

Strengthening the Policy Implementation Gap - State/Federal working relationships in the Nigerian health sector

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2. Context

This case study describes interventions over the last decade in Nigeria and particularly efforts to strengthen health systems in the north of Nigeria. Northern Nigeria has some of the worst health indices globally. Recent security issues (related to Boko Haram) have aggravated a fragile situation. The case study discusses interactions between the Federal and state levels in implementing and strengthening policy changes.

3. Brief description of the intervention

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} As outlined in the 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 the reality on the ground is different⁷, especially as the policy is not backed up with adequate legislation.

If health is a concomitant responsibility and the roles and responsibilities of the tiers are not clear then it can be difficult for innovations, new policy directions, experience developed and planned activities to permeate from one level to the next. For example, how do practitioners who are operating on the ground within states or LGAs influence federal level policy makers and other states? Or, how do Federal level policy makers ensure that activities emanating from new policy directions are implemented across the three tiers of government? This case study will discuss this interaction using three examples:

- Bringing PHC under one roof
- Enhancing access to GAVI (Global Alliance for Vaccines and Immunisation) funds
- Strengthening the Midwives Service Scheme (MSS)

The first example, illustrates how concepts and experience developed at subnational level have been utilised to influence national policy and practice; the second example illustrates how state level experience of an international agency's funds was used to drive changes in how the funds are administered and accessed at federal level; while the third example illustrates how state level practitioners can assist in supporting and adding value to nationally conceived and nationally driven plans.

What emerges is a more nuanced understanding of how policy is developed and implemented across tiers of government.

4. Brief description and reflection on the challenges encountered

Bringing PHC under one roof⁸

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 level⁹ (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 2005.¹⁰

However, the health system was increasingly fragmented and was a mishmash of centralisation and decentralisation.^{11,12,13,14} The fragmentation in the public sector is both vertical and horizontal.¹⁵

In the early 2000s, following the return to democracy after years of military rule, there was a renewed interest in health policy development and legislation.^{16,17,18} At Federal level, the revised National Health Policy was developed in 2004 and draft health legislation formalised. The legislation better defined the role of the three tiers of government and encouraged the formation of State Primary Health Care Boards. These Boards were to be substantially funded.¹⁹ Unfortunately, the legislation (although passing through both Houses of Parliament) has yet to be signed into law. At the same time at state level, several states explored developing district health systems or 'Bringing PHC under one roof' approaches.

In 2011, the National Council for Health, the highest policy body in the country, adopted the policy document and implementation guide on 'Bringing PHC under one roof'²⁰ and encouraged the 36 states to proceed in implementing this concept.

Three key issues²¹ are being addressed by the policy and legislative changes:

- Firstly, health services are being integrated; particularly PHC services where previously all three tiers of government were involved in implementation.
- 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.

This case study will highlight the process adopted in advocating for the adoption of a policy on bringing PHC under one roof and how the outcome of integrated health services (at least of PHC) was achieved.

Enhancing access to GAVI funds

GAVI had made funds available to Nigeria to strengthen the immunisation system. The funds were managed at Federal level. The northern states in Nigeria have some of the worst immunisation coverage data in the world. Following initial engagement in the states, it was realised that several states were able to access the first tranche of the GAVI funds, but as they were unable to retire the monies appropriately, this was their limit. From 2007, the PRRINN-MNCH programme started, at state level, supporting the State Ministries of Health to effectively retire and access ongoing funding tranches from GAVI. This work shifted to the federal level where PRRINN-MNCH assisted the GAVI office in NPHCDA (National Primary Health Care Development Agency) to review the processes and tools for accessing and retiring the funds and participated in developing a set of master trainers who train across all states in Nigeria. This example illustrates how state level experience of an international agency's funds was used to drive changes in how the funds are administered and accessed at federal level. Initial work started within the states to ensure that the proposed system would work. Later this was taken up to federal level where capacity was built to maintain and roll out the 'new' system.

