JIGAWA HEALTH SECTOR GOVERNANCE REFORM CASE STUDY

Part of State-Level Milestone
PO 7999

15 November 2017

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Acknowledgement

This report was authored by Laure-Hélène Piron with Dr. Dale Ogunbayo. Uzo Alutu analysed health data surveys.

The authors are very grateful to all the interview respondents in Jigawa State, Abuja and elsewhere in Nigeria who generously shared their time and insights; to the PERL-ARC, PERL-ECP and MNCH2 teams in Jigawa, who facilitated the field work and shared their experiences; and to the PERL-LEAP team in Abuja who commissioned the research.

Responsibility for any inaccuracies or omissions in this first draft lies with the authors. Feedback on this draft will be appreciated.

This material has been funded by UK aid from the UK government; however, the views expressed do not necessarily reflect the UK government's official policies.

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Acronyms and definitions

ARC	Accountable, Responsive and Capable Government
ANPP	All Nigeria Peoples' Party
APC	All Progressive Congress
CBOs	Community Based Organizations
CHEW	Community Health Extension Workers
CoH	Commissioner of Health
CSOs	Civil Society Organizations
DFID	Department for International Development
DG	Director General
DRF	Drugs Revolving Fund
ECP	Engaged Citizens Pillar
EU PRIME	European Union Partnership to Reinforce Immunization Efficiency
EU SIGN	European Union Support to Immunization Governance in Nigeria
GDP	Gross Domestic Product
GHSB	Gunduma Health System Board
HERFON	Health Reform Foundation of Nigeria
HMIS	Health Management Information Systems
HR	Human Resources
HRH	Human Resources for Health
IMEP	Independent Monitoring and Evaluation Project
JIMSO	Jigawa Medicare Supply Organization
LEAP	Learning Evidencing and Advocacy Partnerships
LGAs	Local Government Areas
LGSC	Local Government Service Commission
MDG	Millennium Development Goals
MoLG	Ministry of Local Government
MTEF	Medium Term Expenditure Framework
MTSS	Medium Term Sector Strategy
M&E	Monitoring and Evaluation
NDHS	National Demographic and Health Surveys
NHA	Nigeria's National Health Act
NPHCA	National Primary Health Care Agency
NW	North West
PATHS	The Partnership for Transforming Health Systems
PDP	Peoples Democratic Party
PEA	Political Economy Analysis
PERL	Partnership to Engage Reform and Learn
PFM	Public Financial Management
PHC	Primary Health Care

PHCA	Primary Health Care Agency
PHCDA	Primary Health Care Development Agency
PHCUOR	Primary Health Care Under One Roof
PRPRHAA	Participatory Rapid Health Appraisal for Action
PRRINN-MNCH	Programme for Reviving Routine Immunisation in Northern Nigeria –Maternal, New-born and Child Health
PS	Permanent Secretary
SAVI	State Accountability and Voice Initiative
SHAWN	Sanitation, Hygiene and Water in Nigeria
SHC	State Health Care
SLGP	State and Local Government Programme
SMOH	State Ministry of Health
SMOLG	State Ministry of Local Government
SPARC	State Partnership for Accountability, Responsiveness and Capability (SPARC)
SUNMAP	Support to National Malaria Programme
UNICEF	United Nations Children's Fund
USAID COMPASS	United States Agency for International Development
WHO	World Health Organization
WINNN	Working to Improve Nutrition in Nutrition in Nigeria

Executive Summary

Over the least 15 years, Jigawa State, in North-West Nigeria, has undertaken a suite of far reaching health sector governance reforms including: (1) improvements in planning, budgeting, human resources and information management, (2) the Gunduma decentralisation that reorganised primary and secondary health care service delivery into district level units, and (3) reforms to drugs supply and management with the creation of a Drugs Revolving Fund (DRF) and Jigawa Medicare Supply Organisation (JIMSO).

During this period, Jigawa has benefited from a continuous and large DFID-funded effort at health system strengthening. This case study adopts a political economy analysis approach and examines why and how reforms have been pursued; what outcomes have been actually achieved; and draws lessons for other public-sector governance reforms.

The success of Jigawa's reforms in terms of improving the health system has been mixed. There have been significant improvements in the quality of financial management marked by a major increase in the health budget and good performance in budget execution, until recently. Challenges remain in terms of human resources management and information systems. The State still suffers from a shortage of skilled professionals. Despite a commitment from officials and health professionals to generate and use health data, the administrative data system is not reliable. By contrast, the medicine supply chain transformation is considered highly successful, in terms of drugs availability, elimination of waste and fraud, reduced costs and financial sustainability.

The most significant reform was the integration of primary and secondary care under a single line of authority and accountability in 2008: the Gunduma Health System Board and its nine Gunduma (district-level) Governing Councils. The system was based on WHO recommendations and modelled on Ghana. Its introduction was promoted and supported by DFID health programmes. Gunduma successfully integrated some key functions such as planning, budgeting, human resources management, operational primary health care delivery and accountability. Discipline was reported to be high, programmes well-funded and offices equipped. Gunduma seemed to have been performing less well towards the end of its eight years of operations. It was abolished following the change in political leadership in the State in the 2015 elections and replaced by a Primary Health Care Agency in 2016.

The case study identifies five critical success factors. First, personalised policy-making in Jigawa has meant that Governors' personal interests, working styles and resources have influenced whether reforms are initiated and funded. Access to Governors by politicians or senior officials, through formal or informal means, has ensured support for reform or resolution of institutional disagreements. Second, DFID has been highly influential as a source for change in Jigawa's health sector, in particular through a series of large and comprehensive programmes since 2001, with dedicated and trusted advisers based in the State. Third, DFID programmes supported a cohort of committed civil servants who effectively used evidence, coalition-building and proactive advocacy to design and implement change.

However, Gunduma and JIMSO differ in the range of interests they affected and the strategies they used to manage opposition, the fourth critical factor. Whereas JIMSO was able to adapt and grow overtime, Gunduma was overturned after eight years. As a semi-autonomous agency, Gunduma took over responsibilities and access to resources from the State Ministry of Health which did not adjust to a policy and oversight role. Gunduma also faced resistance from some medical professionals, but

seems to have overcome local government opposition. Gunduma adapted Ghana's model to suit Jigawa's perceived needs at the time, in particular to improve the system's efficiency by integrating primary and secondary healthcare management at an intermediary (district) level and overcome the lack of trained professionals. These were at the same time fundamental design flaws as they went against some powerful interests Gunduma could not manage. By contrast, DRF / JIMSO remained within the remit of the Ministry which prevented tensions over direct control and accountability. A transparent system to retain and use the mark-up of the sale of drugs has motivated stakeholders.

Finally, technical factors also affected the sustainability of the reforms. Public financial management reforms, or a logistics supply chain, are relatively narrow reforms, whereas human resource management, information management systems and decentralisation are more complex and expensive. Gunduma entailed both geographical and functional restructuring. It attempted to improve performance and efficiency, expecting more of front-line staff and reducing its supervising Ministry's authority. While it was used by DFID's health programmes to advocate national Primary Healthcare Under One Roof reforms, Gunduma became out of synch with its Nigeria-wide institutional equivalents.

Jigawa has seen improvements in health service delivery and outcomes over the period of these reforms, although from a very low base and not always exceeding the region. It is difficult to separate the effects of Gunduma from the other health sector reforms and the influx of DFID assistance to the State. In order to investigate the link between system reforms, services delivery and health outcomes improvement, comparative research across NW States would help understand which institutional factors might have led to improved outcomes (for example comparing Jigawa to another NW State which undertook different primary health systems reforms with DFID assistance and a third one which did not benefit from DFID assistance).

The main lessons for other public-sector reforms are:

Lesson 1: Political commitment to reforms matters, particularly in a personalised political system, where structural and institutional factors put little constraints on the executive. However, while it can be easier for individual politicians to initiate and fund reforms, it can be harder to ensure they are institutionalised and sustained once they leave office, as they need to change the rules of the game successfully and durably weaken or manage opposition and other interest groups.

Lesson 2: External assistance can have an important influence, especially when it is large and long-lasting. What seems to have been important is not only the financial and technical resources made available, but also the way in which these programmes operated in Jigawa, with long-term trusted programme-managers based in the State and strong coordination between DFID Jigawa programmes.

Lesson 3: Participatory processes can generate commitment for reform, but a broad range of strategies have to be used to bring allies on board. A committed cohort in favour of change can become highly effective, using evidence, coalition building with traditional non-state actors, and well as proactive lobbying and information campaigns.

Lesson 4: Managing reform effectively requires identifying which stakeholders' groups have the most to win or lose, and considering how their interests and incentives can be managed. When the political support for Gunduma changed, the system was very quickly dismantled, and some stakeholders were able to regain their pre-Gunduma status. By contrast, JIMSO found a way of making its various stakeholders buy-in into it while enforcing a system of internal oversight.

Lesson 5: The technical aspects of governance reforms do matter, in particular their degree of ambition, complexity and alignment with wider national initiatives. However, this does not mean that more ambitious systems or public sector reforms are not needed. Jigawa's health services will not significantly improve without more health professionals and better managed human resources, which may require more gradual efforts.

Lesson 5: Data can be used and abused to justify policy change or defend programme success. The controversy over whether or not Jigawa has achieved health outcomes improvements shows how data can be used both to justify, and oppose, government's new policy directions. A participatory analysis with key stakeholders to understand what might have driven these results would be useful. This would explore which steps in the Theory of Change mattered most, and whether upstream institutional reforms, such as Gunduma, really made a difference to service delivery and health outcomes in Jigawa.

At present, health sector governance in Jigawa is in a situation of flux as new systems are put in place. This provides a potential entry point for PERL and other development partners to help shape the future reform direction.

Introduction

Purpose

Jigawa, in the North West of the country, is one of Nigeria's poorest States. 75% of its population live in rural areas with very limited access to health services. Over a 15-year period, from 2003 to 2017, some key health indicators have increased significantly, starting from a very low base.

During the same period, Jigawa has benefited from a significant amount of development assistance from the UK's Department for International Development (DFID). The health sector has been a particular focus, including through probably one of DFID's largest continuous efforts to date at health system strengthening.

Given the size and duration of this investment, this case study explores health sector governance reforms in Jigawa. It examines why and how reforms have been pursued; what outcomes have been actually achieved; and draws lessons relevant for public sector governance reforms and service delivery for other sectors or Nigerian states receiving development assistance.

