CASE STUDY ANALYSIS OF THE INTEGRATED MATERNAL, NEONATAL AND CHILD HEALTH STRATEGY IN NIGERIA

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SUB-NATIONAL IMPLEMENTATION OF NATIONAL HEALTH POLICY: A CASE STUDY ANALYSIS OF THE INTEGRATED MATERNAL, NEONATAL AND CHILD HEALTH STRATEGY IN NIGERIA

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ABSTRACT

SUB-NATIONAL IMPLEMENTATION OF NATIONAL HEALTH POLICY: A CASE STUDY ANALYSIS OF THE INTEGRATED MATERNAL, NEONATAL AND CHILD HEALTH STRATEGY IN NIGERIA

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Comprehensive policies exist to tackle Nigeria's poor maternal, neonatal and child health (MNCH) indices, but departures from policy intent during implementation result in less than expected outcomes. In Nigeria's federal system of government, national level policies are transferred to subnational level, the states as mediators of for implementation. Executive powers at the state level reside with governors. This study aims to contribute to a better understanding of the role of states in policy implementation, taking a historical and comparative view of implementation of three complex programmes, which had intergovernmental collaborative aspirations. Study was set in two (subnational) states (Anambra and Ebonyi). In addition, national level data were collected from Abuja – Federal Capital Territory, where policymaking is domiciled. A qualitative case study design triangulated information from document reviews (69) and in-depth interviews (44). Emerson's integrated collaborative governance (CG) framework was used to examine the overarching multi-level governance and how this impacted the policy process. Ethical clearance was obtained. Data was organised and coded with NVivo 11 software and thematic analysis conducted. Member checking, presentation of findings at conferences, journal clubs and PhD seminars, enhanced rigor, and validity. Findings showed that misaligned governance structure- mismatched fiscal and administrative decentralisation, policy design and governance arrangements impacted policy process. Existing system context and drivers did not adequately generate collaboration dynamics for collaborative actions. Leadership is not adequately distributed across, government levels, which are designed to be interdependent, due to the overwhelming executive powers of the state governors, whose interests appeared not adequately incentivised

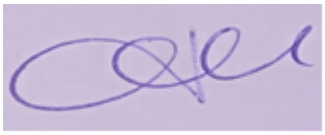
to collaborate with other levels, in these programmes. The key collaborative activity was signing of Memoranda of Understanding, but these were not honoured during implementation. Despite contextual variations across study states, they had similar responses to programmes. So, although, programme design and sub-national stakeholder engagement were perceived as inadequate, an underlying disconnect exists in the multi-level government (MLG) structure. Actor relationships across levels resulted in different power practices, majority being contestations (control, domination, resistance). Key national level actors drove national level policy processes and mobilised programme funds but could not adequately influence sub-national collaboration, rather were seen as meddling in sub-national implementation space. Health commissioners are appointed by governors, so, the pre-existing power imbalance requires skilful navigating by commissioners to appropriately mobilise governors' interests. Collaborative governance brings stakeholders together in collective forums to engage in consensus-oriented decision-making, through face-to-face dialogue, trust-building, development of commitment and shared understanding, to overcome prior history of conflict and contestations. Capacity to act and the decision to act need to balance out across levels. Transaction costs of collaboration, noted to be a constraint in weak health systems like Nigeria, need to be addressed proactively when collaboration is intended. This study proposes an interim structure of coordination and cooperation in these contexts, with further de-concentration of responsibilities, backed by explicit mandates and matching fiscal decentralization, from the federal to the state ministries of health. Sustained advocacy to state governors for stronger collaboration and to domesticate the National Health Act which provides for collaboration across the three levels. Besides advocacy, other innovative ways of achieving a distributed leadership model, require further evidence. Stakeholders need to be made aware of what other drivers are available to them for collaboration and what needs to be built within the system context. Economic and political reforms which incorporate subnational accountability tied to fiscal transfers should also be explored.

November 2021

DECLARATION

I declare that *Sub-National Implementation of National Health Policy: A Case Study Analysis of The Integrated Maternal, Neonatal and Child Health Strategy in Nigeria* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Enyinnaya Ifeoma **Etiaba** November 2021

Signed: . . . 

DEDICATION AND ACKNOWLEDGMENTS

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I began to dare to dream of a PhD programme at the School of Public Health (SoPH), University of Western Cape (UWC), when I was selected as a member of the Emerging Leaders programme under the Consortium for Health Policy and Systems Research and Analysis in Africa (CHEPSAA) (2013-2014), and for that I am grateful to Prof. Lucy Gilson. Subsequently, working with her on different projects has been an academic privilege.

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I thank the Almighty God, who makes everything good in His time!

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ACRONYMS

ACRONYM	MEANING
ANC	Antenatal Care
APC	All Progressives Congress
BHCPF	Basic Health Care Provision Fund
CAS	Complex Adaptive Systems
CBHI	Community Based Health Insurance
CCT	Conditional Cash Transfer
CSO	Civil Society Organisation
CTC	Core Technical Committee
CHEWs	Community Health Extension Workers
CHIPs	Community Health Influencers and Promoters
CHW	Community Health Worker
DFID	Department for International Development
DLI	Disbursement Linked Indicator
ED	Executive Director
EU	European Union
FAAC	Federal Account Allocation Committee
FCT	Federal Capital Territory
FGoN	Federal Government of Nigeria
FMoFBNP	Federal Ministry of Finance, Budget and National Planning
FMoH	Federal Ministry of Health
FSP	Fiscal Strategy Paper
FSSHIP	Formal Sector Social Health Insurance Programme
GTB	Guaranty Trust Bank
NGO	Non-Governmental Organisation
HERFON	Health Reform Foundation of Nigeria
HMIS	Health Management Information System
HPSR	Health Policy and Systems Research
HRH	Human Resources for Health
IMNCH	Integrated Maternal Neonatal and Child Health
IRMNCAH+N	Integrated Reproductive Maternal Neonatal Child Adolescent Health + Nutrition
ITN	Insecticide Treated Net
JAAC	Joint Account Allocation Committee
KI	Key Informant
LG/LGA	Local Government/Local Government Area
LGHA	Local Government Health Authority
LMICs	Low- and Middle-Income Countries
M&E	Monitoring and Evaluation
MLG	Multi-Level Government
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MOU	Memorandum of Understanding
MSS	Midwives Service Scheme
MTEF	Medium-Term Expenditure Framework
NACA	National AIDS Control Agency
NAFDAC	National Agency for Food and Drug Administration and Control
NBS	National Bureau of Statistics

NCDC	Nigerian Centre for Disease Control
NCH	National Council on Health
NDHS	Nigeria Demographic and Health Survey
NHIS	National Health Insurance Scheme
NHIS-MDG-MCH	National Health Insurance-Millennium Development Goals-Maternal and Child Health
NHP	National Health Policy
NNHS	National Nutrition and Health Survey
NPC	National Population Commission
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
NSHIP	Nigeria States Health Investment Project
OOP	Out-of-Pocket
PATHS	Partnership for Transforming Health Systems
PDP	Peoples' Democratic Party
PIU	Programme Implementation Unit
PMV	Patent Medicine Vendor
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
RH	Reproductive Health
RHFP	Reproductive Health Focal Person
SAP	Structural Adjustment Programme
SDGs	Sustainable Development Goals
SHIA	State Health Insurance Agency
SJLGA	State Joint Local Government Account
SMART	Standardized Monitoring and Assessment of Relief and Transitions
SMoH	State Ministry of Health
SOML	Saving One Million Lives
SOML PfR	Saving One Million Lives Programme for Results
SPHCDA/B	State Primary Health Care Development Agency/Board
SSHDP	State Strategic Health Development Plan
SURE-P	Subsidy Reinvestment and Empowerment Programme
SURE-P/MCH	Subsidy Reinvestment and Empowerment Programme for Maternal and Child Health
SUS	*Sistema Único de Saúde* – Unified Health System
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UHC	Universal Health Coverage
UN	United Nations
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Children's Emergency Fund
VAT	Value Added Tax
VHW	Village Health Worker
WB	World Bank
WDC	Ward Development Committee
WHA	World Health Assembly
WHO	World Health Organization
WWII	World War II

CHAPTER 1

GENERAL INTRODUCTION

1.1 BACKGROUND AND PRELIMINARY WORK FOR THE PHD THESIS

Global maternal, neonatal and child mortality rates declined by almost half during the Millennium Development Goals (MDGs) years, but rates remain unacceptably high in sub-Saharan Africa (United Nations, 2015). In Nigeria, the most populous sub-Saharan African country, maternal, neonatal and child health (MNCH) indices remain poor because of persistent high rates of morbidity and mortality. The most recent three National Demographic and Health Surveys (NDHS 2008; 2013; 2018) show that whilst there were some improvements in under-5, neonatal, infant deaths, family planning uptake, antenatal care (ANC), and facility delivery and births by skilled birth attendants, these were not enough to meet the MDGs (NPC and ICF Macro, 2009, NPC and ICF Macro, 2014, FMoH and Jhpiego, 2011, World Bank, 2014b, NPC and ICF Macro, 2019). Post-MDGs, the country is beginning to record some decline in the gains of the MDG years, as observed in the most recent national survey (NPC and ICF Macro, 2019). Presently, this decline has implications for the current Sustainable Development Goals (SDGs) initiative, as Nigeria remains a significant contributor to the global MNCH burden (World Health Organization, 2016).

