Summary Report on Coordination and Alignment in the Nigerian Health Sector (April 2011)

INTRODUCTION

Original report: In 2010, the PATHS2 programme commissioned a report detailing the coordination structure within the health sector, as part of its support to the Federal Ministry of Health's efforts to improve effectiveness and efficiency. The purpose of the work was to map existing coordination and harmonization structures and processes, and discuss the current situation with a range of stakeholders from Ministries, Departments and Agencies (MDAs), development partners and civil society groups. The report (*Review of Coordination and Aid Harmonization in the Nigerian Health Sector*) was presented to the Federal Ministry of Health in October 2010.

Updated report: The report was updated in early 2011 (*Updated Report March 2011: Review of Coordination and Aid Harmonization in the Nigerian Health Sector*), and presented in April 2011 to the Federal Ministry of Health. This updated report has drawn on recent developments: changes in leadership at the Federal Ministry of Health, structural changes in committees since the adoption of the National Strategic Health Development Plan (NSHDP), and the signing of the Country Compact in accordance to international agreements. The report identifies the rapid positive changes, addresses the challenges in the health sector that are both structural and cultural in nature, and provides a set of recommendations based on the updated findings. This summary[1] presents the salient points from the updated report.

Methodology: The review took a straight-forward approach and started by asking a number of basic questions to map out current coordination mechanisms. What coordination mechanisms exist? What are their purposes? Who attends? What do they produce? How and to whom do they report? These questions framed the discussion with representatives from government at Federal, State and local levels, development partners from the United Nations, bilateral agencies and global initiatives, international and national not-for-profit organisations and other private sector groups, as well as civil society networks and organisations[2]. The review team also visited Kano and Jigawa States to gain initial insights and opinions from State and LGA levels. This state level work was exploratory and limited in nature; more work at this level is needed and planned over the next 3 months, initially in the States of Enugu, Jigawa, Kano, Kaduna and Lagos.

EMERGING ISSUES IN NIGERIA

International aid architecture: Over the last decade the international community has highlighted the need to improve effectiveness, harmonisation, and the demonstration of impact of health resources. Some key changes in the international aid architecture that provide the background context are:

- The Paris High level Forum on Aid Effectiveness[3] with its ensuing Principles

[1] The authors of the Summary (David Daniels, Iheadi Onwukwe, Rolla Khadduri) take responsibility for the opinion expressed.

[2] Respondent list is available in the updated report.

[3] Paris Declaration on Aid Effectiveness. (March, 2005)

and Declaration have led to renewed pressures on governments and development partners to demonstrate a new way of doing business and coordinating action.

- The Paris principles have been reaffirmed through the recent Accra Agenda for Action[4], and are now being catalysed locally by the International Health Partnerships / Harmonization for Health in Africa (IHP+/HHA) processes. The IHP+/HHA initiative is a regional mechanism in response to the Paris declaration to provide support to African countries on a demand-driven basis[5].
- The International Conference on Primary Health Care and Health systems in Africa in Ouagadougou[6] (2008) reinforces the commitment to Alma Ata principles. It also restates the commitment of countries to involvement of communities in health development, and the importance of partnerships including civil society, private sector and development partners.

From Paris to Accra to Nigeria: Nigeria has localised these international efforts through a series of high-level agreements and commitments.

- In May 2008, Nigeria signed the Global Compact of International Health Partnerships and Related Initiatives (IHP+), which is committed to the achievement of the principles of the Paris Declaration on Aid Effectiveness, the Accra Agenda for Action and Ouagadougou declaration.
- The IHP+/HHA Joint Mission to the country in November 2009 provided technical assistance to improve quality of health plans; introduced costing approaches to revise high cost estimates; developed a draft National and Sub-National M&E Results Matrix; and also initiated discussions on Nigeria's Country Compact.
- In December 2010 the government and development partners signed the Nigeria Country Compact[7] with NSHDP as its basis.
- The NSHDP development process received tremendous support from all the Development Partners in Nigeria. The NSHDP is fully compliant with the principles of the Paris Declaration on Aid Effectiveness and the IHP+.