This report forms part of a series of case studies undertaken by the Learning, Evidencing and Advocacy Partnership (LEAP) pillar of the DFID-funded Partnership to Engage, Reform and Learn (PERL). The aim of these studies is to understand the process by which public sector and/or policy reform initiatives in Nigeria have been achieved and examine the role of learning, adaptation, and the use of evidence in these change processes. Case studies examine promising reform initiatives in Nigeria, which have led to the achievement of tangible development outcomes and show elements of sustainability.[1]

A parallel LEAP health sector and governance study examines the political economy factors surrounding the implementation of Nigeria's National Health Act (NHA).[2] During field research in May 2017 to document how the Act was being implemented at State level, LEAP identified a controversy over the success, or not, of Jigawa's health sector governance reforms and the reversal of a flagship health system decentralisation. This merited further investigation given the widely-shared positive perception of progress in Jigawa's health system and health outcomes.

1.2 Analytical framework

This paper adopts LEAP's political economy approach. It examines the structural and institutional factors that influence policy change in Jigawa, as well as how and why individuals and organisations have been driving or resisting change.[3]

- *Structural factors* are long-term factors, such as geography, historical legacy or social structures, which are not amenable to rapid change.
- *Institutional factors* include the formal and informal 'rules of the game' which influence individuals and organisations' behaviour, such as the legal framework or widely-shared norms and values.
- *Agents* are the 'players of the game'; they have diverse interests, incentives, ideas and ideologies that motivate them to support or resist change.

The particular characteristics of a health sector, and the different services it provides, affect political dynamics, in terms of political commitment; control and monitoring between politicians, officials and providers; and citizens' power.[4]

- *Political commitment:* Healthcare does not often generate visible immediate benefits to politicians, which is why infrastructure (e.g. new or renovated clinics) is often favoured over

[1] *PERL-LEAP (2016) Research Partnerships Update Note (2016), December.*

[2] *Tulloch, O., Cummings, C., Ogunbayo, D and Oreh, C. (2017), A Case Study of the Implementation of the 2014 Nigeria National Health Act, PERL-LAEP, October.*

[3] *PERL (2016) PERL's Approach to Operationalising Political Economy Analysis: Thinking and Working Politically, December.*

[4] *Richard Batley and Claire Mcloughlin (2015) "The Politics of Public Services: A Service Characteristics Approach" World Development Vol. 74, pp. 275–285 http://www.sciencedirect.com/science/article/pii/S0305750X15001278?via%3Dihub*

human resources and maintenance of these facilities. Improvements in health outcomes can take longer than a political cycle and can be hard to attribute to a political intervention. Tertiary care may have more political relevance than primary healthcare as it benefits a targeted, often wealthier, population.

- *Organisational control:* It can be difficult for government and citizens to monitor and control service delivery because of the information asymmetry (medical knowledge gap) between doctors and their patients, and the power of professional medical groups. By contrast, public health activities, such as information campaigns or vaccinations, are easier to monitor as they involve little professional discretion and provide fewer rent-seeking opportunities.
- *Users' power:* The need for healthcare is less frequent, less predictable and more individual than, for example, education. This creates fewer incentives for collective action to demand better service. Citizens may be able to organise around a specific service delivery point such as a primary healthcare facility, or a service delivery problem such as lack of vaccines to manage a meningitis outbreak, but may not feel able to judge the quality of delivery.

Methodology

Primary research was undertaken in Jigawa by researchers from LEAP and the Nigeria Governors' Forum during October 2017. Over 40 informants were selected on the basis of recommendations from PERL teams in Abuja and Jigawa, DFID advisers and through snowball sampling. The aim was to identify stakeholders representing different constituencies involved in Jigawa's health sector governance reforms since 2001, operating both inside and outside government and donor projects. Field work included a rapid visit to two Jigawa Local Government Authorities (LGAs) to understand the perceptions of past and current reforms by primary health care managers and service providers. Given time constraints, it was not possible to undertake focus group discussions with health service users.

A literature review identified over 50 reports and presentations touching on Jigawa health sector governance reform, mostly Jigawa State Government or DFID-funded programmes' monitoring, evaluation and learning reports. Shared concerns over the reliability of health data in Jigawa is explained in section 4.

Report structure

The rest of the case study is structured as follows. Section 2 summarises Jigawa's political economy context and the most significant health sector governance reforms since the end of military rule in 1999. Section 3 explores why these reforms were designed, implemented, maintained or reversed. Section 4 examines progress with health outcomes in Jigawa. Finally, section 5 proposes a number of lessons learned that are relevant for other sector governance reforms, in Nigeria or elsewhere.

What have been the most significant Jigawa health sector governance reforms?

Understanding Jigawa's health sector's political economy context

Country-wide contextual factors

Nigeria's country-wide contextual political economy factors make reforms of public services particularly challenging (see box 1).[5] The end of military rule in 1999 created an opening for change, which came to be realised in some sectors at the federal level and in some States, but not across the board.

BOX 1: HOW NIGERIA'S POLITICAL ECONOMY CONSTRAINS THE DELIVERY OF PUBLIC SERVICES

Nigeria's dependence on oil, and the legacy of military rule, have created weak state-society relations with limited channels for citizens to demand improved service delivery. At the federal level, the political settlement depends on a balance between Nigeria's ethnic groups. This is replicated within States through the creation of multiple local government authorities. Access to political power provides a source of patronage and rents, through contracts or the distribution of public sector jobs. The policy process is heavily personalised. Change is mostly top-down or the result of informal lobbying, rather than formal consultations. Policy is often not connected to plans or budgets but to personal decisions by leaders, leading to poor expenditure controls. Value systems often promote short-termism and personal benefits.

Structural factors in the health sector

Nigeria's health sector performance was particularly dire by 2000 when it was ranked 187 out 191 Member States by the World Health Organization (WHO). This was the historical legacy of a formal system which provided better access to health in the South than the North of the country; preferring urban centres over rural areas where few trained doctors wanted to live. By 2002, total government expenditure on health was just about one percent of GDP (slightly over two percent of total government expenditure), illustrating the very low political salience of health for politicians.[6]

Jigawa's poor health indicators are consistent with this national analysis. A poor, rural Northern State, recently carved out of urban Kano (where its politicians, civil servants and professionals still prefer to reside), it started from a very low base when DFID initiated its health sector programmes in 2001. By 2009, Jigawa still only had 40 medically trained doctors to serve its 4.5m population. It had two health training institutions: a School of Nursing and a School of Health Technology. The leading causes of ill-health and deaths included malnutrition and communicable diseases (malaria, diarrhoeal diseases, respiratory tract infections and vaccine preventable diseases). Mothers died frequently from complications in child birth and pregnancy. Infant and mortality rates were particularly high.[7] Of the more reliable data, immunization and birth assisted by a skilled provider or in a health facility were lower than the already low regional North West (NW) average (see box 2).

BOX 2: JIGAWA NATIONAL DEMOGRAPHIC HEALTH SURVEY COMPARATIVE RESULTS

Full child immunization was estimated at 0 (compared to 6% regional average and 23% nationally), birth assisted by a skilled provider or in a health facility were 5% each (compared to 10% and 8% regionally, and 39% and 35% nationally). Jigawa only did comparatively better on malaria prevention: 11% of children under five had slept under insecticide treated nets the night before the survey (compared to 4% in the NW ad 6% nationally).

National Demographic and Health Surveys (2008) Key facts NW Zone

[5] Utomi P, Duncan A, Willams G (2007), Nigeria The Political Economy of Reform. Strengthening the incentives for economic growth. Anyebe, Bezzano J, Foot S. (2005). Country level testing: the health sector in Nigeria. An analytical framework for understanding the political economy of sector and policy arena.

[6] *Anyebe et al. (2005), p.25.*

[7] *PATHS2 (2009) Inception Phase Report.*

Institutional factors in the health sector

Confusion over roles and responsibilities, and poor coordination, between the Federal, State and Local Government levels

According to Nigeria's health policies and convention, States and LGAs are responsible for delivering both primary and secondary care, with responsibilities for supervision and management by the State Ministry of Health (SMOH), State Ministry of Local Government (SMOLG) and the Local Government Service Commission (LGSC). This confusion has enabled different actors to vie for access to resources rather than deliver their responsibilities. For example, States that set up capital-expensive tertiary hospitals, in theory a federal-level responsibility, generate another source of rents and access to better services for their urban elites.

In 1999, Jigawa's health sector was similarly comprised of a series of organisations with different interests and capacities. The SMOH was responsible for secondary (hospital) care and supporting LGAs in providing Primary Health Care (PHC). The SMOLG coordinated all the LGAs and their PHC activities and was meant to act as a liaison with the SMOH. A semi-autonomous Jigawa Primary Health Care Agency (PHCA) was created by law in 1999 and the (military era) Jigawa State Hospitals Management Board and its zonal structures scrapped. At the same time, Governor Turaki redistributed the State's Ministries, Departments and Agencies (including health sector ones) across Jigawa's five Emirates. Interviewees complained this further undermined the sector's coherence and ability to plan, budget, or manage staff.

Inefficient health public sector

The 2002 Jigawa health sector situational analysis identified a number of weaknesses, characteristic of rural Northern Nigerian States at the time. These are consistent with the situation of the health sector across Northern Nigeria[8], and included: low management capacity for planning and policy making; inadequate numbers of professional health staff such as nurses and doctors; indiscipline, absenteeism and lateness to work among health staff; inadequate funds for running health facilities with unreliable water and electricity supply; low availability of essential drugs and medical supplies; inadequate basic equipment to carry out basic procedures; high levels of poverty and ignorance among clients and poor communication between health staff and users of health facilities.[9]

Overview of health sector governance reforms

Jigawa was one of the initial four 'focal states' selected by DFID in 2000 and has remained a DFID partner since then. As a result, it has benefited from large UK aid investment in public sector reform, health, education and economic development. The main health sector programmes included a particular focus on health sector governance in order to improve service delivery. The Partnership for Transforming Health Systems (PATHS) operated in Jigawa over more than a decade through PATHS1 (2001-2008) and PATHS2 (2008-2013). PATHS and the Programme for Reviving Routine Immunisation in Northern Nigeria – Maternal, Newborn and Child Health (PRRINN-MNCH, 2006-2013) were instrumental in generating awareness, facilitating consultations, offering technical options and supporting the implementation of Jigawa's significant health sector reform over this period.

The major health public sector governance supported by these programmes were:

1. Strategic planning and financial management (see sub-section 2.3);
2. Reorganisation of primary health care service delivery into a district level 'Gunduma' system, later abolished (see section sub-section 2.4);
3. Drugs supply and management with a Drugs revolving Fund and Jigawa Medicare Supply Organisation (see sub-section 2.4).

These reforms were conceived under Jigawa's first civilian governor; implemented under its second governor; and some were reversed under its third and current governor, elected in 2015. The rest of

[8] *Anyebe et al (2005).*

[9] Sofo Ali-Akpajiak (2010) The Gunduma Story: Integration of secondary and primary healthcare services in the Jigawa State of Nigeria, PRRINN-MNCH, draft.

this section summarises these reforms. The next section examines why they were introduced and how they have evolved.