Comprehensive country MNCH policies exist to address these inadequacies, but departures from policy intent during implementation have created wide gaps and less than expected outcomes (FMoH, 2007, FMoH, 2009, Kana et al., 2015b, Uneke et al., 2016, Eboreime et al., 2017). In Nigeria's federal system of government, as national level policies are transferred to lower levels of government for implementation, several factors, like governance arrangements, policy characteristics, actors' relationships and decisions, and implementation context, all influence policy adoption and implementation (Abimbola et al., 2015, Okpani and Abimbola, 2016, Abimbola et al., 2019). Whilst this nature of policy response is not peculiar to Nigeria (Mahmood et al., 2003, Smith, 2014, Ireys et al., 2018), its MNCH burden contributes significantly

to the global burden, and hence has implications for the Sustainable Development Goals (SDGs) (United Nations, 2015).

My first involvement with MNCH programmes was in 2013 when I was appointed the coordinator in charge of a baseline assessment of the status of some MNCH indicators and health system components in preparation for one of the MNCH interventions in one of the study states. I was struck by how the state health care providers referred to the national level stakeholders in the third person and how they perceived this proposed programme as the national level coming down to assist them and to give them equipment and other resources to work with. They appeared to have been resigned to working with, and were dependent on, whatever resources (medicines, equipment, human resources) were supplied from the national level. Given that the state was closer to the grassroots than the national level, and that programme evaluations are usually at the state level, I had expected more enthusiasm and ownership.

Following the baseline assessment, the intervention commenced and lasted until 2015. Auspiciously, my organisation was selected as a partner with the University of Leeds, United Kingdom, to undertake an evaluation of this programme intervention and the outcomes, and I was appointed the programme manager. During this period, while interviewing sub-national stakeholders, I also encountered a similar attitude; a level of passivity towards the programme, and at the same time, stakeholders admitted (some more reluctantly than others) how the programme had improved access to maternal and child health services in the intervention facilities. National stakeholders in turn portrayed sub-national stakeholders as lacking in commitment and capacity to implement the programme.

As this was not the first of such programmes that was implemented, I became curious to know if my observations were peculiar to the programme I was evaluating. I also wondered if this was peculiar to the state under study. It also raised questions for me, about the stewardship role of the states (being the federating units of the country) in mediating programme implementation processes towards improved MNCH outcomes for their citizens. This was when I decided to immerse myself deeper into

understanding the history of MNCH interventions across different states as my PhD work. The integrated MNCH (IMNCH) Strategy was a good starting point, since it had incorporated pre-existing standalone MNCH policies and had integrated them into one national strategy as a way of addressing Nigeria's slow progress towards achieving the MDGs. Underpinning this was my interest and curiosity in the relationship between national and sub-national stakeholders and how this, it appeared, was not better harnessed towards achieving common goals, and sometimes even appeared to be undermining these goals.

1.2 DECENTRALISATION AND MULTI-LEVEL HEALTH SYSTEMS GOVERNANCE IN NIGERIA

Nigeria gained independence in 1960 and became a Republic in 1963. This was interrupted by about 30 years of military dictatorship, but since 1999, it returned to democratic governance. There is a presidential system of democratic government, and the federal government is led by an elected president. Each state government is led by an elected state governor and elections are usually conducted every four years. Administratively, the country is decentralised into the federal government, a Federal Capital Territory (FCT), 36 states and 774 local government areas (LGAs), hence there are two tiers of sub-national government.

The Nigerian Constitution (1999) places concurrent responsibilities for health care provision on all three tiers of government, but is silent on specific roles and responsibilities for the tiers (FGoN, 1999). The National Health Policy (2004) aligned the health system with the three-tier governance system, and the current arrangement is as follows: the Federal Ministry of Health (FMoH) has responsibility for health policy formulation, technical assistance, and service provision, through tertiary teaching hospitals and federal medical centres. Secondary-level services are administered by the state government, through the State Ministry of Health (SMoH), and are provided at comprehensive health centres, cottage, and general hospitals. The local government health authority (LGHA) is responsible for managing the primary health service delivery through the primary health care (PHC) centres, while the SMoH is expected to support and supervise. PHC services include the bulk of MNCH services – ANC, childbirth care, postnatal care, health education and promotion,

simple laboratory tests and preventive interventions (FMoH et al., 2009, FMoH and Jhpiego, 2011).

The federal government (national level) makes health policies (and other sector policies) and transfers these to lower levels for implementation. This transfer can take the form of one or more of the four different methods of transferring decision-making from the centre to the periphery, as described by the Public Administration Framework (Bossert, 1998b, Bossert and Beauvais, 2002a):

- De-concentration shifts power from the central offices to peripheral offices of the same administrative structure, like the Ministry of Health.
- Delegation shifts responsibility and authority to semi-autonomous agencies.
- Devolution shifts responsibility and authority from central offices to separate administrative structures still within the public administration, and
- Privatisation, the last method, where there is a contractual relationship between public entities and private service providers.

In Nigeria, there is a mix of de-concentration and devolution with regards to health policy implementation. State governments have powers to determine their health care priorities and are not accountable to the federal government regarding the choices they make in health care spending, even though they receive funds from the federal government. This limits national government, as they have little control over implementation. The National Health Policy (NHP), though more prescriptive than the National Constitution, is not legally binding on the states and LGs, and does not clearly state how these various levels should interact (FMoH, 2016a). A National Health Act was signed into law in 2014 (FGoN, 2014b), to provide a legal framework for the NHP and hopefully address the constitutional gaps with respect to health. One of the provisions of the Act is that *"the Federal Ministry of Health shall collaborate with the states and local governments to ensure that appropriate mechanisms are set up for the implementation of national health policy"* (FGoN, 2014b)(P. 2). This is, however, a federal law, hence only applies to the federal government. State governments would need to domesticate this law through subnational legislative process for it to be binding on the states and till date, no state has taken this step. As a result, in practice these three tiers

operate autonomously and are not accountable to one another, because the oversight function of the federal level is not backed up by any legal frameworks nor accountability levers. However, the states are the units of analysis for evaluating health outcomes (FMoH and Jhpiego, 2011, McKenzie et al., 2014, Abimbola et al., 2015, Babalola, 2015, Eboreime et al., 2017, Eboreime et al., 2019).

Whilst the states (middle tier) are the federating units of the country, the third (lowest) tier, the local governments (LGs), have actually never operated as a true third tier in the governance structure of Nigeria (Alao et al., 2015). This is because of the absence of a legal framework that recognises the LGs as a third tier of government (Khemani, 2001, Alao et al., 2015, Babalola, 2015, Ali and Ahmed, 2019). The 1999 Constitution makes provision for the legislative arm, their executive powers, and functions, at both the federal and state levels, but there are no such provisions for the LGs. Rather, existing legal frameworks recognise the LG as an appendage of the state which has absolute discretion (FGoN, 1999).

One of the provisions of the 1999 Constitution which has led to an existing conflict between these two tiers is the State Joint Local Government Account (SJLGA) which limits the fiscal autonomy of the LG tier (FGoN, 1999). The aim of the SJLGA is that federal revenue allocations would reach the LGs via their respective state government and that each state should maintain an SJLGA into which all allocations from the federal and state governments are paid. This account is controlled by the executive governors of the states. Currently, the SJLGA is infamous, as many state governments have reportedly misappropriated the funds at the expense of services that are designed to be accessed at the LG level (McKenzie et al., 2014, Majekodunmi, 2015, Ozohu-Suleiman and Chima, 2015). In the health sector, the LG is allocated oversight for PHC services, where the bulk of MNCH services are accessed in the public sector, but lacks fiscal autonomy to execute these responsibilities as a result of the constraints of the SJLGA (FGoN, 1999, Ozohu-Suleiman and Chima, 2015, FMoH, 2016a). The above description is given to provide a background of the dynamics of the state-LG functioning. However, the focus of this study is the state level, given their discretionary authority over the LGs.

1.3 MATERNAL AND CHILD HEALTH POLICYMAKING IN NIGERIA

Historically, over half a century ago, Nigeria was one of the 53 developing countries which was given assistance by World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF) to develop context-specific policies towards improving maternal and child health (Bierman, 1958). Between 1952 and 1954, for the first time, control of medical services was transferred to the three regional governments. This was followed by the setting up of regional ministries of health. While at the centre, the Federal Ministry of Health was in control of the budget, and the regions' health ministries were given the freedom to make decisions about the budget allocated to them. At about the same time, in 1954, the National Policy for Medical and Health Services stipulated that maternal and child welfare clinics were to be set up in rural areas, amongst other services, to address the urban-rural inequality in health service availability (Scott-Emuakpor A., 2010a). After independence in 1960, Nigeria went through decades of military dictatorship and fragile democracies during which the low budgetary allocation for health impacted the nation's health outcomes. Lack of infrastructure, equipment and supplies with consequent dwindling of health care services characterised these years, until the return to democracy in 1999. This was closely followed by the declaration of the MDGs in 2000, when Nigeria committed to improving spending on health (Scott-Emuakpor A., 2010a, Orubuloye and Oni, 1996).

The first comprehensive National Health Policy in Nigeria was launched in 1988 (FMoH, 2016b). This was followed by a proliferation of several fragmented, vertical, disease-specific policies and programmes, addressing one health system issue or the other and targeted at either maternal, neonatal or child health (Kana et al., 2015a, FMoH Nigeria, 2001, FMoH Nigeria, 2002, FMOH Nigeria, 2006, FMoH, 2006). In 2007, an integrated MNCH (IMNCH) Strategy was developed by the FMoH in collaboration with some of its key developmental partners, namely WHO, UNICEF and United Nations Fund for Population Activities – UNFPA), with the overall objective of reducing maternal, new-born and child morbidity and mortality, using a more comprehensive and cost-effective approach (FMoH and Jhpiego, 2011).