The Nigerian health system: The Nigerian health sector is complex, with a large number of stakeholders, policies, plans and programmes, with ensuing complicated coordination structures. Super-imposed on the multiplicity of bilateral & multilateral agencies and local stakeholders are the relatively new players from Global Health Initiatives such as GAVI and the Global Fund to fight AIDS, Malaria and TB (GFATM). The latter have introduced CCMs (Country Coordinating Mechanisms), which primarily report back to the GFATM Secretariat in Geneva. In addition, there are PEPFAR funds, and funds from the Bill and Melinda Gates Foundation. There are also a significant number of civil society organisations (CSOs) that play a significant role in the health sector, but are not yet sufficiently involved in the planning processes for the health system to fully benefit from their potential. The sheer number of players poses significant challenges for coordination, harmonisation and efficiency, and effect the ability of the health sector to produce improved services and health indicators. There have been a number of reviews of the health system that have looked at public service reforms, budget reforms, human resources for health and institutional analysis of the system[8] as a whole. The general consensus opinion suggests a system that is not functioning well. Also, many of the constraints are similar to those highlighted for more than a decade, suggesting a system that is not easy to change. **However, the recent international developments have been localised in Nigeria, a new health sector plan is now in place, and these have resulted in a welcome realignment behind the effectiveness agenda. This is an opportune time to capitalise on progress.**

[4] Accra Agenda for Action. 3rd High Level Forum on Aid Effectiveness (4 September, 2008)
[5] WHO. (2007). Harmonization for Health in Africa: an action framework.
[6] Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium (30 April, 2008)
[7] Nigeria's Country Compact – "Achieving measurable results for health through the National Strategic Health Development Plan 2010 – 2015.
[8] Crisp, N. Onwukwe, I. (2000). Institutional Audit of the Nigerian Health System (Federal Level). Report to DFID.

The NSHDP: The new National Strategic Health Development Plan[9], 2010-2015 (NSHDP), mandated by the National Council on Health, has been developed under the leadership of the Federal Ministry of Health in collaboration with all major stakeholders. The overarching goal of the NSHDP is to significantly improve the health status of Nigerians through the development of a strengthened, coordinated, re-invigorated and sustainable health care delivery system. The NSHDP provides an up-to-date situation analysis of the health system in Nigeria and also outlines the development policy objectives, interventions and actions to be pursued by the Federal, State and Local Governments as well as other stakeholders from 2010 to 2015. The NSHDP document will serve as the ONE Reference Plan for all and one health investment framework for validation, ownership, alignment, harmonization, and mutual accountability for all national and international development partners working in the health sector. The new NSHDP highlights a set of eight priority strategic objectives that will now underpin development of the sector. Critically, the NSHDP signals a renewed clear willingness to change the health system. It has already had a cascading effect and led to development of the State Strategic Health Development Plans (SSHDPs) by all the States.

Reference Group on NSHDP Implementation: The health coordination structures have evolved rapidly to align behind the plan, most notably with the development of the Reference Group for NSHDP (RG-NSHDP). Over the last few months, the establishment of the RG-NSHDP and its sub-committees has led to the decline in activity of other groups such as the Health Systems Forum (HSF). The RG-NSHDP has built on the positive experience of coordination work linked to the NSHDP development through the work of the NSHDP Steering Committee and the Technical Working Group. The RG-NSHDP includes participation from senior representative of key MDAs and DPs. It is acting as the main committee on NSHDP Implementation, and also acting as a Technical Working Group of the Health Partners Coordinating Committee (HPCC).