Table 1: Timeline

Year	Nigeria politics and health	Jigawa politics	Jigsaw health sector governance reforms	Jigawa donor programmes
1999	Democratic dispensation. Pres Obasanjo (PDP) elected.	Governor Ibrahim Saminu Turaki (ANPP) first term 1999-2003	Jigawa Primary Health Care Agency (PHCA) created by law.	
2001	Abuja Declaration – target of allocating at least 15% of their annual budget		A situational health analysis, using a Peer Participatory Rapid Health Appraisal for Action creates a consensus of the poor state of the health sector	Change Agents (2001-2004)
2002			Health situational analysis discussed at State Health Summit. State Health Sector Reform Forum coordinates reforms	Change Agents PATHS1 (2002 to 2008)
2003	Pres. Obasanjo (PDP) re-elected	Governor Turaki (ANPP) second term	Health Sector Institutional Analysis. DRF starts (decided at Summit)	Change Agents PATHS1
2004			Jigawa Health Sector Strategic Plan (2004 - 2009)	Change Agents PATHS1
2005	PHCUOR policy – supported by DFD (through PATHS and PRINN-MNCH at federal level)		Health Sector Reform Decentralisation Committee consultations start Health Sector Reform Planning and Budgeting Committee costed health strategic plan activities leading to Medium Term Sector Strategy (MTSS)	PATHS1
2006			DRF first central medical store	PATHS1
2007	Pres. Yar'Adua (PDP) elected	Governor Turaki health system study tour to Latin America.	Joint Health Integration Committee (SMOH and MoLG) memo on Gunduma to Governor approved quickly. PHCA scrapped. Legislators study tours to Ghana and Enugu. Gunduma legislation passed September. Gunduma Health System Board created December. JIMSO created	PATHS1
2008		Governor Sule Lamido (PDP) first term	Gunduma Board head changed from Permanent Secretary to Director-General. Gunduma Board inaugurated; study tour to Ghana for Gunduma Board and Councils. Human resources audit	PATHS1 – PATHS2 PRRINN-MNCH?
2009	National Strategic Health Development Plan Framework (2010-2015)	Hand-over meeting ensuring Lamido commitment to Gunduma	PRPRHAA used again. HR Information Management System developed. School of Midwifery set up. Gunduma establishes DRF monitoring teams. Jigawa Drug Management Agency Bill prepared (but not passed).	PATHS2 PRRINN-MNCH
2010	Acting Pres. Goodluck Jonathan (PDP)		State Strategic Plan (2010-2015) and collaboration with SPARC on Jigawa's Comprehensive Development Framework	PATHS2 PRRINN-MNCH
2011	Pres Goodluck Jonathan (PDP); PHC under one roof national policy	Governor Lamido (PDP) re-elected	GHSB DG becomes CoH and new GHSB DG following elections 2011-2013 MTSS with 3 year plan and budget based on strategic plans	PATHS2 PRRINN-MNCH
2012				PATHS2 PRRINN-MNCH W4H starts

Year	Nigeria politics and health	Jigawa politics	Jigsaw health sector governance reforms	Jigawa donor programmes
2013			647 facilities with DRF	PATHS2; W4H PRRINN-MNCH
2014	National Health Act			6 months PATHS-MNCH2 transition; W4H
2015	Pres. Muhammadu Buhari (APC) elected	Badaru Abubakar elected Governor (APC)	JIMSO one central store (Dutse) and three regional stores and N1bn turnover. New CoH following elections. Decision to abolish Gunduma by December	PATHS2 ends in NW / Jigawa MNCH2 W4H
2016	National Health Policy		Gunduma replaced by PHCDA by April	PATHS2 ends MNCH2, W4H
2017			PHCDA staffing change continues	MNCH2 + W4H
2018				MNCH2
2019	Elections	Elections		MNCH2

Health sector financial and human resources management

Between 2002 and 2003, PATHS supported a process of participatory analysis and stakeholders' engagement, which created a shared understanding of the need for reform, in particular from a committed group of civil servants. This paved the way for a Jigawa Health Summit and Reform Forum, which agreed to initiate financial, human resources and information systems reforms.

Health sector public financial management (PFM): Jigawa's PFM improvements have been significant and have underpinned other health sector governance reforms. Jigawa was the first to develop a Health Sector Strategic Plan, Medium Term Sector Strategy (MTSS) and Medium Term Expenditure Framework (MTEF). The annual budget process was strengthened, with annual plans based on evidence used to inform annual budget.[10] Jigawa was seen as having particularly good State plans with community participation, compared to other NW States, as early as 2010.[11]

BOX 3: COMPARISON: STATE-LEVEL HEALTH PER CAPITA SPENDING

In PRRINN-MNCH States

Jigawa performed better than the 3 other Northern States the programme assisted (Katsina, Yobe and Zamfara) in terms of total budget, per capita health expenditure and budget performance.

In PATHS2 States

Enugu: $6.6 (2009) to $16.4 (2012)

Jigawa: $9.1 (2009) to $12.76 (2012)

Kaduna: $6.4 (2009) to $10.78 (2012)

Kano: $3.0 (2009) to $16.98 (2012)

(Note: this per capita data should be contextualised in terms of the total budget and budget performance).

Sources: DFID Business Case for PATHS2 programme extension (2013)

PRRINN-MNCH final report (2013)

Improved health PFM has meant that Jigawa was able to absorb and use its increased health budget, which more than doubled as a share of the State budget between 2009 and 2012, when it reached 17%[12] (see box 3 for a comparison). The budget declined in 2014 and 2015 (due to the elections and an oil shock) but increased once again in 2016 under the current Governor.

Health sector budget performance has been particularly good until 2016, reaching over 90% (with the exception of election year 2011). Interviewees noted how strong Jigawa's health PFM system and execution was by comparison with other Northern States.

The combination of Jigawa's Gunduma system and improved PFM enabled the preparation of single integrated health plans which could use different funding sources to support delivery. For example,

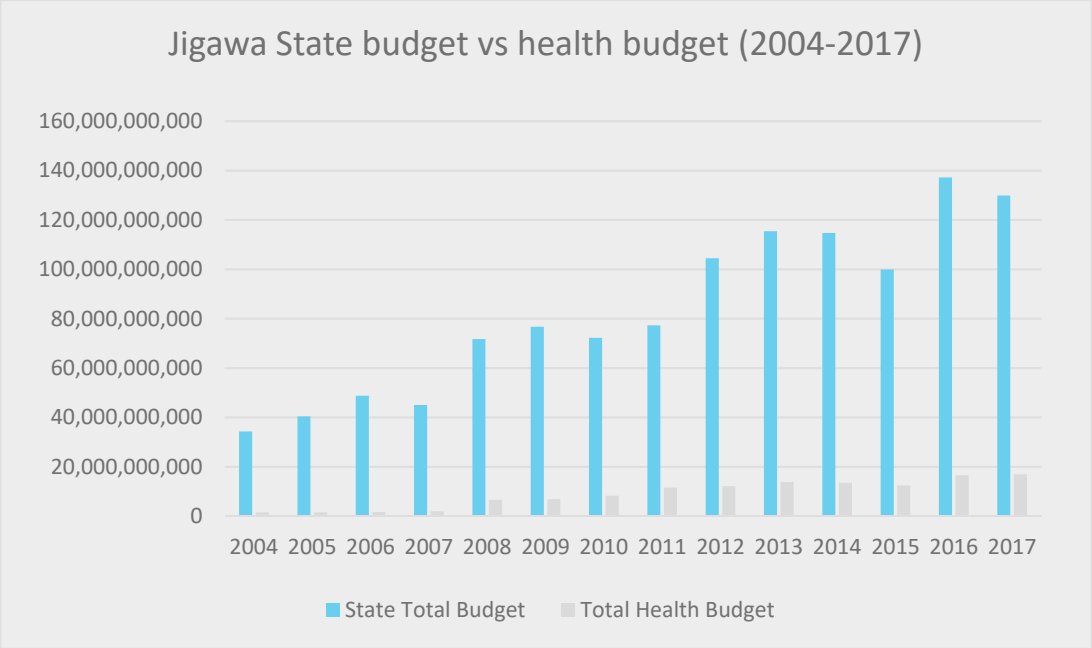
[10] *PRRINN-MNCH (2013) Better Maternal Newborn and Child Health in Norther Nigeria, Final Report.*

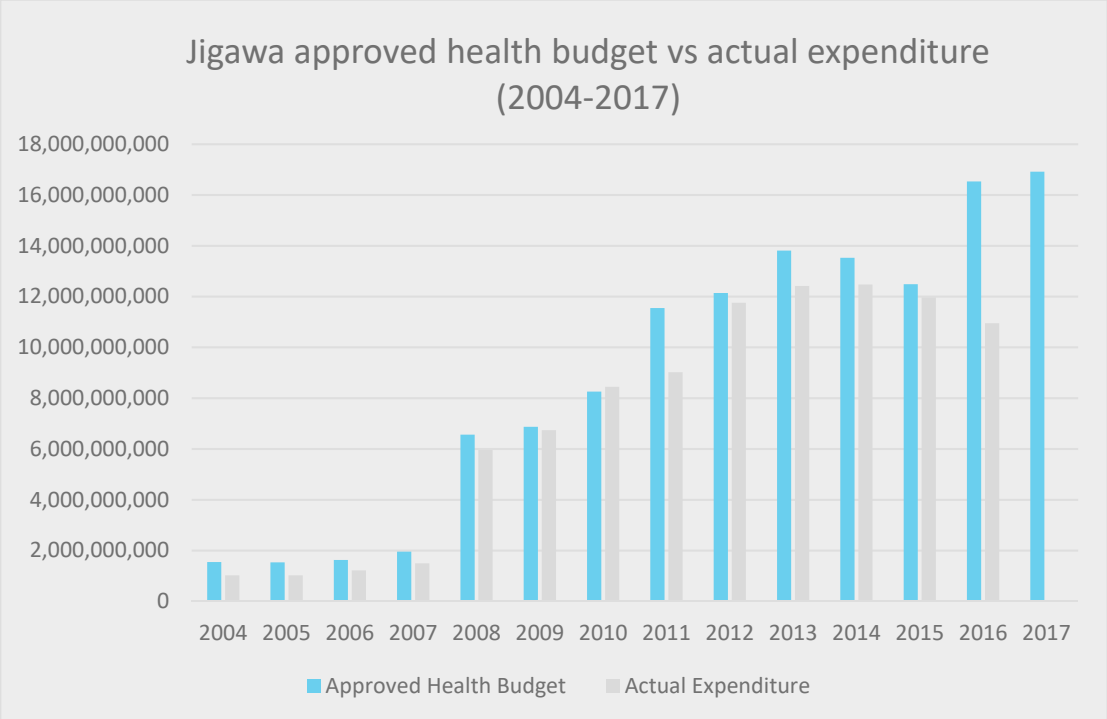
[11] *DFID Health Development Resource Centre (2010) PRRINN-MNCH Annual Review.*

[12] *PRRINN-MNCH final report (2013) pp. 56-57.*

the Gunduma Board was able to use Millennium Development Goals funds to maintain and refurbish facilities during two consecutive years, with a focus on one facility per ward (N377million in 2009 and N609million in 2010).[13] The system also managed internally generated revenue, including from DRFs across all health facilities.[14]

Figure 1: Jigawa State budget vs health budget (2004-2017) and Jigawa approved health budget vs actual expenditure (2004-2017)





Source: SPARC Jigawa budget database analysed by ARC-PERL Jigawa

Other areas of health sector governance reforms have included human resources for health (HRH) and a health management information system (HMIS).

