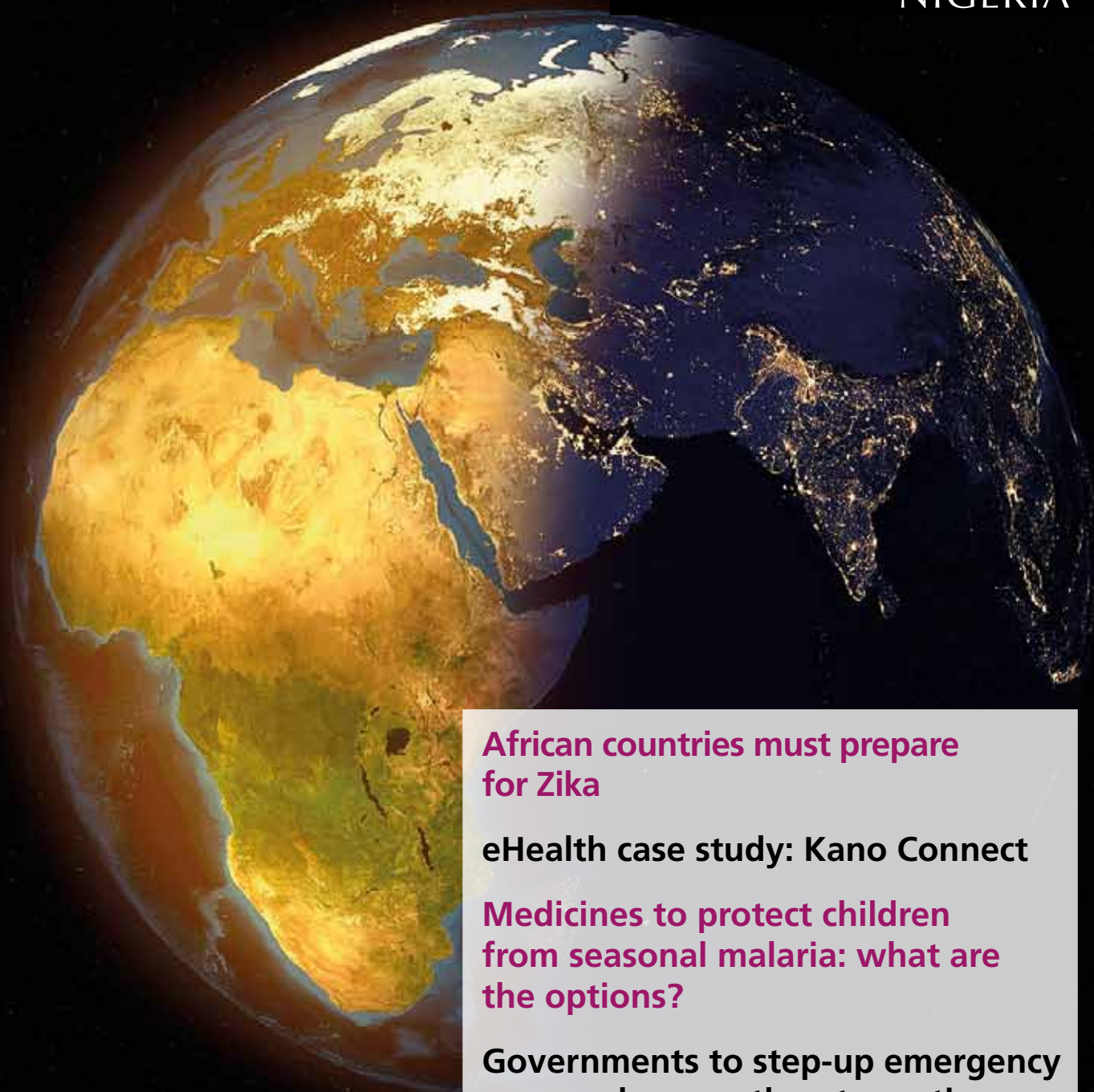


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Editors

Dr Tarry Asoka

Medical Doctor and Health Management Consultant. Based in Port Harcourt
Email: tarry@carenet.info

Shima Gyoh

Dept of Surgery, Benue State University, Makurdi, and ex Chair of the Medical and Dental Council of Nigeria (MDCN).
Email: shimagyoh@gmail.com

Dr Chikwe Ihekweazu

Consultant Medical Epidemiologist who also blogs on Nigerian health issues at www.nigeriahealthwatch.com
Email: chikwe@nigeriahealthwatch.com

Felix Obi

Physiotherapist and Health Policy and Management Consultant who lives and works in Abuja
Email: halal3k@yahoo.com

Can Primary Health Care survive in a broken Local Government Authority environment?