Since the launch of the IMNCH Strategy in 2007, it has been implemented through several consecutive and some parallel interventions, usually conceived at the national level for sub-national implementation. Of these, the three that have been implemented consecutively in every state of the country, beginning from 2009 to 2019, form the focus of this study. They include the Midwives Service Scheme (MSS); the Subsidy Reinvestment and Empowerment Programme for Maternal and Child Health (SURE-P/MCH); and the Saving One Million Lives Programme for Results (SOML PfR). The MSS was primarily aimed at improving human resources for MNCH. It was initially designed as a two-year nationally coordinated programme (2009–2011), after which states were expected to continue independent implementation. Newly graduated, unemployed, and retired midwives were recruited by the national level and deployed to work in rural areas, providing skilled birth attendance in rural facilities (NPHCDA, 2010a). The SURE-P/MCH followed and was designed to improve upon the MSS. Besides human resources, it incorporated additional health system components, like the upgrade of facility infrastructure, supply of drugs and other essential commodities, and strengthened health management information systems (HMIS), and it included a demand-side incentive to encourage pregnant women to access and utilise MNCH services at selected health facilities (FMoH and NPHCDA, 2012, World Bank, 2014a). SURE-P/MCH was discontinued in 2015, following a change in the national government, and replaced with the third study programme, the SOML PfR, a pay-for-performance programme, which evolved from an umbrella initiative of the national government, to harness all MNCH gains and hopefully save one million lives (SOML) of mothers and children by 2015, towards achieving MDGs 4 and 5 (UNICEF, 2012a). In partnership with, and receiving financial assistance from, the World Bank, it was re-designed, with a focus on results rather than inputs, hence the name (UNICEF, 2012b, World Bank, 2015, World Bank, 2016, FMoH, 2016b).

These were all complex interventions with large inputs of resources. The MSS engaged 4,000 midwives and 1,000 community health workers (CHWs) to work in rural facilities and to close persisting gaps. At the time, this was considered one of the largest public-sector led Human Resources for Health (HRH) intervention schemes in Africa (Ohiri, 2012). The SURE-P/MCH followed and engaged 10,000 midwives and

2,000 CHWs, in addition to other health system inputs outlined above (FMoH and NPHCDA, 2012). The World Bank provided a grant of USD500 million towards the implementation of the SOML PfR (World Bank, 2015). A decade after the implementation of the IMNCH Strategy, through these programmes, the MDGs were still not achieved and MNCH indices remained sub-optimal, as reported in national demographic and health surveys (NPC and ICF Macro, 2009, NPC and ICF Macro, 2014, NPC and ICF Macro, 2019). There still remains a critical shortage of human resources as noted in the latest National Strategic Health Development Plan (NSHDP) (FGoN, 2018b, Ebenso et al., 2020). Other health system functions, like infrastructure and medical supplies, have dwindled and gains in HMIS suffered from lack of sustainability (Etiaba et al., 2020, Uzochukwu et al., 2020). However, lessons were learnt during the process and may have guided the design of the last programme which is performance-based (FMoH, 2016b).

During the decade-long implementation of the IMNCH Strategy through these programmes, experiences show that the governance arrangements described above played a key role in impacting observed outcomes (Barros et al., 2010, Banwo, 2012, Abe and Adetoye, 2014, Abimbola et al., 2015, Alao et al., 2015, Abe and Oladeji, 2016, Ali and Ahmed, 2019). The result of the *"mishmash of centralization and de-centralization"* (McKenzie et al., 2014-P.83) is that within the health system, there is a lack of clarity among the multi-level actors as to their specific roles and responsibilities, with consequent overlaps between oversight, supervisory, and implementation roles, such that the federal levels, the FMoH and its parastatal, and the National Primary Health Care Development Agency (NPHCDA), frequently stray into the implementation space of the lower tiers of government (McKenzie et al., 2014).

This study focuses on understanding these processes and their consequences in detail, especially the policy development and implementation processes, and on understanding the impact of the overarching governance arrangements of the Nigerian State on health policy processes. Within this governance arrangement are factors like, inadequate accountability mechanisms for monitoring different levels of government (Abuya et al., 2012, Frumence et al., 2013, Witter et al., 2013, Uzochukwu

et al., 2018a, Twea et al., 2020), and inadequate fiscal decentralisation, resulting in diminished fiscal autonomy of the LG tier of government that is directly responsible for primary MNCH services (Frumence et al., 2014, Kredo et al., 2017, Santos, 2018). Other factors are actors' decisions and actions as a result of relationships across and within governance levels, and the design (characteristics) of the policies (Pelletier et al., 2012b, Adeyi, 2016, Nicholas-Omoregbe et al., 2016, Okpani and Abimbola, 2016, Ukoha et al., 2016, Eboreime et al., 2017, Santos, 2018, Uzochukwu et al., 2018a, Eboreime et al., 2019).

This study takes its point of departure from an understanding of health systems as complex adaptive systems **(CAS)**, which here extends to the understanding and application of a multi-level governance lens and the analysis of IMNCH policy processes. Systems thinking and understanding health systems as CAS has gained currency in the past 10 to 15 years and is now a well-established concept in health policy and systems research (HPSR). WHO's report, "Systems Thinking for Health Systems Strengthening" (De Savigny and Adam, 2009) emphasises that *"systems thinking works to reveal the underlying characteristics and relationships of systems"* (p. 19) and explains that *"anticipating how an intervention might flow through, react with, and impinge on"* (p. 19) these sub-systems is crucial and forms the opportunity to apply systems thinking in a constructive way. Applying a CAS lens allows the addressing of a broad set of questions in order to assess the system-wide effects of complex interventions, and is increasingly being used in developing countries (De Savigny and Adam, 2009, Paina and Peters, 2012, Agyepong et al., 2012). Components of CAS, like path dependence and feedback loops, may be applied in explaining findings, especially where policy has been implemented over a long-time span, as with the case of the IMNCH Strategy, rather than using a linear reductionist approach. Path dependence explains how and why processes and outcomes may differ, after having taken off from the same starting point. Feedback loops allow for incorporation of lessons learnt along the policy process (Bloom et al., 2008, Paina and Peters, 2012). Applications of these concepts in developing countries have contributed to understanding the complexities of health policy process, with the hope of reducing unintended and sub-optimal outcomes (Agyepong et al., 2012, De Savigny et al., 2012).

In contributing Nigeria's experience to the existing body of knowledge, this study hopes to further explore the following areas: i) whilst the literature shows that the national political structure influences how policies are adopted and implemented, where the mid-level government is a federating unit in the multi-level governance structure, the mechanisms through which sub-national actor power and influence may significantly derail a given policy process are under-researched and under-illuminated; ii) in multi-government levels, inadequate fiscal autonomy of lower levels leads to over-dependency on central government. How this becomes so entrenched, such that it also influences processes perceived to be bottom-up, sometimes crowding out the variations in the sub-national context, needs further exploration. These contributions are underpinned by the level of collaboration across the government levels.

1.4 THESIS AIM, OBJECTIVES AND STRUCTURE

This study aims to contribute to a better understanding of the role of intermediate levels of government in health policy implementation in Nigeria, and the level of collaboration with other government levels; by taking a historical and comparative view of MNCH policy implementation in two south-eastern Nigerian states, following policy development at the national level. It explores how these policies came about, what happened after they were developed and transferred to sub-national levels, with a focus on the level of sub-national adherence to the policy goals and collaboration with other government levels within the existing governance arrangement, and how this ultimately influenced MNCH implementation.

1.4.1 Objectives

This research aim has been further expanded into study objectives, as follows:

1. To describe how national MNCH policy processes in Nigeria have evolved in the last decade and to explain what factors have shaped outcomes.
2. To comparatively analyse the MNCH policy implementation processes in two states in Nigeria, towards contributing insights about the mediating role of state level government in health policy and systems functioning in governance debates in Nigeria.

3. To explore how actors' roles and power practices across the government levels influenced MNCH policy implementation and outcomes; and
4. Drawing on the above analysis, to identify intergovernmental processes that may strengthen MNCH policy implementation at the state level.

1.4.2 Structure of the thesis

The thesis is organised into nine chapters.

After this introduction, Chapter 2 gives a detailed description of the Nigerian context, to provide an understanding of the study setting and to situate the study.

Chapter 3 reviews the literature on the theoretical approaches to policy options and processes in a multi-governance context; as well as the frameworks and theories for implementing policies. It also discusses empirical examples from other low- and middle-income countries (LMICs) that operate a multi-level governance or a tiered health care system.

Chapter 4 describes the methodology employed in the study, types and sources of data and analytical methods. It builds on the literature review to develop a conceptual framework which will provide understandings of the study findings.

Chapters 5 to 7 present the results obtained from the study. Chapter 5 presents an overview of the decade-long policy process, appraises the designs of the parent strategy and its subsequent interventions, and discusses factors which have influenced the course.

Chapter 6 critically and comparatively analyses the policy implementation in the two study states, with a focus on policy adoption, implementation and contextual factors that may have influenced outcomes, within the overarching governance arrangement.

