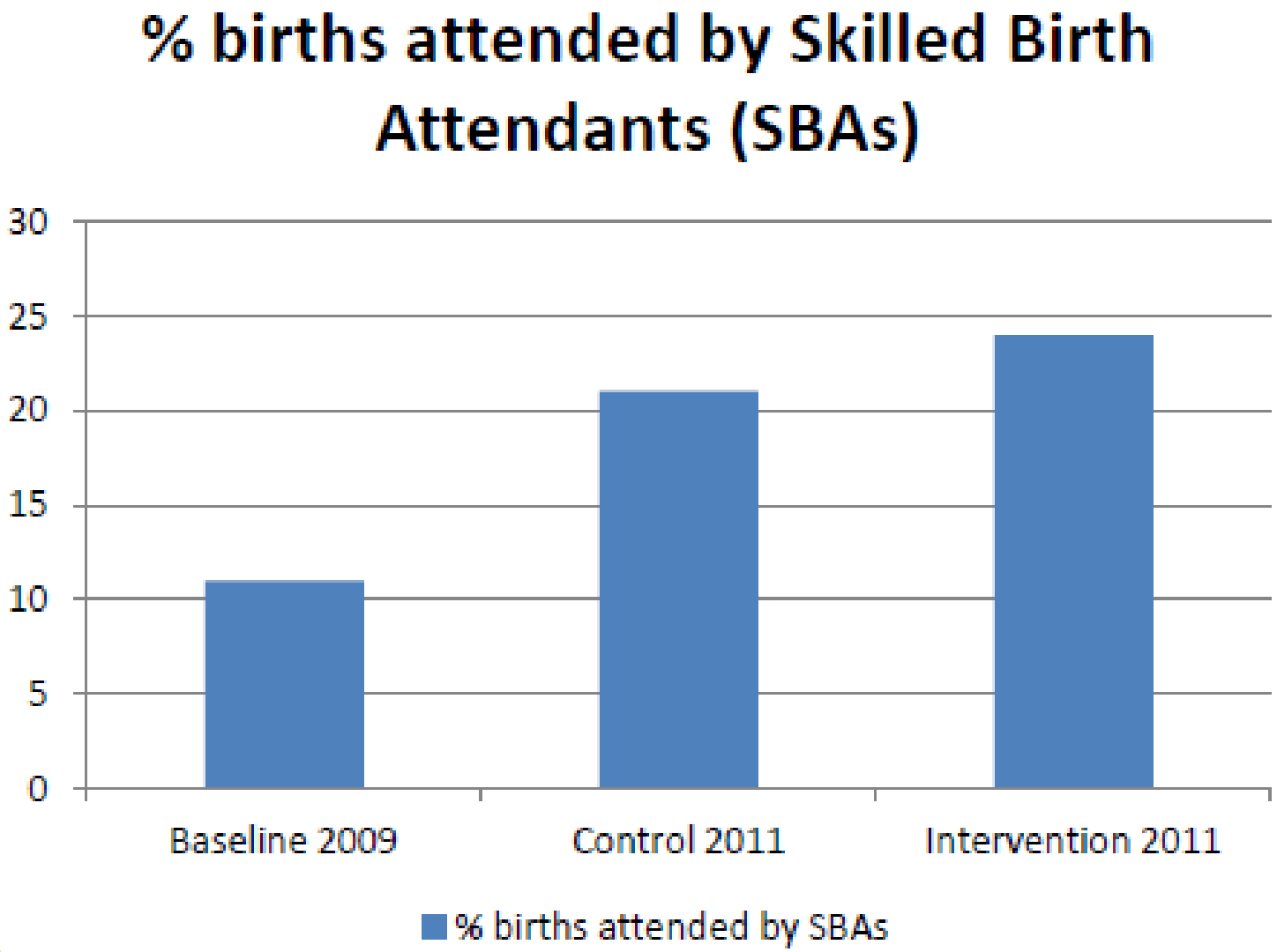

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The three examples illustrate strategies for minimising the policy implementation gap through reducing fragmentation in health systems and stress:

- Governance/systems interface
- Dual track approach
- Internal/external mix in approach
- Length of time needed

What of the theoretical underpinning

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- **health systems** are open systems
- **Interdependency** of the components of the health system
- **Influence** on each other in a non-linear fashion;
- **unpredictable** of the ripple effects
- **Approach –** apply whole system view

Complexity Theory model

- **Structure**: Power relationships between groups in and outside the state, generally based around material, political or ideological interests.
- I**nstitutions:** The rules (either official or generalised in practise) which help to ensure that the interests of elites are sustained, or through which these relationships may be broken down
- **Agents**: Individuals & organisations whose activities are influenced by, & may influence, the structures at at a given time.