Concerned with the magnitude of health problems and inadequate and unjust distribution of resources on a global scale, 'Primary Health Care' (PHC) was presented almost four decades ago, as a pragmatic answer to these public health challenges. Though a concept also rooted in ideology, the thirtieth World Health Assembly in promoting the PHC idea in May 1977 decided that governments and World Health Organization (WHO) should enable all citizens of the world to attain, by the year 2000, a level of health which would permit them to lead socially and economically productive lives.

Nigeria like most low- and middle-income countries started the PHC era with low accessibility of services and low coverage. By implementing vertical programmes and interventions, many were successful in extending coverage in the 1980s and '90s, as long as governments and/or donors provided continuous support. In Nigeria for example, the childhood immunisation coverage during this period was over 80%. To sustain this level of progress, engender community involvement and ownership; PHC became the basis of the Nigeria national health policy, with Local Government Authorities (LGAs) given the responsibility to implement PHC at the community level. But an increasingly dysfunctional local Government system in Nigeria has led to unnecessary donor interference and the gradual takeover of the role of LGAs in PHC delivery by higher tiers of government (States and Federal). For example, even as the Federal government promotes the policy of streamlining the organisation and financing of PHC at the State level through the institution of State PHC management Boards or Agencies, it has developed advanced plans of directly intervening in mobilising 10 000 PHC facilities nationwide.

The three articles in this thematic issue focus on 'PHC in a broken LGA environment', and examine some of these concerns and reflect on their impact on sustainable PHC delivery at the community level. The first is a commentary that takes us through memory lane: from the origins of PHC in Nigeria to the shattered state of the LGA system and the violation of many principles of PHC. The next piece expands the narrative of the PHC journey, but in relation to the way Development Agencies (donors) tend to promote their agendas over and above local priorities, in the face of a failing LGA system. While the last article considers the manner in which the roles and responsibilities assigned to the LGAs in PHC implementation are being absorbed by the State PHC Management Boards as a result of the ineffective LGA system. The fundamental question this issue is grappling with therefore is whether PHC could thrive and prosper in an environment with these weak institutional features, without fixing the damaged LGA system in Nigeria. The resurgence of the wild polio virus after two years of lull should raise the alarm bells that it may be futile to sustain progress in PHC without a strengthened LGA capacity.

In a federal country such as Nigeria, in which vertical relations between centres of power exists, 'the principle of subsidiarity' should prevail in giving a chance to individuals, communities, groups and even sub-national governments to participate in implementing national policies and legislation; within their sphere of influence. It establishes a situation that does not allow the withdrawal from individuals and commit to the community what they can accomplish by their own enterprise and industry. Similarly, it cautions citizens not to transfer to the larger and higher collective, functions which can be performed and provided by lesser and subordinate bodies. The philosophy underpinning PHC appears to be anchored on such a principle and thus cannot be different in its application. Strengthening the capacity of LGAs to effectively undertake their mandate in PHC implementation along these lines would be crucial if PHC is to survive in Nigeria.

Dr. Tarry Asoka

Finding appropriate roles for the three tiers of Government in Primary Health Care delivery

Shima Gyoh, Permanent Secretary during Professor Olikoye Ransome-Kuti's tenure on Minister, looks back on what was supposed to happen

The father of Primary Health Care (PHC) in Nigeria is undoubtedly Professor Olikoye Ransome-Kuti, who was Nigeria's Minister of Health in the eighties. He had been going round the entire country in the 1970s, working on the Basic Health Services Scheme for the nation, the earlier term for this health activity. After an International Conference on PHC made its famous Alma Ata (formerly USSR but now Almaty in Kazakhstan) Declaration in September 1978, Nigeria, like many other countries adopted this nomenclature for its basic health services. Its principles were suitably adapted for implementation in Nigeria.