Chapter 7 explores the roles, interests, and power of key actors in the continuum of the policy processes. It outlines the power practices observed at key actor interfaces across the government levels, and how these practices manifested and impacted on sub-national policy implementation.

Chapter 8 is the discussion. It makes linkages between the main findings, the study objectives and existing literature, with a focus on Collaborative governance. It outlines the study contribution to the literature and to international MNCH debates.

Chapter 9 concludes the thesis, identifies possible intergovernmental structures that could strengthen existing governance arrangements and finally makes policy recommendations for policymakers, programme managers and other stakeholders in Nigeria, and other LMICs with similar contexts.

CHAPTER 2

CONTEXT-THE NIGERIAN POLITICAL AND HEALTH SYSTEM GOVERNANCE

2.1 INTRODUCTION

This chapter begins with a description of the national geography, demography, and socio-economic context of Nigeria, followed by a comprehensive description of the governance arrangements at national and sub-national levels, to further expand on the introduction in the preceding chapter. The final section describes the overall health system and specific MNCH contexts.

2.2 GEOGRAPHY, SOCIO-DEMOGRAPHY AND ECONOMY

Nigeria is a coastal West African country with a total area of 923,768 square kilometres. It is bounded by four countries, Benin (west), Cameroon (east), Niger and Chad (north). The National Population and Housing Census of 2006 placed the population at 140,431,790 (NPC and ICF Macro, 2014), but this has since been estimated to have reached 186 million in 2016, and is projected to reach 392 million by 2050, to become the world's fourth most populous country. This is, because of a sustained population growth rate due to the population momentum and its high birth rate. The 2016 growth rate was estimated at 2.44% (Central Intelligence Agency, 2017).

Nigeria is extremely culturally diversified, with about 374 identifiable ethnic groups and over 500 languages. However, there are three major ethnic groups, Igbo, Yoruba, and Hausa. Half the population are poor, the majority of whom live in the rural areas. Diversity in cultural norms, beliefs and practices also abound. These impact directly and indirectly on the health sector in general and on MNCH policy outcomes in particular (FGoN, 2015).

Economically, Nigeria has a mixed public-private economy with a dependence on oil. The oil and gas sector continues to be the major driver of the economy and contributes to over 90% of export earnings (FGoN, 2015).

2.3 POLITICAL GOVERNANCE

2.3.1 Political system of Nigeria

Historically, Nigeria was a British colony. It gained independence in 1960 and became a Federal Republic in 1963. Since then, governance has been interrupted at various times by approximately 30 years of military dictatorships, the last of which ended in 1999. This period was also interrupted by a three-year long civil war (1967–1970), following the attempted secession of what is now the Southeast region and a large portion of the South-South region (see Figure 2.1), then known as Republic of Biafra. However, since 1999, Nigeria (Fourth Republic) has had, a fairly stable democratic government, with national and sub-national elections held every four years. There are three arms of government, the executive, the legislative and the judiciary. These are theoretically independent of each other in decision-making (FGoN, 1999). The legislature is made up of the ruling political party and other opposition parties. There are currently 18 registered political parties (INEC, 2021), however, there are two main parties (Peoples' Democratic Party – PDP), which was in power for 16 years (1999–2015) and then lost the national elections to the current ruling party (All Progressives' Congress – APC), which has changed its name several times over the last 16 years through alliances and coalitions.

2.3.2. Federalism in Nigeria

Olowu (1991) and a number of other authors outlined in this section, have serially, exhaustively explored the federalism and decentralisation phenomena in Nigeria (Olowu, 1991, Olowu, 2003). Predating independence, Nigeria was once a unitary state, but formally became a Federation in 1946 with the creation of three provinces. True federation was established in 1954 with division lists between central and regional (northern, eastern, and western) governments. However, federalism scholars often refer to Nigeria as a Federation without federalism because the Nigerian-styled federalism remains over-centralised because of rents from oil held by the central government. There remains a continuous clamour for "*true federalism*" (Ugoh and Ukpere, 2012, Babalola, 2015, Majekodunmi, 2015, Babalola, 2017). After independence in 1960, Nigeria became a Federal Republic in 1963, and an additional

region (northern, eastern, western, and mid-western) created. This structure continuously evolved over time into the current 36 states, grouped into six non-administrative regions, as shown in Figure 2.1 below. A detailed chronology of Nigeria's Federation and decentralisation activities is given in the literature review in Chapter 3.

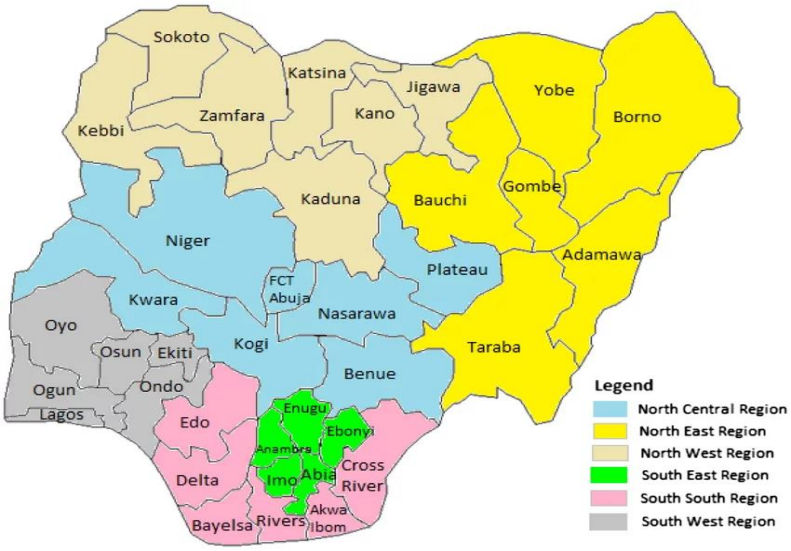


Figure 2.1: Map of Nigeria showing the six geo-political zones and 36 states and the Federal Capital Territory (FCT)

As mentioned in Chapter 1, Nigeria is currently administratively divided into 36 states, a Federal Capital Territory (FCT) and 774 local government areas (LGAs). These are grouped into six non-administrative regions, as shown in Figure 2.1 above.

2.3.3 Fiscal arrangements

The bulk of the government's resources comes from oil revenues to the Federation Account, which is shared according to an allocation formula (52.68%: 26.72%: 20.60%) to the federal, state, and local government levels, respectively. The horizontal distribution formula is constitutionally fixed and allocates 40% to each state in equal amounts and 60% based on six variables. The variables are population (30%); land mass (10%); internal revenue generation efforts (10%); secondary school enrolment

(4%); number of hospital beds (3%); and rainfall (3%). The revenue shares depend positively on the first three variables and negatively on the last three (SMoH, 2010).

In the National Constitution, items to be funded in the budget are placed on either the exclusive list (federal responsibility only) or the concurrent list (joint responsibility of the federal, state and local government tiers) (FGoN, 1999). Federal government then allocates its own portion to different sectors of the budget using a Medium-Term Expenditure Framework (MTEF) – an aggregation of all proposed expenditure based on existing sectoral policies and the Fiscal Sector Policy (FSP) (FGoN, 2018a). The transfers from the Federation Account to the states and local governments are not earmarked, which means that each state and local government decides how their funds are allocated to various sectors. In addition, they are not required to provide budget and expenditure reports to the federal government. Hence, federal government does not have any significant influence on funds allocated for secondary and primary health services.

2.4 THE NIGERIAN HEALTH SYSTEM

2.4.1 Health system governance and health policymaking

The health system operates within the federal design of its political system. As outlined in Chapter 1, the Nigeria National Constitution made health a concurrent responsibility of the three tiers of government but did not clearly articulate specific roles and responsibilities across tiers, which has implications for governance and policy processes. In practice, the National Health Policy (1988; 2004) aligned and articulated health care responsibilities along the three-tier governance system. In this arrangement, the FMoH is responsible for defining the overall policy framework for the health system with the participation of the 36 federating states and the FCT. It is also accountable for strengthening the technical and managerial competence at state level for delivering secondary health services, and for defining norms, standards and protocols for medicines, vaccines, research, hospital services, PHC and human resource training for the sector. Secondary-level services are administered by the state government and are provided at comprehensive health centres, cottage, and general hospitals. The local government health authority (LGHA) is responsible for managing

primary health service delivery through the PHC centres, while the SMoH is expected to provide support and supervision.

There have been attendant difficulties with the implementation of this design, especially with overlaps of responsibilities and poor commitment and ownership of programmes, as no supporting legal frameworks exist (FMoH, 2009, FMoH and Jhpiego, 2011), and as outlined earlier, the National Constitution is silent on the specific responsibilities of each level (FGoN, 1999). Because this federal structure arrangement is constitutional, short of a constitutional amendment, a health system governance reform was instituted to mitigate the constraints of the existing federal structure in the health sector.