CONCLUSIONS

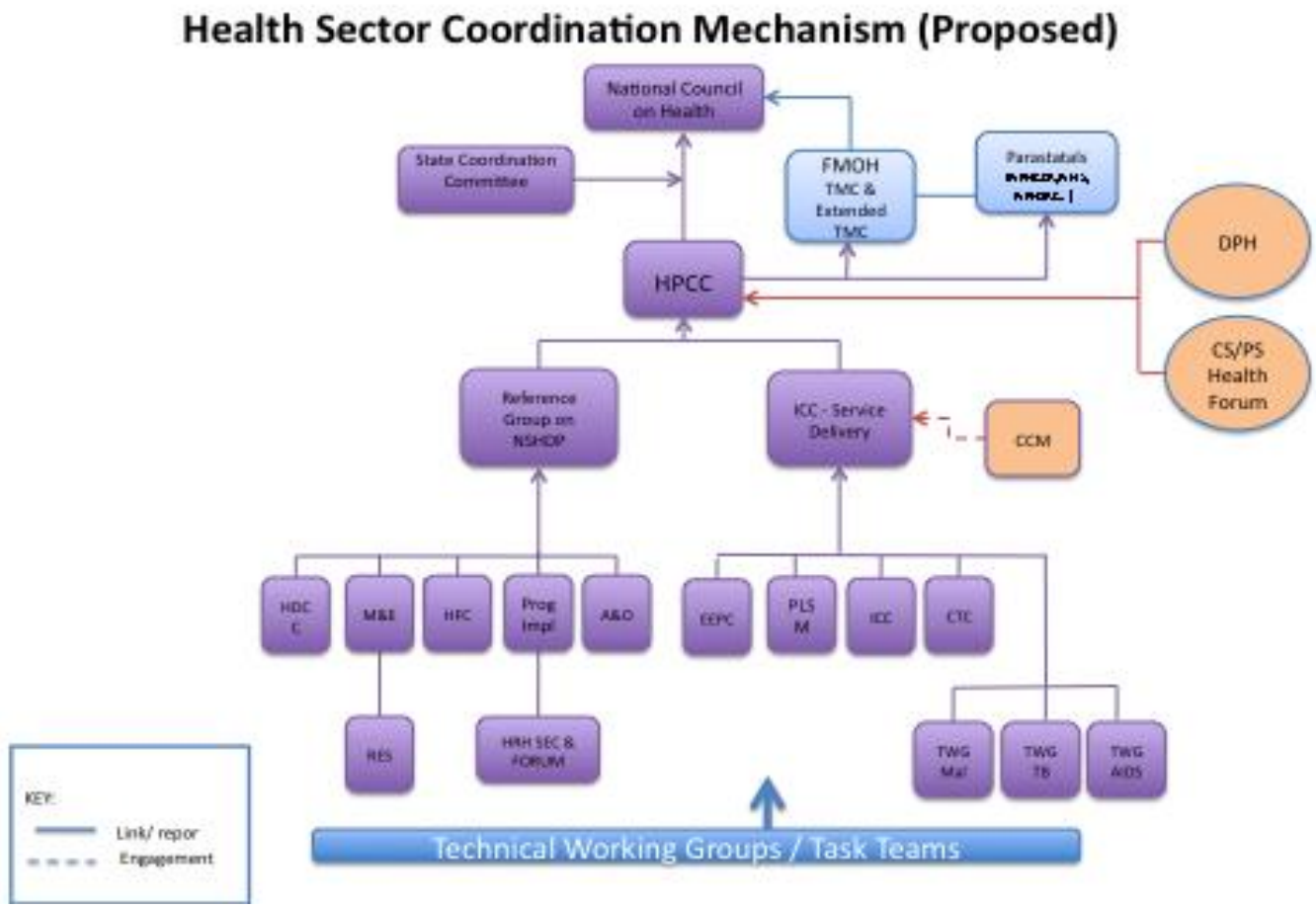
Below are some of the main conclusions and a box of highlighted recommendations. For a full discussion, please refer to the updated report[10].

Rationalising meetings: There are currently too many meetings, at both federal and state level. Senior government and development representatives spend considerable time attending multiple meetings. Duplication, as well as wasting precious time, is an issue. There are numerous uncoordinated groups discussing the same or similar issues but from a particular agenda or interest area (e.g. the large number of M&E committees, sub-groups, task teams etc). There appears to be little cross-referencing or information sharing between groups. There is lack of clarity as to whether particular Committees are policy or strategy focused, or technical committees.

Changing the culture of meetings: Many Committees/Sub-Committees are held infrequently and /or at short notice. This leads to poor preparation and unclear level of participation by partners. There is little use of electronic mailing for meeting information and key documents. There are a large number of partners present at the same time, and the sheer volume of organisations and programmes becomes difficult to manage**.** Meetings start late, often have no agenda, usually have no advance paperwork and minutes of the previous meeting are not available in advance. They are often over-represented and time keeping is poor. In general the transaction costs are seen as much too high. Linked to that is the lack of transparency of information. The current sharing of information on who is doing what and where across the sector is patchy. A spreadsheet that is currently updated by some development partners is a useful initiative but neither comprehensive nor sufficient, nor widely available.