Launching in 1988, The National Health Policy had all it took to provide a sound foundation for the country's healthcare system. It prescribed a three-tier health structure for Nigeria, with PHC, including refined traditional medicine as the foundation, secondary healthcare (SHC) consisting of general hospitals as the supporting pillars, and tertiary healthcare (THC), made up of teaching and specialty hospitals at the apex of the healthcare pyramid.

The policy assigned the responsibility of implementing PHC to Local Government authorities (LGA), SHC to State Governments (SG) and THC to the Federal Government (FGN). The guidelines provided that each government should supervise implementation at the lower tier. Nevertheless, the constitution does not recognise such division of labour on health matters but places health on the concurrent legislative list, meaning that each tier of government has the freedom of action on the entire health sector. Because of its basic nature, PHC was misunderstood to be the substitute if one could not afford THC and SHC. With the return to democratic rule, State Governors often boasted about the number of primary healthcare institutions they had 'upgraded' to hospitals, and this still goes on today.

PHC was regarded as something communities did for themselves. Its functions were to be run by village health committees. Its employees would consist of few full-time but mostly part-time workers and volunteers. The essential function of the government was to guide and technically support the communities set up the systems, and thereafter the communities would completely own the services. All external assistance was to be channelled to the communities through their organisations.

Shima Gyoh has held many posts ranging from village doctor to DG of Nigeria's Federal Ministry of Health and Chair of the Medical and Dental Council of Nigeria.

The Federal Ministry of Health (FMOH) therefore chose a few strategically located local governments in which the Ministry, playing the role expected of State Governments, would assist the communities set up model PHC units, which the local governments could study and replicate throughout their areas of responsibility. The main principle was community ownership. The majority of PHC workers were expected to be people who lived in the area and were prepared to volunteer their services, and maybe accept being paid in kind by the community, like assisting with aspects of work on their farms. The communities, long used to governments providing health services, would eventually accept that health is not what anyone else gave you, but what you actively did for yourself. The FMOH created the National Primary Health Care Development Agency (NPHCDA) to continue with its role. This agency was never meant to run PHC services, but to catalyse their development as its name implies. The new National Health Act gives it the function of disbursement of PHC funds. Since communities are expected to run their PHC services, decentralisation is the best method, but it can be hardly avoided if the Federal or State Governments play roles beyond technical support.

Other important principles of PHC were also violated. PHC workers continued to be recruited outside and sent to the communities on salaries the communities could not sustain. Their loyalties were to the people that recruited and paid them. Then the State Governments, rather than assist the communities, tended to reproduce the civil service structures with their devotion ranks, promotions and allowances. Existing



community development associations, which should have been used, were ignored, and attempts made to establish new committees, which further prevented the communities from true ownership of the system.

The most serious roadblock to implementation of PHC is the emasculation of local governments in nearly every State of the federal republic. State governments frequently exercise the power to dissolve local governments and supervise the election of new ones. The Constitution provides that local governments be run by elected officials, but an editorial of *This Day* newspaper (16 March 2012, page 15) lamented the revelation of Kabiru Gaya, then Chairman of the Senate Committee on State and Local Governments that out of the 774 local governments in Nigeria, 540 were run by 'Caretaker Committees' who were in effect the hand-chosen cronies of State Governors. Most State Governors would not go into an election without first dissolving the local governments and positioning their agents as caretaker chairmen who would ensure their victory. On assuming office, governors tend to sack local government councils, whether they were elected or appointed by their predecessors, without feeling they have an obligation to explain to the citizens the rationality for such action. They then appoint their cronies as caretaker chairmen and councils. It has become the standard way in which State Governors establish their grassroots support. They also appropriate the resources of the local governments with impunity.