[13] *PRRINN-MNCH final report (2013) p.94*

[14] *PATHS2 (2015)*

- **HRH:** By 2015, Jigawa's SMOH and the Gunduma Board had HRH departments. The Human Resources for Health Information Management System had moved from paper to web-based system. A job description manual covered all professional and non-professional health sector staff. Information provided by the system had reportedly been used to establish a School of Midwifery[15] and to recruit more than 200 medical staff in response to gaps it highlighted.[16]

  However, challenges remained:

  - In terms of process, HR was the least good performing area of Jigawa's 2015 Primary Healthcare Under One Roof (PHCUOR) scorecard, which noted the lack of evidence of a recent staff audit, documented procedure for staff recruitment or costed capacity building plan to address staff needs.[17]
  - The doctor/patient ratio was still very low at 1:26,000 in 2015 by comparison with a national average of 1:3,500.[18]
  - The new administration decided to undertake a staffing audit to assess the workforce, clean the payroll and train staff.[19]
  - The scale and impact of these recent efforts would benefit from further investigation. Some DFID programmes reported that staff, such as nurses, were leaving Jigawa as some allowances were no longer being paid.
- **HMIS:** By the end of PATHS2, health managers were trained in using the HMIS database and in the importance of data to evaluate the health system's performance. Facility reporting rates increased from 0% in 2008, 78% in 2012 and 91% in 2014, making Jigawa the most successful PATHS state against this indicator.[20] However, despite a clear commitment to using data expressed by both SMOH and PHC managers during interviews, the quality of Jigawa's HMIS data remains unreliable. It currently relies on staff in every facility regularly inputting data and quality assurance by LGA-based PHC managers. Interviewees identified a number of examples of human error in the system. A dedicated monitoring project set up by DFID assessed HIMS data quality in Jigawa and other NW States over 2012-2015. HMIS data were found to be unreliable, with sporadic reporting and overstated results.[21]

Service delivery governance: Gunduma and the Primary Health Care Agency

Following extensive PATHS-supported diagnostics and consultations, by 2007 Jigawa brought together primary and secondary care under a single line of authority and accountability: the Gunduma Health System Board (GHSB) and its 9 Gunduma (district-level) Governing Councils. The system was based on WHO recommendations. It was informed by a number of visits by the Health Sector Forum Decentralisation Committee and legislators to study Ghana's district PHC system. A new structure was created in order to prevent LGAs or the SMOH from being dominant and give primacy to either PHC or SHC.[22] The SMOH was to be responsible for policy-making and oversight, but health system management, including financial and human resources, was now devolved to Gunduma. 5,000 staff were transferred from the MoLG to Gunduma.[23]

PATHS2's 2016 independent final capability assessment concluded that Gunduma had successfully integrated some key functions such as planning, budgeting, HRM, operational PHC delivery, and had improved accountability between Gunduma and PHC facilities: "the Gunduma Councils substitute for the LGAs in the operational delivery of primary health services and were functioning very competently in providing local leadership of the health system and its day to day management."[24] Each Gunduma

[15] *DFID Human Development Resource Centre (2010) p.8.*

[16] *DFID (2013) Business Case for PATHS2 extension p.18.*

[17] *National Primary Healthcare Development Agency (2015) Primary Healthcare Under One Roof Implementation Scorecard III*

[18] *Jigawa State Ministry of Health "Healthcare delivery: Progress Made Since May 29th 2015" PowerPoint presentation dated 21st September 2017, Slide 4.*

[19] *This entailed N54million monthly saved as at April 2016 and since then a reported N1-4million monthly. It reports that 200 students are studying medicine or health sector profession, and that it has recruited over 500 PHC workers, paid from the payroll cleaning monthly savings. Ibid*

[20] *PATHS2 (2015) The PATHS 2 Legacy Northern Nigeria: Jigawa State impact*

[21] *IME (2015)*

[22] Enyimayew, N. and MacKenzie, A. (2008) Developing Integrated and Decentralised Health Systems Technical Brief, PATHS2, p18.

[23] *PATHS2 (2010) Progress Report 2009-2010.*

[24] *IMEP 2016 p.34.*

Council was responsible for the supervision of health facilities, M&E and HMIS in the three or four LGAs it oversaw. They facilitated bottom-up planning and managed DRF competently. Gunduma Councils were responsible for appointments, supervision, contracts and performance management: "the Gunduma system manages human resource issues in an integrated manner and with roles and responsibilities for HRH defined among the contributing agencies" better than other PATHS2 focal states.[25] Interviews with some ex-Gunduma officials and current PHC staff outside of Dutse reported that discipline was high under Gunduma, programmes well-funded and offices equipped. This improved management was attributed in part to the personal status and professional commitment of Gunduma's first DG.

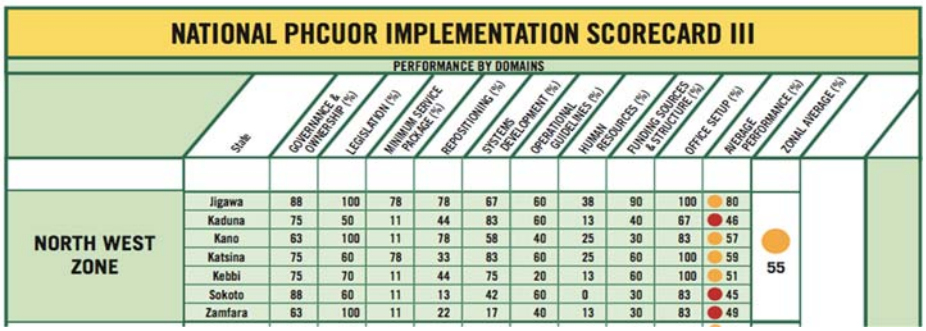
However, available evidence on how the Gunduma system was operating towards its latter period shows some areas needing improvements. For example, the 2015 PHCUOR Scorecard found no evidence of Gunduma 'integrated supportive supervision' to PHC facilities or LGAs. This weakness was confirmed by PHC-level interviewees in two LGAs outside Dutse, who noted that supervision had improved since Gunduma had been abolished, with regular supervision from now LGA-based PHC officials. The reason for this apparent weak supervision may have been the physical distance between Gunduma Councils and PHC facilities (grouped within 3 or 4 LGAs) as well as changes in how Gunduma operated in its latter phase. This may require further investigation.

In 2016, Gunduma was abolished and replaced by a new Primary Healthcare Development Agency (PHCDA), with PHC managers in each of Jigawa's 27 LGAs (rather than in the nine Gunduma Councils). The SMOH regained direct control over secondary care. The SMOH justified the changes as follows:[26]

- The need to align with the National Health Act (2014) in order to access federal health funding and better identify professional counterparts (as Gunduma teams were organised functionally and not professionally).
- Inefficient and costly additional layers between policy making and service delivery (the district level Gunduma Councils). A newspaper headlined that the system had 'wasted' N40 billion over eight years.[27]
- Bloated health sector staff bill, with too many non-medical staff.
- As a result, underachievement of Gunduma in terms of low health outcomes.

These claims have been challenged by those previously involved in Gunduma, who quote, for example, the 2015 PHCUOR Scorecard that rated Jigawa as the top performing State nation-wide in terms of systems and processes (scoring an average of 80%, ahead of Rivers (73%) and Bauchi (67%)). See figure 2 below.[28]

Figure 2: National PHCOUR Implementation Scorecard II



NATIONAL PHCUOR IMPLEMENTATION SCORECARD III

PERFORMANCE BY DOMAINS

	State	GOVERNANCE & OWNERSHIP (%)	LEGISLATION (%)	MINIMUM SERVICE PACKAGE (%)	REPOSITIONING (%)	SYSTEMS DEVELOPMENT (%)	OPERATIONAL GUIDELINES (%)	HUMAN RESOURCES (%)	FUNDING SOURCES & STRUCTURE (%)	OFFICE SETUP (%)	AVERAGE PERFORMANCE (%)	ZONAL AVERAGE (%)
NORTH WEST ZONE	Jigawa	88	100	78	78	67	60	38	90	100	80	55
	Kaduna	75	50	11	44	83	60	13	40	67	46	
	Kano	63	100	11	78	58	40	25	30	83	57	
	Katsina	75	60	78	33	83	60	25	60	100	59	
	Kebbi	75	70	11	44	75	20	13	60	100	51	
	Sokoto	88	60	11	13	42	60	0	30	83	45	
	Zamfara	63	100	11	22	17	40	13	30	83	49	

Source: National Primary Healthcare Development Agency (2015) Primary Healthcare Under One Roof Implementation Scorecard III

[25] *IMEP 2016 p41.*

[26] *Jigawa State Ministry of Health "Healthcare delivery: Progress Made Since May 29th 2015" PowerPoint presentation dated 21st September 2017. In interviews, the same arguments were put forward by SMOH's current political and civil service leadership and others reporting SMOH's justification.*

[27] *Aliyu M. Hamagam "Jigawa dissolves drug supply outfit for 'wasting' N40 billion" Daily Trust, 17 December 2015. https://www.dailytrust.com.ng/news/jigawa/jigawa-dissolves-drug-supply-outfit-for-wasting-n40-billion/124759.html*

[28] *National Primary Healthcare Development Agency (2015) Primary Healthcare Under One Roof Implementation Scorecard III pp. 63-64.*

Drugs supply and management in Jigawa: DRF and JIMSO

In 2004, as a result of the institutional health sector review, Jigawa established a Drugs Revolving Fund (DRF) to respond to the shortage of drugs. It was initially piloted in 10 facilities, with 12 additional facilities by 2005. A new central procurement structure was then established to unify pricing, which became the Jigawa Medicare Supply Organisation (JIMSO) in 2007. It serviced all state health facilities by 2013.

The fund was initially capitalised by DFID with N408million in 2007. It currently has an annual turnover of about N1 billion, with a capital base of N300million. Its three regional stores (one in each senatorial zone) supply with medical supplies and consumables all of Jigawa's 647 health facilities as well as one patent medicine vendor per political ward and the State's 11 private hospitals. Mini-medical stores are located in every LGA to supply local facilities and vendors. 92 companies have been pre-qualified competitively.