The Primary Health Care Under One Roof (PHCUOR) reform policy is a partial re-centralisation reform. The initial concept predates the IMNCH Strategy but was only endorsed as a national policy agenda in 2011, and implementation guidelines developed in 2013. Due to the perceived inadequate capacity of LGs to deliver PHC services, PHCUOR aimed to integrate the PHC structures and programmes (originally the responsibility of LGs) under one state-level body – the State Primary Health Care Development Agency or Board (SPHCDA/B), based on the principle of one management, one plan and one monitoring and evaluation system (NPHCDA, 2010b). This also required that each state institute their own SPHCDA/B. There are nine domains of implementation: Governance and Ownership; Legislation; Minimum Service Package; Repositioning; Systems Development; Operational Guidelines; Human Resources; Funding Sources and Structure; and Office Setup. A scorecard evaluation of these domains in 2015 showed a wide regional variation in the average score of the implementation domains – the lowest score (19%) being in the South-East Zone and the highest score (55%) being in the Northwest Zone (NPHCDA, 2015). Eboreime et al. (2017), in their analysis of the PHCUOR policy, noted that no state was compliant with the Human Resources and Funding Sources and Structure domains. These two domains have direct implications for sub-national MNCH policy implementation, as will be presented in later chapters (Eboreime et al., 2017).

In the third study programme (SOML PfR), inauguration of a functioning SPHCDA/B became one criterion to be met by each state before accessing the programme funds from the FMoH, and the PHCUOR would go on to be incorporated into the disbursement-linked indicators of the programme (FMoH, 2016b, FMoH, 2017a, FMoH, 2019a).

The private health sector is worth mentioning before further description of the public health system structure. The private sector care providers play a significant role in health care service provision. They provide an estimated 60% of the health care services, even though they own only 30% of the health facilities in the country. There is a higher concentration of private facilities in the southern part of the country, and a wide variation across states, as will be later shown in the two study states. The private sector is made up of the formal private health care sector, which includes private not-for-profit (operated by missionaries and non-governmental organisations) and private for-profit organisations, and the informal sector, which includes traditional medicine providers, patent medicine vendors (PMVs), medicine stores, and complementary and alternative practitioners (FGoN, 2018b). Chapter 6 outlines how the availability of MNCH services from the private sector may have impacted the MNCH service delivery outcomes in one of the study states.

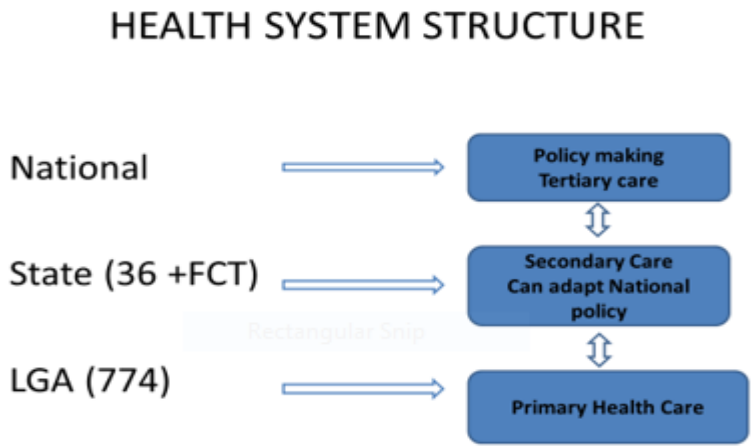


Figure 2.2: Organisation of the health system tier responsibilities

The FMoH is the national organisation responsible for the health care policymaking for Nigeria citizens, and has other responsibilities as outlined in Figure 2.2 above. It has various parastatals and agencies with, and through which, it is expected to achieve

different health sector goals. These include: i) National Primary Health Care Development Agency (NPHCDA); ii) National AIDs Control Agency (NACA); iii) National Health Insurance Scheme (NHIS); iv) National Agency for Food and Drug Administration and Control (NAFDAC); and v) Nigeria Centre for Disease Control (NCDC). The NPHCDA has oversight of implementation of PHC services where the bulk of MNCH services are accessed as the first point of entry. This will be described in more detail later in this chapter.

The National Council on Health (NCH) is the highest decision-making body of the FMoH. It meets annually to review key health issues of national importance. It is led by the Minister of Health. All FMoH staff and all state health commissioners and other key stakeholders are expected to attend the annual review meeting. The activities of the FMoH, parastatals, agencies, state ministries and other stakeholders, are in theory coordinated through the NCH (FMoH, 2016a).

Notably, state governors, who retain executive powers at the sub-national level have not historically attended the NCH meetings, rather, they are represented by the commissioners for health. However, what the commissioners commit to at the meetings, through memoranda of understanding (MOUs) or other means, are not automatically accepted by the governors (Eboreime et al., 2017, Gyuse et al., 2018). In Chapters 5, 6 and 7, the findings will show that the way this relationship plays out during sub-national programme implementation is of key importance in the MNCH policy processes, especially in the discrepancies between the policy and the practice during implementation.

The NPHCDA is one of the parastatals of the FMoH with its mandates outlined in the NPHCDA Act of 1992 (FGoN, 1992). It is made up of a Governing Board whose chair (Executive Director of NPHCDA) is directly appointed by the president of the Federation, while the rest of the Board is appointed by the Minister of Health. It is not clear from the NPHCDA Act whether it is directly funded from the presidency or from the FMoH, however it is stated that audited accounts of the agency should be submitted to the presidency through the Minister of Health. The main responsibility of the NPHCDA, as outlined in National Health Policy (2016), is to provide support

for the implementation of the National Health Policy in all matters relating to PHC in Nigeria (FMoH, 2016a). When policies emanate from the FMoH, the NPHCDA, as one of its parastatals, focuses on the portion of the policies that concern PHC, produces guidelines, builds capacity, and provides support and oversight for the states and LGAs to implement these policies. They are also mandated, where possible, to generate revenues, nationally and internationally, to support PHC activities (FGoN, 1992). In practice, they have also functioned as national level PHC implementers, which has led to an overlap with the responsibilities of the lower tiers, as applied in the National Health Policy (Eboreime et al., 2017).

Historically, since gaining independence in 1960, Nigeria has adopted five successive national health policies. The first four were incorporated into various national development plans, formulated between 1960 and 1985. The initial guiding philosophy of pre-1985 policies assumed that improving the health of the population was essentially dependent upon the availability of health providers and access to health facilities. In 1988, a PHC-focused health policy was adopted by the Federation with subsequent review in 2004 (FMoH, 2004b).

The IMNCH Strategy was developed in 2007 (FMoH, 2007). Although the Strategy was said to have been guided through a wide range of multi-level stakeholder consultations, policymaking in Nigeria is still very much linear, sometimes with just a handful of stakeholders and development partners, and hardly involving the end users of the policy and other societal groups. This has the potential to constrain implementation (Etiaba et al., 2015, Onwujekwe et al., 2015).The degree of stakeholder involvement and the government tier level of the various stakeholders, clearly impacted on MNCH policy processes, as will be described in Chapters 5–7.

As noted in the introductory chapter, the national level (FMoH) makes health policies and transfers these to the sub-national (states) government to implement, with no clear constitutional accountability levers to ensure adherence to policy goals during implementation. There are political tensions around these different stages of the policy process, predominantly driven by actors, policy characteristics, and governance, such that implementation departs from policy intent (Eboreime et al., 2017).

2.4.2 Health care financing and fund flow

Nigeria has consistently underspent on health and is reported to spend less than nearly every country in the world (Hafez, 2018). Health financing in Nigeria is typically characterised by high levels (over 60%) of household Out-of-Pocket (OOP) spending and low public spending, with a consequent high level of household impoverishment (FMoH, 2009). Current health financing mechanisms, besides OOP and government budget, include a Formal Sector Social Health Insurance Programme (FSSHIP) and pockets of community-based health insurance (CBHI) programmes. All the mechanisms have operated sub-optimally as a result of contextual political structures, institutions, power groups, legal commitments and fiscal space, with the result that so far coverage aspirations have not been met towards achieving universal health coverage (FMoH, 2009). In 2014, the National Health Act provided for 1% of the consolidated revenue to be made available for PHC, known as the Basic Health Care Provision Fund (BHCPF). Although the Act was signed in 2014, the first budgetary release was only in 2019. This persistent weakness of the health financing block of the Nigeria health system also means that efforts to reduce the MNCH burden, which remains a country priority, have yielded less than desired results (Olakunde, 2012, Onoka et al., 2013, Uzochukwu et al., 2015b, Ibe et al., 2017, Etiaba et al., 2018, Onwujekwe et al., 2018, Uzochukwu et al., 2018a, Onwujekwe et al., 2019). Budgetary allocation for health has gradually increased from 1999, but has not met the Abuja Declaration of 15% (FMoH, 2007).

The proposed potential sources of funding for the IMNCH Strategy over the plan period (2007–2015) were, government sources (federal, state and LGA through, for example tax revenue, VAT, Custom Tariffs, Debt Relief Fund, dedicated tax, donor financing and other external sources of funding, and direct employer financing); compulsory insurance (NHIS, Public–Private Partnerships, private health insurance, pre-payment mechanisms, voluntary insurance, community health insurance, community self-help/solidarity, subsidy, deferral and exemption); philanthropic sources; faith-based organisations; OOP Payments; and other special funds (FMoH, 2009).

As stated earlier, MNCH services are primarily accessed from PHC centres which are under the management of the LG tier of government. At the LGs, the Ward (made up of communities and villages) is the lowest grassroot political and administrative structure, and to align with this, is the Ward Health System which aims to deliver a range of defined PHC services at that level known as the Ward Minimum Health care Package (WMHCP) (NPHCDA and WHO, 2007). Although all tiers receive funding for health services from the Federation Account according to an allocation formula (Uzochukwu et al., 2018b), the LG allocation is routed through State Joint Local Government Accounts (SJLGAs) (Eme et al., 2013). Every state has a Joint Account Allocation Committee (JAAC), which oversees the SJLGA and determines financial allocations for each LGA, based on criteria which include population size; social development indicators; and internal revenue efforts. Inadequate allocation and disbursement of funds by the state to LGs have constrained LGs from successfully executing needed tasks. Misallocation of funds happen due to a number of reasons. As funds are not earmarked, sometimes funds are reallocated to perceived competing priorities, and at other times problems arise because of mismanagement (Eme et al., 2013, Ozohu-Suleiman and Chima, 2015, Majekodunmi, 2015, Nwogwugwu and Olusesi, 2015). Another challenge to the health financing function is that over time, the percentage of the health budget for PHC activities has gradually decreased, from 8.4% in 2012 to 4.7% in 2015 (Uzochukwu et al., 2016).