Originally, some of the dismissed Chairmen and Councillors went to court. Without the positive support of the Federal Government, these officials ended up

losing, whether or not the court ruled in their favour. Thereafter, the State Governors regarded them as foes and attempted to ruin their political careers. These days, the local governments are left entirely to the mercy of State Governors. It is also an open secret that most State Governors would be happy if the local governments were legislated out of existence, as questionnaires have shown on several different occasions.

To save PHC and ensure success for the present government's plan to resuscitate it, the authorities responsible for its implementation should be spelt out. They need not be the same everywhere in the country: the principle of federalism allows for that. PHC naturally falls into the responsibilities of local governments and they should be vibrant and elected, and their frequent dissolution before the expiration of their tenure should be restricted by regulation and law. Their subventions should be direct and not mixed up with that of the State Governments.

Of course the Minister of Health cannot do this on his own. He must join forces with the appropriate ministers and the presidency, do robust lobbying and raise a powerful, perhaps joint memorandum with the Ministry for Local Government to the Federal Executive Council to ensure that urgent action is immediately taken. The changes needed can in fact be done within the present Constitutional provisions if applied responsibly, but if further amendments are needed, they can be done without delaying urgent action needed to strengthen local governments and permit PHC take roots throughout the nation within the shortest time.

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Implementing frontline Primary Health Care services: local priorities versus donor-driven agenda

Felix Abrahams Obi traces the bottle-necks and disputes that have thwarted the emergence of a robust primary care system

Nigeria transitioned into the 21st century with one of the weakest health systems in the sub-Saharan African region. The 2000 World Health Organization (WHO) ranking of the health systems of member nations placed Nigeria 187 out of 191 countries - only ahead of three countries; the Democratic Republic of the Congo, Central African Republic, and Myanmar.¹ As the 'Giant of Africa', Nigerians felt ashamed and scandalised with this poor ranking, and it was imperative that comprehensive reforms were necessary to turn around the country's poor health indices. With the transition from decades of military rule to civilian democracy in 1999, hopes were high that the health sector, especially the Primary Health Care (PHC) system would receive considerable focus.

But the state of healthcare services in Nigeria has not always been a bleak one. For instance, Nigeria achieved the universal child immunisation target of over 80% in the 1980s through the PHC system.

The foundation of Nigeria's PHC system was laid in the mid-1970s through the establishment of the Basic Health Services Scheme (BHSS) ahead of the Alma Ata Declaration of 1978. The adoption of the Bamako Initiative by African Ministers of Health in 1987 further strengthened the framework for strengthening the PHC system in Nigeria. Between 1986–1990, Prof. Olikoye Ransome-Kuti, who was the father of PHC in Nigeria, initiated the establishment of Schools of Health Technology to train junior cadres of health workers for the provision of services at PHC facilities. These efforts resulted in the expansion of PHCs from the 52 pilot LGAs in 1986, funded by the Federal Government to all LGAs in Nigeria by the early 1990s. Subsequently, the responsibility for PHC services was devolved to the LGAs, which was articulated also in the 1988 National Health Policy, which had PHC as the pillar of Nigeria's health system. And by 1992, the National Primary Health Care Development Agency (NPHCDA) was established to coordinate the PHC services based on the recommendations of the WHO High-Level Review Team.

Despite the laudable initiatives to strengthen the PHC system in Nigeria, the seeds that led to its gradual collapse were sown also within the same period. For instance, the National Programme on Immunisation (NPI) was established in 1996 to replace the Expanded

Programme on Immunisation (EPI), which was launched in 1979 with the aim of achieving Universal Childhood Immunisation (UCI) against childhood killer diseases.² With time NPI as an institution rose in ascendancy over and above NPHCDA, especially with the global push for polio eradication, thus displacing the strategic focus of strengthening and improving the delivery of PHC services in Nigeria. By the mid-1990s, the collapse of the PHC system had commenced with the reversal of the progress achieved in immunisation services coverage of up to 80% for all antigens recorded during the Universal Childhood Immunisations (UCI) days (1986–1990s).³ In 1996, the national immunisation coverage had decreased to less than 30% coverage for all antigens, which further decreased to about 12.9% by 2003, according to findings of the National Immunisation Coverage Survey.⁴ According to Prof. Eytayo Lambo, the PHC success was short-lived due to the withdrawal of support from donors to PHC during Gen. Abacha's military dictatorship without a strong political commitment to PHC development by the three-tiers of government between 1993 to 1999. Although donors like WHO, UNICEF and DFID continued to support NPHCDA in the process of PHC devolution, Prof Lambo suggests that factors such as instability in governance, lack of visionary leadership, low staff morale, and lack of preparedness by LGAs to shoulder the responsibilities associated with the devolution of PHC further contributed to the collapse of PHC system in Nigeria.⁵