While other Nigerian states have DRFs, JIMSO is seen as particularly successful: "one [of] the greatest success stories and legacies of the PATHS2 programme in the country."[29] PATHS2 claimed that "This new structure has nearly eliminated waste and fraud, while increasing drug availability and reducing costs through improved supply chain logistics costs."[30] However, the PATHS 2016 capacity assessment identifies improvements in drugs supply and management systems across all PATHS2 states, without noting any particularly significant over or under performance in Jigawa. It considered the DRF/JIMSO as more sustainable than other PATHS2 initiatives as it is self-financing (as long as it is not decapitalised and resources are not diverted to cover facilities or free health care costs).[31]

[29] *PATHS2 (2015) p2.*

[30] *PATHS2 (2015) p4.*

[31] *IMEP (2016) Study on PATHS2 Capacity Assessment p.32.*

Why were health sector governance reforms designed, implemented, maintained or reversed?

Critical factor 1: Personalised policy-making

The first key factor which explains why health sector reforms took off in Jigawa, especially after 2007, is the relative importance of actors over contextual (structural and institutional) factors in *initiating* (as opposed to sustaining) reforms.

Jigawa's structural factors, including its rural base and low economic development, has not generated an active business community or vocal middle class putting pressure on the Governor or Government for specific service delivery improvements. While patronage systems are similar to the rest of Nigeria (including through advance payments for contracts, inflated prices or politicised appointments), a Governor has more room for manoeuvre from demanding constituents than, for example, in Lagos or Kano.[32]

Interviewees consistently described how the different stages of Jigawa's health sector transformation have been heavily influenced by Governors' personal interests, working styles and resources.

- Governor Ibrahim Saminu Turaki (ANPP, 1999-2007), Jigawa's first civilian Governor following the end of military rule, was instrumental in attracting DFID to Jigawa. He was open to change, with creative ideas such as making his State Nigeria's internet hub. He gave DFID programmes abundant space to propose and support reforms. He was described by interviewees as "out of the State a lot" and "allowing reforms to happen quickly", without a particular commitment to the health sector, "probably not knowing what we were doing", but convinced because "DFID was taking charge and with good consultation".
- Governor Saminu Lamido (PDP, 2007-2015) was persuaded during the transition meeting with his predecessor to continue the health reforms which had reached a critical point during the 2007 elections. Gunduma and JIMSO were both established by the end 2007. He seemed interested in the results that could be achieved through improved PFM, and doubled the health sector budget with a high execution rate. Interviewees noted that "he spent more efforts in building structures, and didn't interfere much with systems". His commitment to the health sector can be related to his intention to build the legitimacy of his government on the basis of its public goods delivery record and his early political career as part of the left-of-centre People's Redemption Party. He reportedly managed to favour politically important actors in the award of contracts, but also expected performance.
- Governor Badaru Abubakar (APC, 2015 - present) has been seen has having little direct interest in health sector beyond a push for infrastructure and financial savings across all sectors, according to interviewees from outside government. He has let his Commissioner for Health determine new priorities, such as replacing Gunduma by a PHCA. The SMOH has put a renewed emphasis on constructing or rehabilitating facilities, in line with the Governor's focus, but is also continuing other Jigawa health sector management initiatives such as JIMSO, HRH and HMIS. Health systems reform is probably of less interest to the public, who only experience the system at the point of delivery.

[32] *SPARC (2012) Executive Summary of Political Economy Analysis for Nine States', Final Report.*

Access to Governors by politicians or senior officials, through formal or informal means, has ensured support for reform or resolution of institutional disagreements. Gunduma's first Director General, a former SMOH Permanent Secretary, had particularly good access to the Governor and could make the case for Gunduma. Her successor seems to have faced more barriers. Interviews provided a range of examples of informal access, ranging from drawing on family links or ad hoc conversations to make the case, such as on a flight (see box 4).[33]

BOX 4: THE IMPORTANCE OF DIRECT ACCESS TO GOVERNORS

In 2007, the then Governor was on the same plane from Abuja to Jigawa as Senators recently returned from a study tour to examine Ghana's district level health system, during which time "the decision to pass the [Gunduma] bill was arrived".

However, while Governors can introduce and fund reforms, they do not have the same power to ensure they are *institutionalised and sustained*. For reforms to last beyond a Governor's two terms, they need to successfully change the rules of the game and durably weaken or manage opposition and other interest groups. This is where the Gunduma experience contrasts with the DRF.

Critical factor 2: The influence of development partners

In a resource-constrained state such as Jigawa, external funding support can have significant influence. Interviewees repeatedly confirmed the role of DFID itself and its health sector projects, in particular the perception that "pressure from DFID was the source for change in Jigawa", but that though "DFID influenced reform, it did not dominate". Many stakeholders were surprised that DFID did not act to a greater extent to prevent the abolition of Gunduma, seen sometimes as "DFID's baby".

What seems to have been important is not only the financial and technical resources made available through DFID programmes, but also *the way in which these programmes operated in Jigawa*, through long-lasting and dedicated advisers based in the State. One of the implementers noted "Our experience is that you need senior, experienced support over a long time to make a difference. Stakeholders on the ground won't trust you, let alone listen to you, until you have served some time, paid careful attention to those directly facing the problems every day, understood the complexity of the issues".[34] Several programme staff and managers have remained involved in DFID health and other programmes in Jigawa over the years, thus helping with continuity and trust.

Jigawa, as a DFID focal State, also benefited from synergies between the various DFID governance and sector programmes, most of which became physically co-located. The State and Local Government Programme (SLGP) and its successors State Partnership for Accountability, Responsiveness and Capability (SPARC) and PERL-ARC would collaborate with core Ministries, such as the Department of Budget and Planning, while PATHS and PRRINN-MNCH would focus on their health sector counterparts. Through (State Accountability and Voice Initiative) SAVI and then PERL-Engaged Citizens Pillar (ECP), DFID could also engage CSOs and community activities.

PATHS and PRRINN-MNCH seem to have therefore enjoyed a high level of influence. However, the *content* of the technical advice might not always have run 'with the grain' of what could be sustained over time in Jigawa, given political economy factors. The choice and influence of Ghana as a model for Gunduma, with its district system and merger of PHC with SHC, would need further investigation (including the degree of influence of Ghanaian consultants in PATHS). The model was adapted to suit Jigawa's perceived needs at the time. While it was used by PATHS and PRINN-MNCH to advocate national reforms, it became out of synch with Nigeria-wide institutional equivalents and quickly reversed in 2016.

[33] *Sofo Ali-Akpajiak (2010) p.50, as well as interviews.*

[34] *Bryan Haddon (2015) 'Ten essential ingredients for governance reform and health system transformation', posted on December 21, 2015 Health Partners International http://healthpartners-int.co.uk/ten-essential-ingredients-for-governance-reform-and-health-system-transformation/ and also MacKenzy et al (2015)*

Box 5: DFID Health Programmes Active In Jigawa State (2001-2017)

*Jigawa stakeholders were involved in DFID's **Change Agents Programme (2001-2004)** which aimed to build a cadre of reform-minded health professionals and led to the creation of Health Reform Foundation of Nigeria (**HERFON**) in 2004. Several past and current Commissioners for Health and other civil servants participated in Change Agents' trainings and study tours.*

***PATHS1 (2001-2008) was followed by PATHS2.** The latter notably concentrated on 'improving the planning, financing and delivery of sustainable and replicable pro-poor services for common health problems in up to six states'. PATHS also collaborated and then incorporated the Health Commodities Project to support the DRF and the passage of the JIMSO bill. PATHS2 final spend was £177million over 2008-2016.*

*PATHS2 collaborated with **PRRINN-MNCH** (Programme for Reviving Routine Immunisation in Northern Nigeria – Maternal, Newborn, and Child Health) which to improve effective access to MNCH (including routine immunization – RI) services in four states. It operated during 2006-2013 and received £38 from DFID and £27m from Norway. In Jigawa, PATHS2 took on the MNCH aspects and PRRINN-MNCH focused on operational research and MNCH health system strengthening such as assisting Gunduma Councils in their planning and finance activities and wider Jigawa planning (Health Sector Plan, State Comprehensive Development Framework). The integration of both health system strengthening and vertical health interventions was seen as innovative.*

***MNCH2** (2014-2019, £140million across Nigeria) continues its predecessors focus on MNCH, RI, health sector planning and budgeting, demand and access to PHC services, but with relatively less attention to systems' reform.*

***W4H** (2012 – 2017, £30million) is another health system strengthening programme to address the acute shortage of women health workers in Northern Nigeria.*

Other DFID health programmes in Northern Nigeria include programmes on: Support to National Malaria Programme (SUNMAP, 2008-2015); nutrition (Working to Improve Nutrition in Northern Nigeria – WINNN, £56m), and Sanitation, Hygiene and Water in Nigeria (SHAWN, £96m).

***Other health donor programmes** active in Jigawa during the period include: WHO, UNICEF, USAID COMPASS, EU PRIME and EU SIGN, World Bank Saving One Million Lives, Médecins Sans Frontières, Action Against Hunger and Rotary International.*

Sources: PATHS2 inception report (2009) and DFID business case for extension (2013); PRRINN-MNCH annual review (2010), final report (2013) and DFID project completion review (2013)

Critical factor 3: Creating allies through evidence and incentives

Gunduma and JIMSO were introduced as the result of a long process of analysis and consultations supported by PATHS1 during 2002-2007. Interviews showed that not all stakeholders were sure of the types of reform that might be needed at the start of the process. Some of the elements used to convince them included:

Evidence-based policy: data generated from the situational and institutional analysis "opened the eyes" of a number of stakeholders that change would be better than the current situation. Similarly, establishing a PHCDA as a policy reversal in 2015 has been publicly justified by the SMOH by using survey as opposed to administrative data, considered less reliable.

Committed cohort of change agents: stakeholders involved in the Health Sector Reform committees and then Gunduma continue to project a strong sense of common purpose, which seems to have lasted for over 10-15 years. This was generated through collective activities, such as working groups, study tours to Ghana, retreats and trainings supported by PATHS. All three sets of reforms (PFM, Gunduma, DRF/JIMSO) have benefited from committed civil servants, who were either freed from political pressures because of their own individual power base or were able to manage them effectively. Personal pride and job-satisfaction seems to have been a strong motivator: "the civil service technically wanted reforms [and] were able to convince those opposed of the value of reform". Further research could examine what shaped the motivations of these civil servants not fully evident from interviews, such as the influence, if any, of shared education, religion or class.