With the three programmes under study (MSS, SURE-P/MCH and SOML PfR) however, there were dedicated funds which were held separately from the central purses at the national and state levels, respectively. The MSS was largely funded from the MDG funds, which was pooled at the national MDG office at the presidency for all sectors. MDG funds allocated to states were also pooled at the MDG offices of the state government house for all sectors (United Nations, 2015). For the SURE-P/MCH, funds from the oil subsidy removal were also pooled at the SURE-P secretariat at the presidency. Similarly, SURE-P funds allocated to states were held at the state SURE-P secretariat for all sectors (United Nations, 2015). For the SOML PfR, funds from the World Bank were clearly earmarked for the programme, held at the FMoH and disbursed directly to the SMoH according to programme design (FMoH, 2016b).

Chapter 6 elaborates on how these funding arrangements impacted the MNCH programmes.

2.4.3 Human Resources for Health

Nigeria is said to have one of the highest numbers of Human Resources for Health (HRH) in the sub-Saharan African region (FGoN, 2018b). However, this has not directly translated into optimal health system performance, because of a number of systemic weaknesses. Key ones are maldistribution of numbers and skills across north and south, but more important to MNCH service delivery, is the maldistribution of HRH across health care tiers (FGoN, 2018b).

Each government tier is responsible for employing and remunerating its HRH. One of the consequences of this arrangement is that health workers at the same grade level are remunerated differently across tiers, with the LG tier being the most poorly paid. This is a key challenge in retaining health workers at the PHC level (Adeloye et al., 2017, FGoN, 2018b).

Categories of HRH at the PHC level (first point of access for MNCH services in the public sector) are community health extension workers (CHEWs), community health assistants, community health officers, doctors, nurses, midwives, laboratory staff and public health nurses. Most doctors and nurses work in higher government levels and in private practices: 88% of the 26,361 practising doctors work in hospitals, with the majority of those (74%) working in private hospitals. Only about 12% of practising doctors work in PHC services, in both the private or public sectors (FGoN, 2018b). Poor attraction and retention of senior cadre health workers has resulted in inequitable distribution of the community health workforce at the PHC level, and the consequent inequity in access to quality health services (Uzochukwu et al., 2016).

Other challenges include a lack of effective governance and leadership structures for HRH, embargo on staff employment in some states for a number of years, low level of implementation and domestication of HRH policy and strategy at federal and state levels, respectively, poor motivation of health workers, recurrent strikes and poor working relationship between various professional groups, and a weak supportive supervisory structure (Uneke et al., 2012, FGoN, 2018b). In addition, the salary

disparity mentioned earlier, between national and state health workers, has led to continuing attrition, with health workers moving into national level employment (tertiary facilities) as soon as they get the chance (FMoH, 2009). The implication is that the LGA tier, with responsibility for the bulk of MNCH services, suffers the most consequences of this structure.

Another challenge associated with HRH planning is the complex and bureaucratic civil service recruitment process, resulting in lengthy procedures that are not responsive to the dynamics of maintaining health workforce balance in the health sector. Also reported is a lack of workforce projections based on recruitments – the obsolete population-based calculations currently used are not sufficiently responsive to socio-demographic changes (FMoH, 2015). Hence, following the development and launch of the IMNCH Strategy, the HRH situation was the first issue to be addressed. This gave rise to the first of the national programmes under study, the Midwives Service Scheme (MSS). In Chapters 5 and 6, we see that HRH who were recruited and deployed could not be retained due to weak governance and accountability structures (NPHCDA, 2010a, Abimbola et al., 2012a, Adogu, 2014, Okoli et al., 2016, Okpani and Abimbola, 2016, Okeke et al., 2017, Ikpeazu, 2018, Adewole et al., 2019).

2.5 MATERNAL, NEONATAL AND CHILD HEALTH IN NIGERIA

At the time of the development of the Strategy, the maternal mortality ratio (MMR) was estimated at 800/100,000 live births, with wide north/south and urban/rural variations. Neonatal mortality and child (under-5) mortality rates also mirrored the MMR distribution across the country. Key determinants of these poor indices were identified mainly as: i) access (financial and geographic, and access to information); and ii) socio-cultural factors. A baseline assessment prior to development of the IMNCH Strategy showed that although 71% of the population had access to primary health care centres, most of these centres were non-functional, lacking equipment, supplies and skilled staff, and the division of health care responsibilities between the secondary (state) and primary (LG) levels was a structural barrier to full implementation of the referral system (FMoH, 2007).

Table 2.1: Trend of national MNCH context

MNCH Indices	2003	2008	2013	2018
Maternal Mortality Ratio (per 100,000 live births)	-	545	576	512
Antenatal Care (ANC) uptake (%)	63	58	61	67
Facility Delivery (%)	33	35	38	39
Family Planning (%)	13	15	15	17
Neonatal Mortality Rate (per 1,000 live births)	48	40	37	39
Infant Mortality Rate (per 1,000 live births)	100	75	69	67
Under-5 Mortality Rate (per 1,000 live births)	201	157	128	132
Vaccine Coverage (%)	27	29	25	31

Source: NDHS, 2003; 2008; 2013; 2018.

Table 2.1 shows that indices remain poor a decade after implementing the Strategy. A state level disaggregation of MNCH indicators and their trend in the two study states will be outlined in Chapter 4, as this formed the basis for their selection.

2.6 SYNTHESIS OF THE NIGERIA CONTEXT

Nigeria is a large multi-ethnic and diverse LMIC with a high MNCH burden. The MNCH burden is widely varied across the country, underpinned by cultural and socio-economic differences. Specific political, socio-economic and MNCH contexts of the two study states are detailed in Chapter 6. Nigeria runs a three-tier system of government and health system. The National Constitution provides that health care responsibility be shared across the three levels and be thus placed on the concurrent legislative list. In the past, this has led to overlaps and repetition of activities, as specific roles and responsibilities are not clearly spelt out constitutionally. Crosscutting is the fact that within the current governance arrangement, the LG is assigned primary responsibility for PHC services. MNCH services constitute the bulk of this, however, LGs do not have the fiscal capacity to adequately oversee this responsibility. The financing arrangement directly impacts HRH in the LG tier, which indirectly impacts the outcomes of MNCH and other PHC services at this level.

CHAPTER 3

LITERATURE REVIEW

3.1 INTRODUCTION

This thesis aims to understand the successes and failures of 10 years of MNCH policies in Nigeria, focusing on the role of intermediate levels of government in policy formulation and implementation. The literature review weaves together several strands of academic and policy debates that shed light on the factors that impact policy processes and government functioning. It starts by introducing key concepts of health systems as complex adaptive systems (CAS) as the foundation of understanding systems functioning, and then moves to discussing governance, and specifically the history and role of multi-level governance and its impact on policy processes. To support these theoretical debates, there are also empirical examples of how national level policies have been implemented at sub-national levels in multi-governance contexts, and what factors have influenced these, with a focus on low- and middle-income countries.

3.2 COMPLEX ADAPTIVE SYSTEMS

Systems thinking and understanding health systems as CAS has gained currency in the past 10 to 15 years and is now a well-established concept in health policy and systems research (HPSR). WHO's report, "Systems Thinking for Health Systems Strengthening" (de Savigny and Adam, 2009) emphasises that "*systems thinking works to reveal the underlying characteristics and relationships of systems*" (p. 19) and explains that "*anticipating how an intervention might flow through, react with, and impinge on*" (p. 19) these sub-systems is crucial and forms the opportunity to apply systems thinking in a constructive way.

Applying a CAS lens facilitates understanding of a broad set of questions in order to assess the system-wide effects of complex interventions (De Savigny and Adam, 2009, Paina and Peters, 2012). Components of CAS thinking, like path dependence, feedback loops and emergent behaviour, rather than a linear reductionist approach, may be

applied in explaining policy processes, outcomes, and impacts, especially where policy has been implemented over a long-time span, as with the case of the IMNCH Strategy. Path dependence explains how and why processes and outcomes may differ after having taken off from the same starting point. Feedback loops allow for incorporation of lessons learnt along the policy process. Emergent behaviours in the health sector result from re-organisation of health actors to protect themselves, and also responding to external stimuli and contexts (Bloom et al., 2008, Paina and Peters, 2012). Applications of these concepts in developing countries have contributed to understanding the complexities of health policy processes, with the hope of understanding and reducing unintended and sub-optimal outcomes (Agyepong et al., 2012, De Savigny et al., 2012). Understanding health systems (and within those, policy processes and governance within and beyond the health sector) as CAS, trains the lens on understanding the misalignments and disjuncture between policy intents and outcomes, which are at the core of this study, underpinned by its complex governance structure. The starting point is an exploration of the concept of governance in its different forms.