The year 2003 is epochal owing to the mass rejection of polio immunisation in the northern States of Nigeria, triggered by key elites and highly respected opinion leaders in the North who had become wary of the undue focus on polio immunisation by donors over and above the delivery of essential PHC services.⁶ The promotion of polio immunisation campaigns by donors in collaboration with NPI had unwittingly sowed the seeds of suspicion among beneficiaries, especially in Northern Nigeria.⁷ With the mass rejection, Nigeria eventually exported the wild polio virus to 20 countries in Africa, Middle East and South-East Asia leading to a global outbreak.⁸ Huge resources were deployed by donors and the Nigerian Government for the expensive diplomatic and remedial actions, which involved religious and traditional leaders, who should be custodians of a functional PHC system.

This is a classic case of donor priorities at variance

Felix Abrahams Obi is a Physiotherapist and Health Policy and Management Consultant who lives and works in Abuja



with local priorities. Rather than promote routine immunisation anchored on a strong primary healthcare system, enormous resources were channelled into conducting countless polio immunisation campaigns, at the expense of routine immunisation and provision of essential services for priority diseases affecting children and vulnerable populations. With time Nigeria and its donor partners had to review the strategy and introduced the National Immunisation Plus Days (NIPDs), which ensured 'add-ons' like deworming drugs, Vitamin A supplements among others were included in the bouquet of services provided to children and mothers during immunisation campaigns.

Overall, each national immunisation campaign was an expensive one-off project, with supplemental campaigns repeated several times in a year, depending on the burden of wild polio virus across the high-risk States. Aside the logistical nightmare that the polio vaccination campaign entailed, it progressively weakened the PHC system across the different States in Nigeria. In a country with endemic poverty and poor wages, frontline health workers preferred to participate in the polio campaigns rather than provide services at their respective PHCs because of the incentives that donors paid them.⁹ With health workers gone for days and weeks from their duty posts, most PHCs became redundant and patients in rural areas had to rely on long-trusted alternative providers—patent medicine vendors, traditional medicine healers, and traditional birth attendants. And the vast majority had to head to secondary and tertiary hospitals for minor ailments that

PHC could have handled.

The Health Sector Reform Programme (2003–2007) initiated by Prof. Eytayo Lambo (former Minister of Health) to help in revitalising the weak health system and the 2004 National Health Policy put a focus on PHC as the pillar of Nigeria's health system. However, the reform unduly focused on equipping and refurbishing of tertiary hospitals at the expense of PHCs through the controversial VAMED Engineering project which cost millions. The only notable PHC-related reform appears to be the successful merger of NPI and NPHCDA in 2007, and Prof. Olikoye Ransome-Kuti was invited to chair the board of the new NPHCDA to help in the rebuilding process for both the organisation and PHC in Nigeria. The Ward Health System was introduced with clearly-defined Ward Minimum Health Care Package to be delivered at PHCs in Nigeria. With the development of a Blueprint for the Revitalisation of PHC in Nigeria to cover the period of 2004–2008, PHC it appeared was on the ascendancy. More so, PHCs were beneficiaries of laudable donor-driven or donor-supported initiatives such as the Health Systems Development Projects (bankrolled by the World Bank and African Development Bank), the OSSAP-MDGs Debt Relief Grants through which States constructed new PHC facilities and refurbished existing ones. The Partnership for Transforming Health Systems (PATHS) funded by DFID also supported selected States to improve their PHC system, by introducing the District Health System in Enugu, while Jigawa adapted the concept into the Gunduma System; both widely celebrated as

groundbreaking reforms. Sadly, Enugu State discarded the District Health System a few years after, while Jigawa in 2015 scrapped the Gunduma System for under-performance and lack of value added to their health system, replacing it with a State PHC Agency.¹⁰