Coalition-building: giving powerful actors a stake in the reforms has been essential. Gunduma, through its Board structure, could readily absorb different interest groups, such as traditional leaders (see box). DRF/JIMSO was also able to do so by taking into account the interests of patent medicine vendors which might feel excluded from the State-control system by giving them access to State-purchased medicines.

Proactive lobbying: Gunduma stakeholders were extremely active at the time of the 2007 political transition; lobbying politicians of all political parties on the need to maintain their proposals. By contrast, no such proactive campaigning seems to have taken place around the 2015 political transition to maintain Gunduma, which they may have perceived as secure after eight years. Following the dissolution of Gunduma, its proponents continue to actively defend its legacy, including through newspaper articles.[35]

BOX 6: TRADITIONAL RULERS

Outside the State Government, political and social power resides in Jigawa's five Emirs. Governors and civil servants need to work with traditional rulers to bring them into a reform coalition in order to benefit from their authority and access rural populations. This was successfully achieved through the Gunduma reforms:

- *Gunduma means 'district' in Hausa. The name was chosen in order to make it more understandable. The Gunduma system adopted the geography of Jigawa's five Emirates, grouping together several LGAs to form a district.*
- *Several traditional rulers were involved in the consultation process that set up Gunduma. They also had a mandatory place on the nine Gunduma Councils and on the Gunduma Board.*
- *Local committees assisting and monitoring the performance of health facilities (ward committees) were made of local community leaders. While they were established prior to DFID programmes, they have been fully involved in their "demand-side" and "community-engagement" strategies.*

Civil society advocacy or direct citizens voices do not seem to have been particularly influential either in the creation of DFR/JIMO or in Gunduma. Community based organisations and media were used as part of the campaign to establish public awareness of Gunduma, but do not seem to have acted as particularly independent voice.[36]

Critical factor 4: Managing resistance effectively

Gunduma and DRF/JIMSO offer contrasting examples of two institutional reforms which started as part of the same overall process and were therefore subject to a similar State and sector-wide political economy. They differ in the range of interests they affected and the strategies they used to manage them. Whereas JIMSO was able to adapt and grow overtime, Gunduma was overturned after eight years. The risk of Gunduma's contestation by "stakeholders whose power and influence will be eroded under the new system" was identified by DFID from the beginning.[37]

Ministerial resistance against a powerful, semi-autonomous agency

Gunduma took over a significant share of SMOH authority, responsibilities and access to resources, both on paper and in practice. Formal mandates have to be combined with personal authority to explain Gunduma's performance.

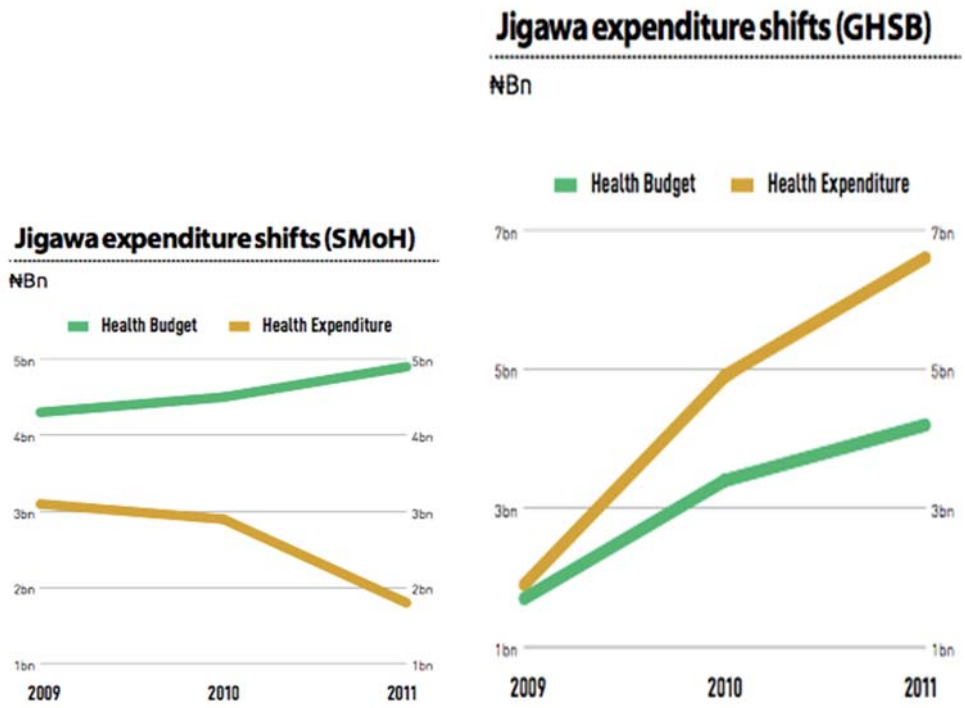
The critical factor seems to have been access to financial resource and appointments. The SMOH lost a significant share of expenditure when Gunduma took over responsibility for both primary and secondary healthcare. SMOH budget reduced to under N2billion while Gunduma reached N7billion by the end of its fourth year in 2011. The first Gunduma Board Chair is reported to have focused on capacity building and professionalism, rather than infrastructure, presumably in order to avoid conflicts over contracts with the SMOH. Later tensions between SMOH and Gunduma reportedly related to access over finance (see figure 3 below).

[35] *Adamu Muhd Usman This Day News posted on 05 Feb 2016 in Medical News https://www.medicalworldnigeria.com/2016/02/between-badaru-lamido-and-the-jigawa-health-sector#.WfeqBEyZNxg*

[36] *Sofo Ali-Akpajiak (2010) p.29, as well as interviews.*

[37] *DFID Human Development Resource Centre PRRINN-MNCH Annual Review (2010) p.86.*

Figure 3: Jigawa expenditure shifts (SMoH) and Jigawa expenditure shifts (GHSB)



Source: PRRINN-MNCH final report 2013, pp. 98-90.

The abolition of Gunduma in 2016 by the present Jigawa administration has restored the primacy of the SMOH over both primary and secondary care. The PHCA Executive Secretary reports directly to the Commissioner for Health (who had been Executive Secretary of Jigawa's initial NPHCA in 2001). The SMOH controls budgets for secondary care hospitals. The technical justification is that this change was required by the NHA and will enable Jigawa to access federal health funds. However, the 2015 PHCUOR Scorecard explicitly recognised Gunduma as its PHCDA equivalent.[38]

The abolition of Gunduma has also enabled the SMOH to regain control over staffing. The process of re-allocating Gunduma managers and technical staff or appointing new ones to the LGA PHC structures was still ongoing as of 2017. It is likely to have affected the performance of the health system during 2016 (and may have affected some of the health outcomes indicators reviewed in section 4). The SMOH stresses the benefits of reappointing staff across PHC, such as enabling payroll cleaning and checking professional credentials (see section 2). However, interviewees from different stakeholder groups complained that its result has been a politicised system, with positions within the PHCA or LGAs allocated as a reward for political support during the 2015 elections This politicisation could also have theoretically taken place when Gunduma was set up though no interviewees raised it as a concern.

Were the tensions between the SMOH and Gunduma a fundamental design flaw, or could they have been overcome and Gunduma 'tweaked' to become acceptable to the 2015 administration? It is noticeable that no other Nigerian states adopted the Gunduma (integrated district) model and Enugu's PATHS-funded experiment did not last. This suggests design flaws in terms of managing stakeholders' interests in a comparative Nigeria-wide context. Difficulties were reported within a few years of Gunduma being set up, such as in a 2010 case study. Efforts by PATHS2 to 'reorient' the SMOH to focus on its policy and monitoring roles did not succeed; the challenge was not one of reorientation, but rather control and accountability. Tensions were still evident in the 2016 independent review of PATHS2 capacity building, which noted that "Although there was a monthly liaison meeting between them, it was reported to be impossible for SMOH to assess the performance of the GHSB as required in law because of the absence of reporting processes, with the GHSB believing itself to be independent

[38] *NPHCDA (2015) pp. 63-64.*

of SMOH. The lack of counterpart officials and one-to-one relationships created a divide between the two bodies."[39]

By contrast, DRF / JIMSO remained within the remit of the SMOH, which prevented tensions over direct control and accountability. The SMOH Director of Procurement and Supplies is accountable to the Commissioner. Though a Bill had been prepared, it was never passed. JIMSO was not established as an independent parastatal. This was reportedly a Governor's decision to avoid additional layers and competing interests.

LGA resistance[40]

Another source of potential opposition to Gunduma included the MoLG and LGAs, which had responsibilities for PHC prior to Gunduma. Setting up Gunduma required collaboration between the SMOH and MoLG, which, for example, jointly submitted a Memo to the Governor in 2007 to support the reform. The abolition of PHC at the LGA level was justified technically at the time by the very low number of health professionals and facilities; regrouping resources in nine Gunduma Councils each with a responsibility for three or four LGAs would pool resources and facilitate coordination. Finally, there was some precedent for this arrangement, as under military rule, secondary health facilities were already managed on a zonal (now district) level.

How did Gunduma overcome LGAs resistance, which had lost posts and direct access to funding? The restructuring left LGAs with some responsibilities, such as for environmental health (water and sanitation). LGAs were also involved in the Gunduma Councils and contributed to bottom-up planning. The 2016 PATHS capacity assessment noted that relations were better than in Enugu or Lagos where "SMOH and LGAs were operating independently".[41] It could also be hypothesised that LGAs are weaker organisationally and politically, and therefore less able to proactively resist Dutse-led change. While LGAs participated in Gunduma, they have now regained more direct access to resources under the new system. A PHC manager and their technical team are based in every LGA.

As with its relationship with the Ministry, the DRF/JIMSO was able to keep LGAs on board. LGA staff manage sub-stores for medicines under JIMSO, and order their supplies according to funds available in the DRF. They are allowed to keep a certain percentage of the mark-up, which plays a motivating role (see box 7).

BOX 7: INTERNAL ACCOUNTABILITY THROUGH DRF MARK UP

Under the DRF/JIMSO drugs management system, a transparent mark-up system has been established. Different levels are allowed to retain different percentages of the sales of the drugs (5% at the JIMS central store, 15% at SHC facilities, 8% at PHC facilities and 7% at the LGA level). The PHC facility mark-up of 8% includes 4% allowed for facility logistics and imprest account and 4% for inflation, losses and so on. The 7% LGA mark-up is made up of: 2% for PHC LGA supervision, 2% day-to-day running of the store at LGA level, and 3% inflation loses, breakage and expiry of drugs. While DRFs are supervised, use of the DRF mark-ups is not accounted for, giving various levels some autonomy.

DRF committees monitor performance at different levels, ensuring internal oversight. The SMOH assess the level of performance of each facility annually, reviews the cash flow and allocates funds to augment the financial needs of the facility.