3.3 UNDERSTANDING GOVERNANCE

There exists extensive and very diverse literature on, and numerous definitions of, the concept of governance, which at their essence explore, "*the way in which collective impacts are produced in a social system*" (Hill and Hupe, 2009), i.e. the relationships, structures and processes that make up "governing". Kooiman (1999), in an early reflection, identified at least 10 ways in which the term "governance" was used, including "governance as international order" and "governance as governability". In a later book he elaborated on different modes of governance: self-governance, co-governance, and hierarchical governance (Kooiman, 2004). The concept of collaborative governance is first briefly described, and it is then picked up again in the discussion and concluding sections.

Collaborative governance is a concept that has gained currency in discussions about complex health systems, and is used to emphasise,

> "*...the processes and structures of public policy decision making and management that engage people across the boundaries of public agencies, levels of government and/or the public, private and civic spheres to carry out a public purpose that could not otherwise be accomplished*" (Emerson et al., 2012).

The authors argue that,

> "*Collaborative governance has become a useful covering term for the study and practice of cross-sector collaboration. Whether 'sector' refers to the public, private for-profit and non-profit arenas, or to different public policy domains, the concepts, challenges, and opportunities for cross-boundary collaborative systems are similar*" (Emerson et al., 2012, p. 2).

They propose that one or more of the drivers – leadership, consequential incentives, interdependence, or uncertainty – are necessary to initiate a collaborative governance regime (CGR). The more drivers present and recognised by actors, the more likely a CGR will be initiated. The form and direction of the CGR is shaped initially by the drivers that emerge from the system context; however, the development of the CGR, as well as the degree to which it is effective, is influenced over time by its two components: collaborative dynamics and collaborative actions (Emerson et al., 2012).

Following their broader definition above, Emerson et al. (2012) further proposes an integrative framework for understanding collaborative governance, and argue that there are specific drivers (leadership, consequential incentives, interdependence, and uncertainty) which give impetus for collaboration to succeed. Focusing on public-private sector collaboration, Ansell and Gash (2008) further describe this concept as bringing stakeholders together in collective forums to engage in consensus-oriented decision-making, and they identify critical variables that will influence successful collaboration as follows; a prior history of conflict or cooperation; incentives for stakeholders to participate, power and resource imbalances, leadership, and institutional design. They further propose that during the collaborative process, factors like face-to-face dialogue, trust-building and development of commitment and shared understanding are crucial for successful collaborative outcomes (Ansell and Gash, 2008).

Also known as multi-sectoral governance, this concept has long gained ground in Europe and the United States of America and is now being increasingly applied to addressing challenging and complex public health issues as are found in most LMICs (Emerson, 2018). Early work in Europe (France and Italy) by Culpepper et al. (2004) explored different sub-national approaches to different cross-boundary arrangements employed to manage decentralised government and report that, "*the social capacities of principal associations and the ties between local and central politicians are in fact the principal determinants of how well decentralised government institutions function*" (Culpepper, 2004). After Indonesia embarked on full administrative and fiscal regional decentralisation, it maintained intergovernmental collaboration to address issues that spilled over administrative boundaries (Okitasari and Kidokoro, 2013). On a broader scale, collaborative governance has been argued to be crucial, and features strongly in discussions around implementing the SDGs successfully (Florini and Pauli, 2018). However it is also noted that the high transaction costs of collaborative governance make it difficult for LMICs to embark on it, given their weak structures, paternalistic political structures, and the lack of other incentives that may make them reluctant to cross boundaries and work together (Emerson and Nabatchi, 2015, Emerson, 2018). Collaborative governance was the aspiration in the study programmes, as per design and intent, but findings will show that there were not adequate drivers to foster collaboration in the Nigerian-styled multi-level governance. This will be picked up again in the discussion chapter.

3.3.1 Multilevel governance

The heuristic of multi-level governance (MLG) has its origins in a different body of literature, namely the study and practice of governance in the European Union (EU) (Hooghe and Marks, 2003), i.e. across national states, but it has since been used extensively to explore different levels of governance within countries (Tortola, 2017, Zürn, 2020). While the term suffers from definitional ambiguity, as pointed out by several authors (Daniell and Kay, 2017, Tortola, 2017, Zürn, 2020), it is of particular importance for this study for its analysis of the "*dispersion of authority upwards, downwards and sideways between levels of government – local, regional, national and supra-national*" (Daniell and Kay, 2017) and for an explicit use in, and focus on, the

understanding of federalism. However, within the study of inter- and intra-state processes and relationships, the MLG paradigm moves,

> *"...from the study of the formal structures of governance (whether at the constitutional or ordinary level of legislation), to the analysis of the entire process of policymaking and implementation, inclusive of all those factors – informal rules, routines, exchanges, bargaining, etc. – that are not exhausted by the letter of the law"* (Tortola, 2017).

Evidently, this focus on the everyday practices, rather than only the formal structures of governing across levels, is closely aligned with literature on collaborative and inter-active governance (Kooiman, 1999, Emerson et al., 2012), and it was surprising to find that these bodies of literature and debate barely intersect.

Much of the MLG literature focuses on the "*unravelling of the central state*" (Hooghe and Marks, 2003), and the emergence of the EU; and a smaller body on the history of federalism and different forms of federalism (Zürn, 2020), again with a focus on the global North. However, in a 2003 article, Dele Olowu not only explored the usefulness of the paradigm in understanding "*governance as the fundamental rules of the political game*" (Olowu, 2003) in LMICs, but he importantly located the concepts and understandings of MLG, federalism and decentralisation in their historical context, as will be elaborated further below. Olowu (2003) also highlighted the contrast in MLG between industrialised and less developed countries. In most industrialised countries, decentralisation was more effective because strong local governments existed before the central organs, and power was polycentric between autonomous entities (regions, churches, municipalities, trade unions, etc.).

On the other hand, in developing countries (and particularly former colonies), there were highly centralised models of government that were reinforced by patrimony – all powers and resources flowing from the centre. Reasons for this were that less developed countries, most of them emerging from colonialism, required rapid economic and social development. It was thought that this would be better actualized through central planning, and so opted for just administrative decentralisation or de-concentration, hence the sharing of responsibilities between central and local administrations which do not exercise any discretionary authority nor have independent access to resources. Hence, they were administratively decentralised, but

without full autonomy. Later on, countries began to move from this to some form of polycentricity, to different degrees in each country, giving rise to devolution and MLG (Olowu, 2003).

Federalism and decentralisation are two of the conceptual pillars in the understanding of relationships across levels in MLG (Blank, 2010), that are relevant to this study. Conceptual literature borrows transferable principles from developed countries but empirical examples in this review are limited to developing countries, for comparability and manageability.

3.4 FEDERALISM AND DECENTRALISATION

Federalism is a constitutional non-centralisation, with delimitation of responsibilities between two separate political entities, usually one at the national level and the other at the regional level, potentially providing opportunities for collaboration in strategic areas, whilst federating units maintain relative independence over domestic or local matters (Olowu, 2001). This official division of power among different levels of government, with each being given a certain degree of constitutional autonomy (Gardner, 2018), is what distinguishes a federation from a decentralised unitary state, where the powers of sub-national governments are typically granted, and are revocable through ordinary national legislation (Suberu, 2009). Another key difference is that whilst federations operate at the national (macro) and regional (meso) levels, local governments (micro/community level) are the focus of decentralisation (Suberu, 2009).

Gardner's work, based on the Madisonian theory, describes federalism as an inherently unstable form of government organisation, in danger of fragmentation or collapsing into unitary government (Gardner, 2018). However, the theory also suggests that federalism can be permanently maintained in its instability by institutionalising permanent contestation between national and sub-national levels of government, through a constitutional design. He applied this theory in studying federalism in nine developed countries with federal or quasi-federal states (Argentina, Austria, Belgium, Canada, Germany, Italy, Spain, Switzerland, and the United States) and reported two key findings. First, that sub-national levels of governments do at

times assert themselves against national power, in line with Madisonian theory; secondly, that sub-national levels have devised methods in an "*attempt to shape, influence, or thwart national policies…and have not confined themselves within the boundaries of their formal constitution*" (Gardner, 2018 P.508). Methods applied by sub-national units were found to range from uncooperative (secession, defiance, violent resistance) at one end, to more corporative and integrated methods (negotiation and bargaining, etc.) at the other end. In the middle lies individual exercise of autonomous power and power entrepreneurialism, amongst others. Power entrepreneurialism occurs when a sub-national unit unilaterally expands its scope of power with the hope that it is eventually recognised as legitimate (Gardner, 2018).

In developed countries, federalism was a mechanism for uniting entities (states, provinces) that were once autonomous (e.g., United States and Canada) and already had strong functioning local governments (Olowu, 2003). These supra-state formats have not been successful in Africa and other developing countries (Suberu, 2009). Rather, in developing countries, federalism became a means of dividing unitary governments into national and sub-national levels, Brazil being a prime example (Rosenn, 2004). Brazil's original unitary government was unsatisfactory to most of the provinces, and this eventually led to a military revolt and declaration of a Federal Republic in 1889, subsequently constitutionally entrenched in 1891, making it one of the oldest federations in the developing world. Due to its immense size and diversity, federalism was considered the most sensible form of government, however it is reported that it remains far more centralised than developed federations (Rosenn, 2004).