When the findings of the 2008 Nigeria Demographic and Health Survey were released, the nation was in shock. Nigeria posted one of the highest maternal and infant mortality rates globally. The then First Lady, Hajia Turai Yar'dua and Prof. Dora Akunyili, feeling scandalised by the poor performance, openly disputed the maternal mortality rate attributed to Nigeria during the official launch of the 2009 State of the World Children Report at the UN House in Abuja.¹¹ But to all and sundry, it was obvious Nigeria had made little or no progress in the health-related Millennium Development Goals (MDGs). And this gloomy state of health outcomes was captured in the States' scorecard developed by the Federal Ministry of Health, which Prof. Babatunde Osotimehin (former Minister of Health) shared with State Governors during the first Presidential Summit on Health in November 2009. At the summit, President Yar'dua, State Governors and representatives of Donor Agencies signed a health compact for joint accountability on delivering improved and measurable results and targets set in the 2010–2015 National Strategic Health Development Plan (NSHDP); the health component of the Vision 20:2020.¹² The first Joint Annual Review of the NSHDP late 2010 showed that donors haven't quite aligned their programmes with the priorities set in the NSHDP save for the UN group that sought to harmonise their projects in pilot States.

The NSHDP implementation provided NPHCDA the opportunity of attempting to institutionalise a novel initiative called PHC Planning and Reviews¹³ in 2011. It uses the 'Bottleneck Approach' to help identify and address service delivery (both demand and supply-side) constraints or bottlenecks in all PHCs in Nigeria, and also incorporates plans for addressing the capacity building of State and LGA health teams in the implementation and monitoring of planned activities. The PHC Planning and Reviews. If well implemented, the initiative was to help increase State/LGA ownership and capacity while assuring evidence-based planning, implementation as well as monitoring and evaluation of PHC services.

With limited donor support, the initiative has yet to be institutionalised across the 36 States save for Kaduna State, which continues to conduct PHC planning and reviews with available resources. The Midwives Service Scheme (MSS) and SURE-P MCH initiatives, which started in 2009 and 2012 respectively, with the aim of addressing critical human resource gaps at selected PHCs, have also suffered a similar fate. It was also hoped that the Saving One Million Lives (SOML) initiative, which started in 2012, would help address weak PHC systems and strengthening them to increase access to priority health services with the target of increasing utilisation rate of skilled birth attendants up to 80% by 2015. As the MDGs came to an end in 2015, Nigeria shamefully did not meet the expected targets despite the huge resources spent by donors and the government. Stakeholders have always doubted the sustainability and scalability of donor-driven

PHC strengthening initiatives such as the Nigeria State Investment Programme (NSHIP) and SOML (phase 2), funded by The World Bank, the Programme on HIV/AIDS Integration and Decentralisation (PHAID), and Community in Action (CIA) by US government, the Integrated Service Delivery Initiative, and Accountability Framework for Routine Immunisation (AFRIN) supported by GAVI, among others.

For Nigeria to meet the health-related Sustainable Development Goal targets, there has to be a strong alignment between government priorities and interests of donors. The 2015 National Health Act provides that the Basic Health Care Provision Fund (BHCPF) shall include donor funds in addition to the 1% consolidated revenue of the Federal Government. For this to happen, however, the mutual distrust between donors and government has to be interrogated to find a viable way of pooling funds and resources needed to implement priority programmes for strengthening the PHC system such as the Primary Health Care under-one-roof (PHCUOR). A lot of lessons can be gleaned from the running of the Emergency Operation Centres (EOCs),¹⁴ which helped in the push against polio remains a useful model of joint collaboration between the government, and donors that can be explored for wider PHC systems strengthening. The year 2016 provides a unique opportunity for the convergence of the interests and priorities of the Nigerian government and donors with the drafting of the new 2016 National Health Policy, which incorporates the key provisions of the 2014 National Act as the pathway to achieving universal health coverage. Efforts should be made to craft a more realistic new National Strategic Health Development Plan (NSHDP II) for the implementation of the new health policy, through a strong collaboration between government and partners.