[9] FMOH (2010), National Strategic Health Development Plan Framework (2010-2015)

[10] Updated Report March 2011: Review of Coordination and Aid Harmonization in the Nigerian Health Sector



Supporting a new coordination structure: The diagram presents a new coordination structure for the Sector at Federal level. It recognises the national mechanisms of NCH and senior management committees. It also continues with the central role of the HPCC for government – development partner coordination. However it calls for a substantial reorganisation of the overall structure.

The Reference Group is now an active group with good representation, and could replace the HSF as it is duplicating its functions. A strong commitment to sharing information on discussions should be made. Membership should be focusing on bringing together leading thinkers in health sector strategy and planning. Chaired by the Department of Planning, Research and Statistics, it should provide regular structured quarterly reports on progress to the FMOH, Agencies and Health Partners Coordinating Committee (HPCC). It will need to draw on information coming from the high level technical Committee on Service delivery (the proposed ICC-SD, see below). This Reference group is now established and operational with 4 sub-committees. Similar structures should be considered at State level with a mandate to track progress on the SSHDPs. The RG-NSHDP would meet monthly, with an option for intensified meetings at key stages in the budgetary and planning cycle. Partners working at National/State level and who have aligned with the NSHDP should participate (criteria to be further developed through consultation led by the Director Planning. Research and Statistics). The RG-NSHDP will provide update reports to the HPCC (or equivalent State level structure). The RG-NSHDP should provide short briefing/progress note to the FMoH/SMoH TMC. Briefings should also be shared among all State Commissioners of Health and Agency senior management groups. As well as the current sub-committees the RG-NSHDP should establish time bound and task specific Task

Teams. A number of these can be considered now such as: a Task Team on the Joint Annual Review (August - December 2011); and a Task Team on Health Sector Coordination (May-July 2011).

ICC-SD: In order to improve coordination on service delivery issues it is recommended to establish an expanded Interagency Coordinating Committee (ICC). This could be named the ICC-Service Delivery for the next period to maintain continuity and indicate the wider mandate of the group. This would have new terms of reference to cover all key technical areas of service delivery. Chaired by the Executive Director of the NPHCDA it should provide regular reports to FMOH, Agencies and the HPCC. The current high level ATM Task Team would be changed to committees dealing with technical issues on Malaria, TB and HIV/AIDS and reporting to the ICC-SD. This would be a monthly technical committee meeting chaired by the Executive Director of the NPHCDA or designate given their role in primary health care and service delivery.

Joint Annual Review: The introduction of the JAR has been a key part of improved coordination, sector analysis and information sharing. It should include all key government and agency groups, core development partners and UN agencies and major international and national private sector and civil society representatives. Planning for the second JAR should be given priority and adequately resourced to enable pre-JAR technical consultations. The NSHDP Reference Group, or appointed sub-group should act as the secretariat to the JAR. An equivalent approach should be encouraged at State level.

Coordinating international development assistance: There are a large number of actors within the Nigerian health system, including a plethora of international actors. The current sharing of information on who is doing what and where across the sector is patchy. Recent efforts at providing an updated matrix of programmes through the Development Partners for Health (DPH) group are encouraging; but this is still a limited system, and does not capture all the sources of support. There needs to be a data collection tool introduced by the FMOH that is accessible to all partners, with the request for information to be entered and kept up to date by partners themselves. There is now the option of web-based systems that capture information of this type that could be managed through tiered levels of access and password protection as appropriate. The tool could be further developed into a simple Dashboard format with Federal, State level and thematic Dashboards. Participation in sharing of information should be seen as a clear sign of commitment to supporting government's efforts, and could be a criteria for inclusion in higher policy and planning dialogue. Currently, the FMoH-led structure (International Cooperation and Resource Mobilisation Unit) seems under-resourced to coordinate donor missions or the provisions of technical assistance, and its capacity needs to be strengthened

Engaging non-state actors: Health-focused CSOs in Nigeria have contributed immensely to improving the health of the population by providing necessary information and basic health services. Non-state actors can play significant roles in the design, implementation and monitoring of health plans and strategies, and especially in holding all partners accountable for delivering on their commitments and achieving improved health outcomes. However, civil society is currently facing a number of key challenges, the most pertinent one being a lack of a single platform for engagement of non-state actors (including civil society organizations, the private sector, and NGOs) with the government. This can be remedied by creating a Civil Society Forum that represents a unified position in key meetings.