Strengthening the Midwives Service Scheme (MSS)²²

The NPHCDA initiated the MSS using funds from the Millennium Development Goal (MDG) fund. Nigeria has a very high maternal mortality ratio, low antenatal attendance and births

attended by skilled birth attendants. The MSS was a federally conceived and driven scheme to place retired and unemployed midwives in health facilities. Later this was extended to Community Health Extension Workers (CHEWs). PRRINN-MNCH has supported the states it works in to implement this scheme.

This third example illustrates how state level practitioners can assist in supporting and adding value to nationally conceived and nationally driven plans. In this case the NPHCDA had no jurisdiction but clearly needed support to implement a very laudable scheme with exceptional results.

Data and results from all three examples will be shared to illustrate outcomes and impact of the three initiatives.

5. Reflection on the (possible) contribution to conflict transformation

The governance and systems work in Nigeria 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.

The examples illustrate different aspects of strengthening the policy implementation gap. Strengthening state and federal interactions and interlinkages has allowed for key policies to be developed and implemented more effectively.

6. Evidence of impact of intervention on health, health system, and/or conflict transformation

One of the problems of systems and governance work is how to interpret whether the results are directly attributable to the interventions. However, compelling evidence will be shown that illustrates impact. In the first example, bringing PHC under one roof, the process will be described on how work at state level has been adopted by Federal government and rolled out to 21 of the 36 states of Nigeria. The second example, access to the GAVI fund, illustrates the interaction between state and federal levels to improve systems for accessing funds and subsequent increased use of these funds. While the third example will highlight changes in service delivery consequent to the implementation of the MSS scheme.

Data on increased state access to GAVI funds and on increased skilled birth attendants at birth and increased ANC attendance will illustrate some of the changes.

Changes will be analysed against the components of complexity theory and seeing health systems as complex adaptive systems (described below) and linked to the drivers of change/political economy approach to understanding change as alterations in the power balance between structures, institutions and agents.

7. Other relevant information

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 how to strengthen health systems. The three chosen examples illustrate aspects of this framework/theory of change. The examples and the results 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 system²³; '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).²⁴ 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.

¹ PRRINN-MNCH is the Partnership for Reviving Routine Immunisation in Northern Nigeria, Maternal Newborn and Child Health programme; HPI is Health Partners International

² Zhou Y. Strengthening Local Governance in Nigeria: Issues and Options for the World Bank

³ Freinkman L. Inter-government Policy Coordination and Improvements in Service Delivery

⁴ Barron P, McKenzie A, Kumba J. Policy Note for health: Better inter-governmental coordination in the delivery of health services: Issues for analysis

⁵ Khemani S. Local Government Accountability for Health Service Delivery in Nigeria

⁶ Ibid (Barron)

⁷ McKenzie A and Sokpo E Draft Paper

⁸ For more details see McKenzie A and Sokpo E draft paper

⁹ Ibid (Khemani)

¹⁰ Ibid (Freinkman)

¹¹ Ibid (Barron)

¹² Ibid (Freinkman)

¹³ Enyimayew N, McKenzie A. Developing Integrated and Decentralised Health Systems

¹⁴ Health Sector Reform Program. Strategic Thrusts; Key Performance Objectives; and Plan of Action 2004 – 2007

¹⁵ Memorandum to the National Council for Health: 'Bringing PHC under one roof' (PHCUOR) in line with the requirements of the new national health bill

¹⁶ Ibid (Health sector reform program)

¹⁷ Revised National Health Policy. Federal Ministry of Health (2004)

¹⁸ National Health Bill (2011)

¹⁹ Ibid (Barron)

²⁰ Ibid (Memorandum to the National Council for Health)

²¹ For more details see McKenzie A and Sokpo E Draft paper

²² Extracted from the PRRINN-MNCH Annual Reports for 2011 and 2012 available from www.prrinn-mnch.org/

²³ Dattee B, Barlow J. Complexity and whole-system change programmes

²⁴ Paina L, Peters D.H. Understanding pathways for scaling up health services through the lens of complex adaptive systems.