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State Primary Health Care Management Boards or Agencies: micromanagement or strengthening Local Government Authority capacity?

Dr. Tarry Asoka describes the current tensions in Primary Health Care delivery. Interventions are needed if another failure is to be avoided

These are the often quoted national health statistics in recent times: maternal mortality ratio estimated at 560 per 100 000 live births¹ accounts for about 10% of global maternal deaths; and under-5 mortality rate assessed at 128 per 1000 live births² is above the sub-Saharan Africa average of 121 per 1000 live births.³

With health indicators remaining below nationally and internationally recognised standards, poor stewardship and governance of the health sector is blamed, as one of the main reasons that has undermined the performance of the Nigerian health system. Fundamentally, this is seen as the result of the fragmented, poorly managed and inadequately financed basic healthcare services, which also have low political profile. But the root causes, which mask these apparent features (and that must be tackled) include: (a) failure of political leaders to invest sufficient effort and resources to improve health services; (b) the structure and organisation of health services that are not fit for purpose; and (c) health workers and managers who lack the capacity to improve the health delivery system. It is possible to overcome some of these problems by streamlining the delivery of Primary Health Care (PHC) at State level by bringing the financing and administration of PHC services under one health authority. So goes the 'theory of change'.⁴

PHC is often seen as an ideology and not as a framework to operationalise equity and health gain in the widest sense.⁵ In Nigeria, superimposed on an institutional context in which the power relationships between the three tiers of government in their collective responsibility for the delivery of healthcare are poorly defined and their respective roles in PHC are not very clear; such a notion created a lot of difficulties as PHC delivery was implemented, especially at the State level.

With minor variations among States, PHC implementation was supported, supervised, monitored and evaluated by several Ministries, Department's and Agencies (MDAs). Notable among the MDAs that interfaced with Health Departments in the Local Government Areas (LGAs) were: the State Ministry of Health (SMoH), State Ministry for Local Government (SMLG), the Local Government Service Commission (LGSC) and in some cases the State Governor's Office.⁶ While this institutional arrangement created a lot of difficulties in supporting LGAs to implement PHC, there was also no setting for generating the synergy

required for effective healthcare delivery at the community level.⁷

Thus in response to the expressed theory of change as outlined above, a national policy to bring 'PHC under one roof' (PHCUOR), with support from donor organisations, was championed and promoted by the National Primary Health Care Development Agency (NPHCDA) - a federal parastatal set up primarily to ensure the institutionalisation and sustainability of PHC in the country. Basically, this policy creates the State Primary Health Care Management Boards or State Primary Health Care Development Agencies aimed at providing technical support and supervision for the development and delivery of PHC.⁸ It is expected that these Boards or Agencies would be responsible for the coordination of planning, budgeting, provision and monitoring of PHC services in each State. Though the implementation of PHC remains with the Local Government Health Authorities (LGHAs), these are to be supervised by the Boards or Agencies. But crucially, the policy aims to ensure that Ministries of Local Government, Local Government Service Commissions, and Offices of Executive Governors cease to have significant roles in PHC implementation.

Linked to the PHCUOR policy is the enactment of the National Health Act (NHA), which provides a comprehensive legal framework for the coordination, administration, financing and governance of PHC services in the country. It incorporates a National Basic Healthcare Provision Fund⁹ that can be accessed by States through their respective State PHC Boards or Agencies. Therefore, other than the desire to establish a single management body with adequate capacity and that has control over services and resources (personnel, funding and material); it could be assumed that another motivation for setting up these bodies by the States is to have a slice of this national largesse.