Leadership within the government: There are complex organisational arrangements that have been in place for many years that include a range of active MDAs with different roles and responsibilities. For this to work effectively good relationships, communication and coordination between these organisations is required. The Top Management Committee (TMC) and Expanded Top Management Committee (E-TMC) needs to fully resourced to deliver on their joint mandate of providing effective leadership and coordinating the activities of the health sector MDAs. A similar process should be encouraged at the state level.

RECOMMENDATIONS

Basic problems in coordination

(1) Establish a system of fewer, more focused, better managed meetings, which are tasked with: taking decisions, identifying implementing actions, and developing/maintaining meetings calendars.
(2) Structure the meetings with a clearer hierarchy so that representation can be at an appropriate level with clear reporting lines. Ministers and senior management need to review their participation to focus on key strategic level meetings. The impact of senior level presence in Nigeria is clear and can result in over-attendance, rapid or ad hoc convening of meetings.
(3) Implement new approaches to sharing basic information (e.g. using the new MoH website and circulars)
(4) Change the meeting culture, so that participants are better prepared, there are clear reporting requirements, and more attention is paid to secretariat functions including: agenda preparation, document preparation, time-keeping, report dissemination.
(5) Introduce continuing professional development programmes, for example short-course management training for Chairpersons and Secretaries. This could be extended to Associate Directors, Deputy-Directors and Directors of all MDAs, based on a technical needs assessment.

Restructuring meeting mechanisms:

(6) Introduce a new coordination structure across the sector that will see rationalisation of existing committees, sub-committees and task teams.
(7) Replace the former Health Systems Forum with the new Reference Group on NSHDP Implementation and its sub-committees. These will need to be reworked to cover some of those previously under the HSF.
(8) Establish a stronger integrated health service delivery focus with the upgrading of the ICC to become an ICC on Service Delivery.
(9) Discontinue the ATM Task Force as the tasks would be taken over by the ICC-SD.

Engaging non-state actors:

(10) Conduct a mapping of all health-focused non-state actors through collating existing databases, and initiate a consultative process on how best to formalise a single forum for their engagement.
(11) Once established, nominated Civil Society Forum representatives should be invited to participate in key meetings with government, development partners and other stakeholders.

Coordinating international development assistance:

(12) The FMOH could introduce a web-based system that captures information on partner activities. This could include self-reporting and updating by Partners. Such a system would increase transparency of information, as well as supporting decisions on the division of labour in terms of thematic and geographic focus.
(13) The Federal Ministry of Health should consider the potential of pooled funds for technical assistance, especially linked to joint activities such as tracking of NSHDP, data collection and analysis, and areas such as preparation and facilitation of JAR.

Leadership within the government:

(14) Coordination needs to be improved across the health sector with strong and clear leadership from government, and regular dialogue and exchange of information between the tiers of government.
(15) The Permanent Secretary could convene a high-level meeting specifically to discuss coordination, and clarify roles and participation of MDAs.
(16) Detailed frameworks for state level coordination need to be developed using SSHDPs as their basis.

NEXT SUGGESTED STEPS

In view of the number of recommendations, a short work-plan detailing proposed next steps is provided, with a suggested timeline to ensure the momentum gained in the past few months is maintained and capitalised on by certain milestones within this year.

	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Present key conclusions/recommendations to the HPCC and NCH	X							
Conduct further consultations with key stakeholders on restructuring of coordination meetings, ensuring alignment of mechanisms with NSHDP strategic objectives. This includes drawing up a detailed guideline for each committee. This could be done by a time-bound Task Team on Sector Coordination under the RG-NSHDP		X	X	X	X	X	X	X
Introduce new meeting schedule for the rest of 2011			X					
Institute recommended changes to key coordination groups (including revising TORs, and membership). This will allow the ICC-SD to hold its first meeting			X					
Provide support to second JAR (by establishing a Task Team and developing TORs for JAR Preparatory Reviews)					X			
Expand on state and LGA-level coordination mapping		X	X	X	X			
Implement a web-based solution for improving information-sharing in the health sector								X
Conduct a management training guidelines and course, with a focus on developing a better meetings culture for key players					X	X	X	X