A PHC management team described how they sanctioned a N100,000 theft from the DRF by deducing the same amount from the person's salary. Some of the visited PHC facilities did not want to touch the DRF mark-up they were entitled to, in order to ensure they remained well stocked-up, and due to the fear of audit of the use of funds.

Professional resistance[42]

[39] *IMEP, 2016 p.23.*

[40] *This sub-section is based on secondary literature, as no interviews were conducted with MoLG or LGAs officials, past or present. Future Jigawa field work could extend to interviews with them.*

[41] *IMEP (2016), p.24.*

[42] *Interviews with pharmacist professional associations and non-medical staff association could not be held during the research time frame. They would add important insights.*

Gunduma and DFR/JIMSO both had to manage professional groups' resistance, from doctors, non-medical health sector staff and pharmacists.

This was less of a challenge for DRF/JIMSO, as interest groups that would lose out from a cleaner and more efficient drugs supply and management were not as powerful. Patent medicine vendors are private people with no particular civil or political power to resist the introduction of DRF/JIMSO. They were not organised nor particularly connected to "big men". Unscrupulous pharmacists could not easily oppose the reforms.

By contrast, Gunduma introduced a radical change in the responsibilities and status of one of the health sector's most powerful stakeholders, medical doctors. Gunduma placed doctor-managed hospitals under a unified control structure with PHC facilities, usually managed by community health extension workers (CHEW) or other non-medically trained staff. While hospital supervision remained under the control of doctors (Gunduma Councils' deputy director for hospital), only about half of Gunduma Councils' directors were doctors (initially none given the shortage of doctors in the state). Gunduma officials were proud that the initial Councils recruitment was based on merit and competency-based assessment, not medical qualifications.

However, as a result, the medical profession became divided on the overall system, with strong technical arguments for rejecting decision-making structures which would give less trained officials a say. This organisational feature also undermined the professional pride of doctors. The merger of secondary and primary healthcare was one of the most frequent criticisms of the Gunduma system in doctors' interviews and a strong justification for the current Jigawa administration's abolition of Gunduma.

Critical factor 5: Technical feasibility

Jigawa's health sector governance reforms were driven by the State's civil service, in the context of a supportive political environment (critical factor 1) and significant donor support (critical factor 2). To be sustained, they had to successfully manage interests, both of potential supporters (critical factor 3) and opponents (factor 4).

The factor which differentiates all three sets of reform consists in their technical aspects: their degree of ambition, complexity and alignment with federal initiatives.

- **Public financial management reforms** require changes to a narrow set of systems and procedures. In the wider literature PFM is considered usually more successful than PSR. Jigawa also benefited from DFID support for state-wide PFM strengthening, first through SLGP, SPARC and currently ARC. In addition, the current PS (and formerly Director) of Budget and Planning is recognised as a particularly dedicated official, working beyond the call of duty to institute reforms.
- **Wider public administration reforms, such as human resources or use of evidence** are more complex and expensive to implement. Training, recruiting and retaining medical and non-medical staff depends on wider factors such as education levels in the State, affordable but attractive salaries, and the perceived quality of life in rural Jigawa. Special benefits to attract staff, such as salary supplements, can increase the wage bill and create distortions, such as attracting non-medically qualified staff to the sector (e.g. accountants). Similarly, data quality assurance requires ongoing routine efforts, difficult to maintain with poorly qualified staff in PHC facilities facing numerous and more immediate pressures on their time, such as meeting immediate health needs. This may explain why Jigawa is still struggling in these two dimensions, despite 15 years of assistance.
- **Gunduma was a complex re-organisation of the entire health service delivery system and remained out of sync with the rest of Nigeria.** It entailed both geographical and functional restructuring. It attempted to improve performance and efficiency, expecting more of front-line staff and reducing its supervising Ministry's authority. As a result, it created more points of potential resistance than DRF / JIMSO. While Gunduma was presented as a front runner of the Nigeria's PHCUOR policy model adopted in 2011,[43] it potentially took on too many aspects of the WHO and Ghanaian integrated district model without adapting them to Nigeria's

[43] *See PRRINN-MNCH final report (2013) and other donor programmes publications.*

complex three levels of government involved in health, generating a fourth (district) level. Gunduma was developed by paying attending to the then draft 2004 NHA. By the time the NHA was passed in 2014, Gunduma was no longer aligned to the Act and had not been replicated in other states.

- **DRF / JIMSO** is a simpler reform, concentrating on drugs supply and distribution. DRFs had been in existence across Nigeria since the 1980s so it was not a radical re-invention. It built on what was already there, such as a World Bank funded medical store in Jigawa's second city, Birnin Kudu. It was scaled up progressively. It was also timely, benefiting from a federal level push to combat fake drugs. The design created a system more financially sustainable than the other reviewed health governance initiatives, through a one-off capitalisation and incentivised mark-up system.

What outcomes have these reforms achieved?

Theory of Change: from health sector governance to improved outcomes

The objective of Jigawa's health sector reforms has been to improve systems in order to achieve: i) improved service delivery and therefore ii) improved health outcomes. The implicit Theory of Change behind the suite of reforms can be simplified in the following way: improved strategy, planning, budgeting, implementation and oversight by health sector managers (through PFM, HRH, HMIS), grouping scare PHC and SHC resources at an intermediary level so they can be better managed with accountability to non-sector actors (Gunduma Board and Councils), together with timely quality medical supplies (through DRF/JIMSO) would enable PHC facilities provide better services to underserved rural areas, thereby improving their health outcomes if demand for health was also stimulated. Jigawa initiatives not reviewed here also covered such complementary elements, such as local committees collaborating with health facilities and awareness-raising campaigns to encourage the use of services, in particular by women and children.

DFID programmes operating in Jigawa were expected to improve health outcomes in this way, through the combination of systems and service delivery improvements. PRRINN-MNCH's integration of both health systems and vertical health service delivery was seen as "an approach that has not often been used before and may yield when outcomes can be measured some years in the future, especially in reducing maternal and child health mortality. This programme is one to watch."[44]

However, the major reviews of these DFID programmes avoid attributing Jigawa's health outcomes improvements to system reforms, or donor interventions. For example, the 2016 independent review concludes: "there is evidence of improved health outcomes in the PATHS2 States […] though the extent to which these improvements can be attributed to PATHS2 interventions is difficult to establish".[45]

Comparative research across NW States would help understand the institutional (health sector governance) factors that might have led to improvements. Comparing States with similar contextual factors and health challenges, but changing key institutional variables along the five critical success factors noted in the previous section, would help draw stronger conclusions.[46]

The use and abuse of data: politicisation of health outcomes data

Health data is not neutral. It has been used in Jigawa to justify reform (2001-2010), reverse it (new Jigawa government in 2015) and defend past efforts (some ex-Gunduma and PATHS/PRRINN-MNCH staff). For example, the 2010 National Immunisation Cluster Survey data was used to show the positive effects of Gunduma and convince other NW states. Jigawa coverage jumped from 0.1% in 2003, through 16% in 2006 to 76.6% in 2010, among fully immunisation 1-year olds. From being one of the worst- performing states in the country Jigawa had the 4th highest coverage, higher than any of the other 19 Northern States.[47]

Different data sources, from project data, administrative data and health surveys have been used overtime to advocate different reforms. Which ones should be used to assess Jigawa's health outcomes?

DFID established an Independent Monitoring and Evaluation Project (IMEP) to assess the performance of its suite of state-level programmes. IMEP found administrative health data weak. Nigeria-wide survey

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[44] DFID Human Development Resource Centre, PRRINN-MNCH Annual Review 2010

[45] IMEP (2016) p.43.

[46] For example, a second stage of the research could entail a comparison of Jigawa with Katsina (where there has been interesting reform according to HERFON) and with Sokoto (with no DFID assistance).

[47] Andrew McKenzie, Ahmad Abdulwahab, Emmanuel Sokpo and Jeffrey W. Mecaskey (2015) Building a Resilient Health System: Lessons from Northern Nigeria IDS Working Paper 454 Institute of Development Studies, April. p16.

data were more reliable than DFID programme data, and National Demographic and Health Surveys (NDHS) more reliable than Multiple Indicator Cluster Surveys (MICS), for sampling reasons.[48]

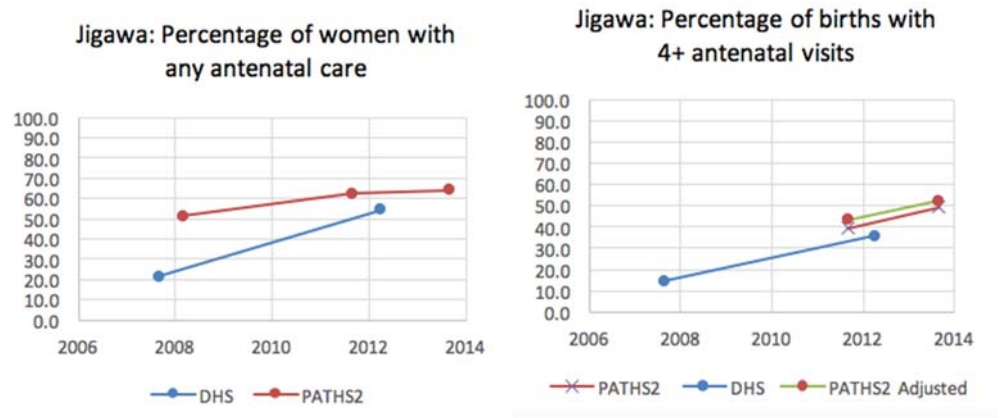
Jigawa's health outcomes improvements

Taking these caveats into accounts, Jigawa nonetheless appears to have seen clear improvements in a number of dimensions related to DFID health sector investments.