Nevertheless, experiences in several States in the past five years or so that this institutional reform has taken place are quite instructive. The *Primary Health Care Under One Roof Implementation Scorecard III Report*¹⁰ published by NPHCDA in November 2015, observed: '...28 States now have State Primary Health Care Development Agencies or equivalent institutions with 26 of them having a legal basis for establishment. Content analysis, however, revealed that majority of laws passed and the bills in process are not in conformity with the national guidelines. It was also observed that most States with SPHCDA or equivalent

Dr. Tarry Asoka is a Medical Doctor and Health Management Consultant based in Port Harcourt.

structures, still struggle with repositioning and human resources management as staff are being managed and paid by their parent MDAs. Furthermore, most States with SPHCDA are yet to establish Local Government Health Authorities (LGHAs), which are expected to be the implementing arm of the SPHCDA. Findings reveal that only eight States have collapsed the LGA health departments into LGHAs'.

No doubt a policy reform of this nature in a complex institutional environment such as Nigeria is bound to encounter some difficulties. As some observers¹¹ have noted, the likelihood of getting a policy adopted is assumed to depend not only on the skills and commitment of its advocates (and opponents), but also on the established situation. Therefore, the findings of the recent PHCOUR Scorecard could be attributed to either lack of capacity and resources to implement the policy or institutional hostilities inherent in the Nigerian political economy.^{12,13} However, of greater concern is the nature of the emerging relationship between the State-level coordinating bodies — the respective PHC Boards or Agencies, and their associated implementing entities - the LGHAs. While the operating word is 'supervision' of the latter by the former, in reality, existing LGHAs or the yet to be converted LGA Health Departments (but acting in similar capacity) have been made to function only as administrative appendages of the Boards or Agencies, rather than as semi-autonomous, self governing organisations.¹⁴

Many stakeholders at the LGA level that this author has interacted with during several field visits in many States; including staff of international development partners observe that what will be required to ensure that LGAs are involved in the development and provision of PHC services is to enhance their capacity to really manage and not just to support or supervise what is going on in PHC facilities. This would entail: making effective use of the available human resources, designing and implementing high impact programmes not on assumptions but based on data, tracking progress and reacting to changes, handling the entire logistics spectrum for all health commodities, among others.

In a setting whereby LGAs have very little latitude with respect to either policy-making or budgeting,¹⁵ LGHAs are not likely to fulfill their role of implementing PHC on the frontline. In several conversations with stakeholders at the LGA level, this author was informed that the capacity of LGAs to support the development and provision of PHC services has been largely undermined through the operations of State-LGA joint accounts, in which LGAs no longer have direct control over their funds. Moreover, it is mainly LGA resources that have been pooled by the States to run the State PHC Boards and Agencies. Therefore, the question of whether the policy of PHCOUR that privileges the establishment of State PHC Boards or Agencies - strengthens or weakens the capacity of LGAs in PHC service delivery becomes imperative.

A key lesson from the era of 'Health for All (HFA) by the year 2000' when PHC delivery played a pivotal role in 1980s and '90s, showed that a bottom-up approach,

which requires highly motivated staff and intensive relations with 'the community' seems to be more successful on a local scale.¹⁶ Furthermore, 'the contact between the world of the communities, the daily struggle for survival and the world of the institutions seems to be the key to permanent improvement as a process, rather than a product'. But as the identified blacksmiths in this process (the LGAs in Nigeria) are being disempowered, it would be difficult to create a solid coin out of the two faces of PHC.

With the future development of PHC in Nigeria somewhat linked to the further implementation of the policy of PHCOUR, each State PHC Management Board or Agency has to reflect on these issues and do things differently. Rather than imposing its will on the LGHAs as it is the case now; a State PHC Agency must first build an organisation dedicated to the goal of enabling LGHAs to provide a meeting place where communities (the people) and institutions (governments and donors) can meet and negotiate health development contracts, as well as enhancing the capability of LGHAs to execute these contracts. Profoundly, State PHC Boards or Agencies cannot reach their political goals or justify their existence if integrated planning, provision of professional skills, essential drugs etc. are not converted to promotion of health, prevention of endemic diseases, and effective treatment of common health problems in the communities. To achieve this goal, the same policy (PHCOUR) that helped to set up the State PHC Boards and Agencies should also activate the LGHAs with the capacity to actively manage PHC within their domains - by providing the required bridge between what the people demand and what the institutions supply. Even at that, it is unlikely that much success would be attained unless the broken LGA environment is repaired.

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