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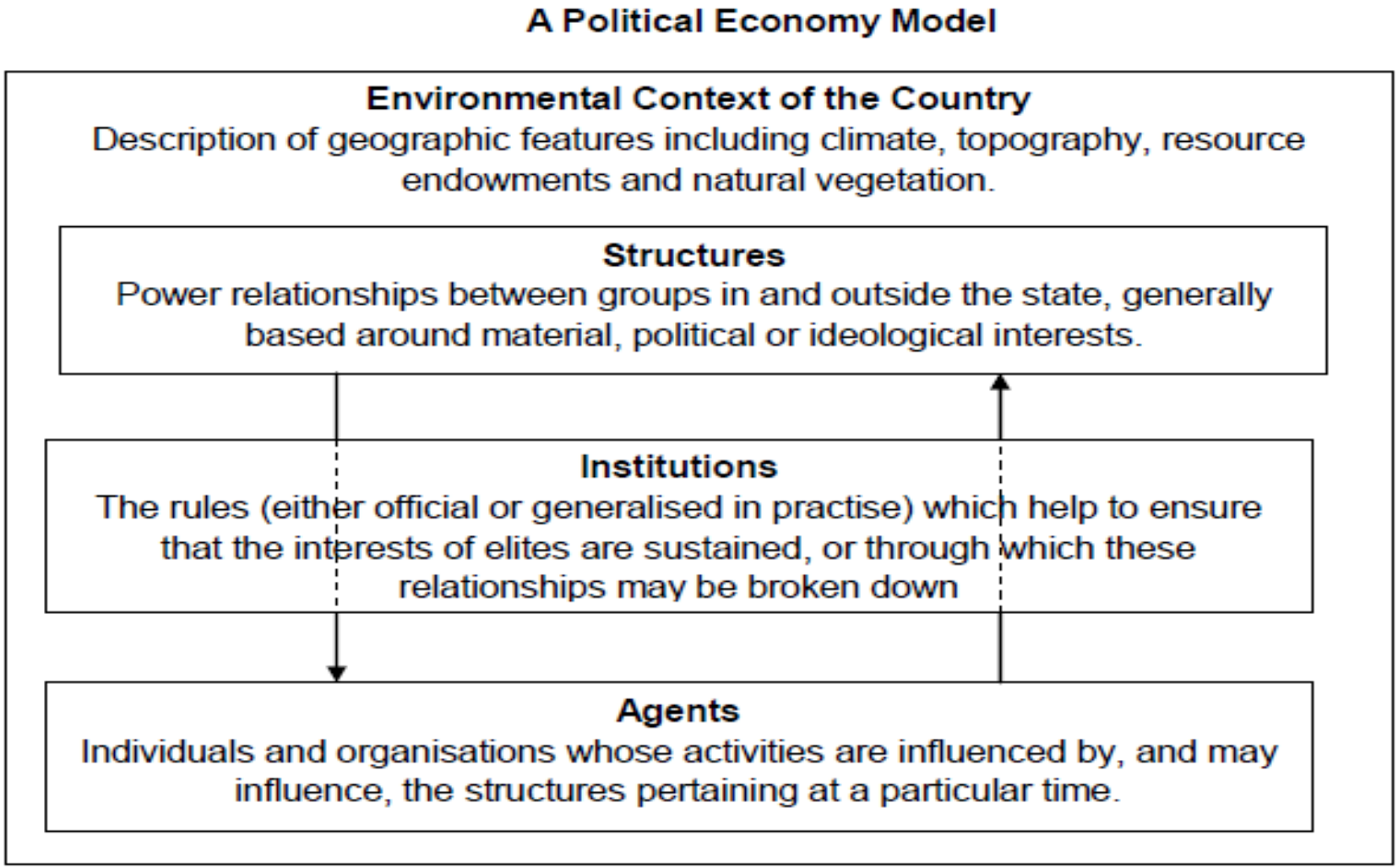

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Thank You