Service delivery seems to have improved. For example, in 2013 DFID reported that between 2008 and 2012 the proportion of births attended by skilled birth-attendants in PATHS2 States had doubled to 53%, including a quintupling of the rate in Jigawa State from 5% to 25%.[49] An intendent scorecard process also found MNCH improvements.[50] By 2015, IMEP's analysis was able to confirm that Jigawa had achieved good results, but needed to adjust for methodological issues:

- **Antenatal care improved**, with the percentage of women having had any ANC care increasing by around 10 percentage points over the period as a whole.
- **Increasing percentage of health facility deliveries and deliveries attended by skilled birth attendants** with an improvement in these indicators of perhaps 5-10 percentage points.[51]
- Against all three indicators in the five reviewed States, **the evidence was most consistent in Jigawa** "where data from most surveys are in agreement on trends, if not on levels".[52]

Figure 4: Antenatal care



[48] *For example, National Demographic and Health Surveys (NDHS) vs PATHS2 baseline, midline and end line surveys in Elizabeth Omoluabi, David Megill, Patrick Ward (2015) Assessment of Nigeria's Maternal Health Data Sources Final report, IMEP*

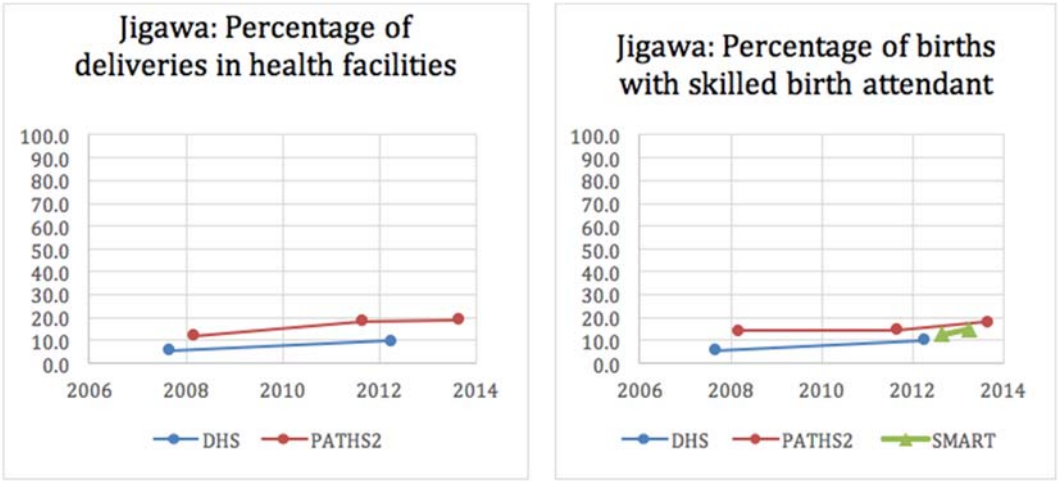
[49] *DFID (2013) p.24.*

[50] *Mamaye Jigawa State Maternal Newborn and Child Health Scorecards (2010-2012)*

[51] *Elizabeth Omoluabi, David Megill, Patrick Ward (2015) Assessment of Nigeria's Maternal Health Data Sources Final report, IMEP pp. 29, 42 and 46-48.*

[52] *Elizabeth Omoluabi, David Megill, Patrick Ward (2015) Assessment of Nigeria's Maternal Health Data Sources Final report, IMEP p. 5.*

Figure 5: Jigawa health facility deliveries and SBA births



Source: IMEP (2015) pp. 29, 42 and 46-48.

The Theory of Change assumes that improved service delivery would lead to improved health outcomes. This case study compared some of the available survey evidence for Jigawa against five indicators (details at Annex C). It concludes that Jigawa improved on all these health indicators; very strongly between 2003 and 2013 and sustained in most cases until 2017.

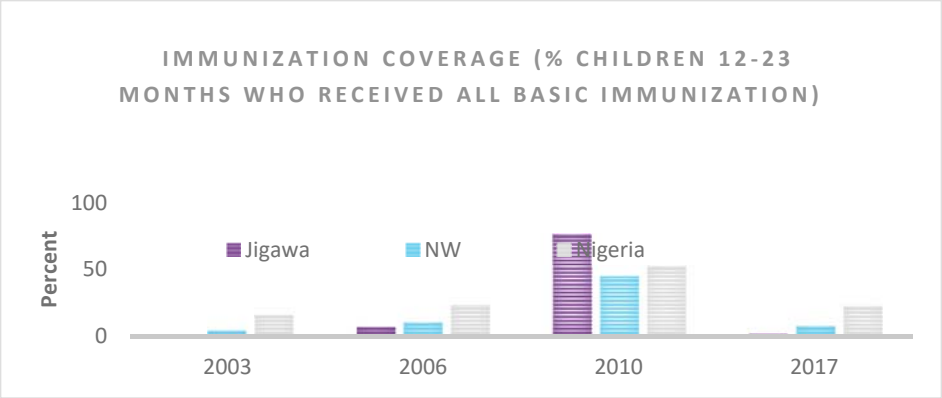
Four indicators showed sustained improvements. However, immunization coverage appears to have declined tremendously in 2017. When compared with the rest of the North West (NW), Jigawa's performance on these five indicators has not been particularly outstanding, with the exception of progress on children under 5 who slept under insecticide treated nets (ITN) the night before the survey (see box 8).

Given the selective use of data to justify or reverse reforms in Jigawa, participatory analysis with key stakeholders to understand what might have driven these results would be useful. This would explore which steps in the Theory of Change mattered most, and whether upstream institutional reforms, such as Gunduma, made a difference to service delivery and health outcomes.

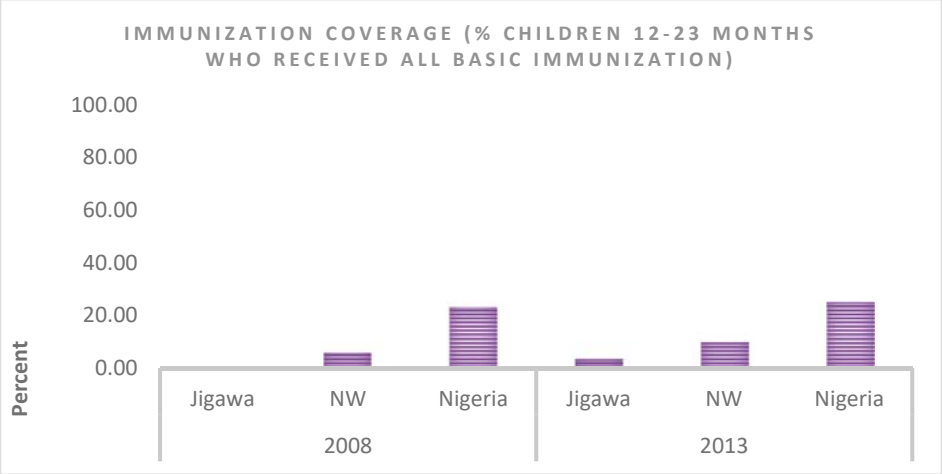
BOX 8: JIGAWA COMPARATIVE ANALYSIS OF IMMUNIZATION AND BEDNETS 2003-2017

Indicator 1: Immunization coverage

The 2010 NICS result where Jigawa outperformed NW regional average was not confirmed by the 2013 NDHS. Overall, Jigawa appears to have performed poorly when compared with the NW regional average.

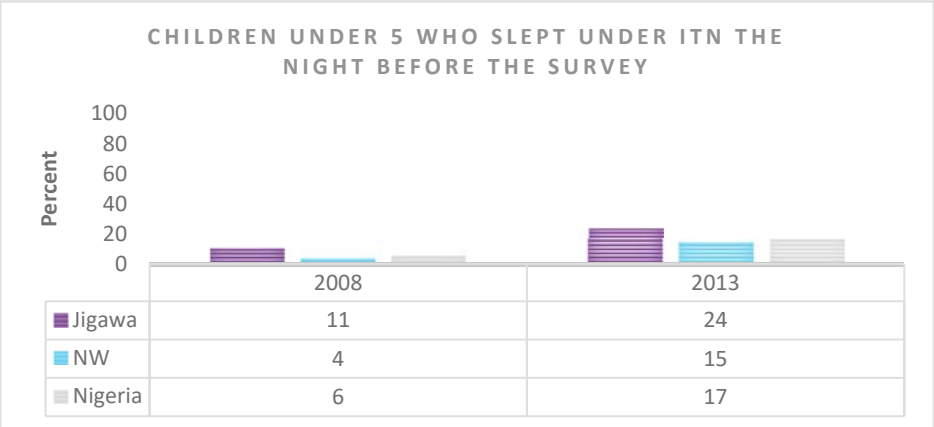


Source: NICS



Source: NDHS

Indicator 2: Children under 5 who slept under ITN the night before the survey
Jigawa clearly out-performs the rest of the NW (regional average).



	2008	2013
Jigawa	11	24
NW	4	15
Nigeria	6	17

Source: NDHS

What lessons can be learned?

This review of DFID's support for Jigawa's health system governance reform over 2001-2017 provides a number of lessons, both positives and negative. They are relevant for public sector governance reforms and service delivery for other sectors or Nigerian states receiving development assistance.

Lesson 1: Political commitment to reforms matter particularly in a personalised political system, where structural and institutional factors put little constraints on the executive. However, while it can be easier for individual politicians to initiate and fund reforms (e.g. approve a new structure through a new law or authorised increased budgets), it can be harder to ensure they are institutionalised and sustained once they leave office. For reforms to last beyond a Governor's two terms, they need to change the rules of the game successfully and durably weaken or manage opposition and other interest groups. This is where the Gunduma experience contrasts with the DRF. Working with a cadre of civil servants that will stay in post though political transitions can provide continuity unless political leaders decide to pursue different objectives. DFID therefore could play particular attention to political transitions.

Lesson 2: External assistance can have an important influence, especially when it is large and long-lasting as DFID's combination of health system strengthening reforms in Jigawa. What seems to have been important is not only the financial and technical resources made available, but also the way in which these programmes operated in Jigawa, with long-term trusted programme-managers based in the State and strong coordination between DFID Jigawa programmes.

Lesson 3: Participatory processes can generate commitment for reform, but a broad range of strategies have to be used to bring allies on board. A committed cohort in favour of change can become highly effective, using evidence, coalition building with traditional non-state actors, and well as proactive lobbying and information campaigns. DFD programmes were able to identify and support this demand for change from the civil service and health sectors workers.

Lesson 4: Managing reform effectively requires identifying which stakeholders' groups have the most to win or lose, and considering how their interests and incentives can be managed. Gunduma in Jigawa faced varying degree of opposition from the SMOH, professional doctors and LGAs officials. When the political support for Gunduma changed, the system was very quickly dismantled, and these stakeholders were able to regain their pre-Gunduma status. By contrast, JIMSO found a way of making its various stakeholders buy-in into the system while enforcing a system of internal oversight.

Lesson 5: The technical aspects of governance reforms do matter for their success in particular their degree of ambition, complexity and alignment with wider national initiatives. PFM is likely to be easier to introduce and sustain under a supportive political leadership than wider administrative reforms that involve more stakeholders and constraining structural factors. Gunduma might have been too complex, creating more points of resistance, and overtime did not remain consistent with the national framework (such as the merger of PHC and SHC). JIMSO was more targeted and also benefited from a federal push to combat fake drugs. However, this does not mean that more ambitious systems or PSR reforms are not needed. Jigawa's health services will not significantly improve without more health professionals and better managed human resources, which may require more gradual efforts.

Lesson 5: Data can be used and abused to justify policy change or defend programme success. The controversy over whether or not Jigawa has achieved health outcomes improvement shows how data can be used to both justify, and oppose, government's new policy directions.

Recommendation: In order to investigate the link between system reforms, services delivery and health outcomes, a second stage of this research could entail a comparison of Jigawa with Katsina (where there has been interesting reform according to HERFON) and with Sokoto (with no DFID assistance).

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