Since becoming a Federal Republic, Brazil has gone through many eras, and several decades of military regime between the old and new Republics. With a new Republic declared in 1985, and a national constitution was drafted in 1988 which "*significantly decentralized governmental powers and reinvigorated federalism"* (Rosenn, 2004). The key challenge of this new era was finding a balanced fiscal federalism. There was a mismatch, as constitutionally designed, where more resources than responsibilities were allocated to the states and municipalities, whilst the centre had less resources than responsibilities, with a resultant large federal deficit and rise in inflation. Any

attempt at changing the structure required a constitutional amendment, which happened in 1994 when the *Plano Real* ("Real Plan") was instituted to stabilise the economy. It involved a constitutional amendment to change the revenue allocation formula, leading to a phased increase in fiscal re-centralisation over the years. Despite this ongoing re-centralisation of the federal system, the health sector and its policies remained underpinned by the 1988 Constitution which provided for vigorous decentralisation of health care, with the result that states are not fulfilling their roles in tacking health issues (Ribeiro et al., 2018). With this arrangement, their Unified Health System (SUS) policy, proposed concurrent responsibilities across the three levels (centre, states, and municipalities), backed by the Constitution and a legislative framework in the form of a cooperative federalism. Thirty years after the policy, evaluation found that the federal system did not produce a strong coordination of the health policy at the local level. Other obstacles to implementation were inadequate fiscal autonomy and capacity of local government to meet their responsibilities, high dependency on national funding. Side-lining the states (mid-level) at a time, and contestations with federal level actors strained the tripartite relationship (Ribeiro et al., 2018, Santos, 2018, Cavalcante et al., 2019).

In Africa, there have been 10 notable federal or quasi-federal states (Cameroon, Zaire, Uganda, Kenya, Sudan, Ethiopia, Tanzania, Comoros, South Africa and Nigeria) at different stages of the federal experiment (Suberu, 2009).

Cameroonian federalism involved the coming together in 1961, of two of its territories that had different colonial legacies – one British and the other French. Rather than an equal partnership, the union became an integration of the anglophone Cameroon into a strong unitary state. This led to protests by anglophone Cameroon against their being marginalised and exploited. Amidst ongoing agitation which has lasted decades, Cameroon is presently administered in a highly unitarized structure (Konings and Nyamnjoh, 1997, Konings, 1999, Mehler, 2014).

The Zaire (Democratic Republic of Congo) federalism experiment started in the 1960s, but quickly fragmented and crumbled due to deep divisions of the state,

because of ethno-regional problems that led to internal violence and a civil war in 1994 (Osaghae, 2004, Suberu, 2009).

The focus of the design of Uganda's federal system in 1962 was "*to accommodate the autonomist sentiments of the Kingdom of Buganda*" (Suberu, 2009, p. 69) but this lasted only four years (Suberu, 2009). However, through successive elections, the Kingdom continues to promote its demand for federalism (Sjögren, 2020), and debates continue about whether federalism is a viable design for the country (Ssali, 2017, Ssali, 2020).

Kenya's federalism (*majimbo)* was also constrained by deep divisions among the political elite and ordinary Kenyans (Maxon, 2016), the problems coming to a head following the 2007 elections. Recently there have been new calls for Kenya to reconsider federalism while maintaining devolution (Kiplagat, 2016).

The motivation for the initial Sudanese federal experiment (1972–1983) was to restore peace after prolonged conflict between the North (predominantly Arab and Muslim) and the South (predominantly African and Non-Muslim), and guaranteed self-government for the South. The arrangement was continuously undermined by the government which eventually introduced Islamic law, which then led to a civil war (El-Gaili, 2004, Suberu, 2009). After two civil wars, federalism re-emerged as a compromise in 2004 before eventual independence of the Republic of South Sudan in 2011. South Sudan maintains a federal system of government (El-Battahani and Gadkarim, 2017).

Tanzania can be referred to as a quasi-federation, as currently it is predominantly a unitary state, with the federal relationship applying only to the 5% of the population living on the islands of Zanzibar (Egboh and Aniche, 2015).

Although federations tend to be big states, Comoros is one of the exceptions. It has been referred to as a microstate, which nevertheless satisfies the criteria and attributes of a federation (Anckar, 2003). It is a coming-together federalism of three islands. However, one island (Grand Comoros) is larger and more populous than the other two islands, thereby skewing the configuration. This awkwardness has been at the root of its instability and repeated conflicts (Baker, 2009, Suberu, 2009).

The other three African federations (Ethiopia, South Africa and Nigeria) have also been referred to as the "*three great federations of Sub-Saharan Africa*" (Erk, 2014). Ethiopia's nine regions are ethnically heterogenous, but unlike other African states, this is not because of the scheming of colonial imperialists, as it was never colonised, but because of a later expansion of the empire. Through expansions and conquests Ethiopia initially emerged as a unitary and centralised state. The initial federation experiment involved the coming together with Eritrea, a former Italian colony, but this did not last as Ethiopia was disproportionately much bigger and the arrangement eventually broke down in 1962. Following years of military repression and a joint rebellion of ethnic movements, Ethiopia eventually transited to a federal state through a phased process of devolution, completed in 1995. The biggest challenge to the federal system has been the lack of administrative capacity at both national and regional levels, and the poor fiscal capacity of the regions, hence continuing to depend heavily on federal transfers (Suberu, 2009, Tewfik, 2010, Beken, 2015, Assefa, 2015). In addition, the ethnic federal system was said to emphasise ethnicity and lacked a genuine democratisation process (Abebe, 2012).

There are differences of opinion as to whether South Africa is a federal state or not (Schwella, 2016), however there is a constitutionally recognised arrangement of three levels of government – national, provincial and local (Suberu, 2009). The federal principles entrenched in South Africa's interim and final Constitution in the 1990s, played a key role in the transition to democracy and contributed to the success of negotiations. However, the quasi-federal arrangement is now said to have become highly centralised and the constituent units less autonomous (Tepeciklioğlu, 2018) as a result of "*the strong commitment of the ruling African National Congress to political centralization, and the weak political, administrative and fiscal capacities of provincial and local governments*" (Suberu, 2009).

A later addition, Somalia has also been attempting to employ federalism in rebuilding the nation since emerging from military rule in 1991, and still faces the challenge of inadequate fiscal federalism (Isak and Ali, 2019).

Generally, the poor success of the federalism experiment in Africa has been attributed to its being mostly external, from colonial imposition without adequate local resources and capacity, and an apathy of African dictators to sub-national autonomy (Suberu, 2009, Osaghae, 2004). Nigeria is said to be the most enduring federal structure, because it took steps to adapt federalism to its multi-ethnic and diverse peculiarities (Suberu, 2009). This is further explored in the next section.

Decentralisation is an act of the centre to transfer some of its powers to regional and local governments. Hence, decentralisation can exist in both federal and unitary states (Erk, 2014). It is a multi-dimensional concept with different dynamics; mainly political, fiscal, and administrative. **Political decentralisation** refers to direct elections into sub-national offices. Where this is practised, sub-national elections tend to gain a high level of importance for the political actors as well as the citizens, but it does not imply that the country is fully or highly decentralised, as fiscal and policy autonomy are also taken into consideration (Montero and Samuels, 2004).

Fiscal decentralisation comprises two main dimensions: revenue decentralisation and expenditure decentralisation. Revenue decentralisation is the relative degree to which sub-national governments come to control the sources of their revenues, usually taxes and/or national government transfers. Expenditure decentralisation refers to the degree to which sub-national governments may autonomously decide how to spend their revenues, and how much of their revenues to spend, independent of central government guidelines or earmarking. In practice, fiscal decentralisation may occur on both of these dimensions and to distinct degrees in the same country and over time (Montero and Samuels, 2004). Arguments in favour of allocative efficiency have been proffered for pushing fiscal decentralisation, and it is also argued that sub-national governments are in a better position to prioritise their health needs effectively, even more so where citizens have a voice (Oates, 2005, Banwo, 2012, Abimbola et al., 2015, Fredrick et al., 2017). However, this may be countered where there is room for clientelism in the voting behaviour, as evidenced in some developing countries, especially with poorer voters (Bardhan, 2002, Wantchekon, 2003, Stokes, 2005, Bardhan and Mookherjee, 2012, Robinson and Verdier, 2013, Khemani, 2015).

Administrative decentralisation, also known as **policy decentralisation** is sub-national policy autonomy; where sub-national (state/district and local/municipal) governments can set goals, write their own policies, generate resources to administer and implement a public health policy; and also have autonomy to adopt (or not) policies transferred from a higher level of government (Mookherjee, 2015).

These three dimensions of decentralisation (political, fiscal, and administrative) have been applied in the public administration framework to classify decentralisation into four key models of transferring decision-making from the centre to peripheral governments, as briefly outlined in Chapter 1:

- De-concentration shifts power from the central offices to the peripheral offices of the same administrative structure, like the Ministry of Health.
- Delegation shifts responsibility and authority to semi-autonomous agencies.
- Devolution shifts responsibility and authority from central offices to separate administrative structures still within the public administration; and
- Privatisation is where there is a contractual relationship between public entities and private service providers (Bossert, 1998a).

These models have been used in combinations or individually, and vary from country to country; both in intent and practice (Montero and Samuels, 2004, Bossert and Beauvais, 2002b). Some models include varying degrees of fiscal decentralisation and political centralisation, where regional governments cooperate with central government and are sanctioned when they do not (Mookherjee, 2015); or the other way round with more fiscal centralisation. Nigeria is a typical example of more fiscal centralisation – the central government retains rents from petroleum products, which is the key source of the country's income (Banwo, 2012). However, this partial or hybrid decentralisation, where responsibilities and personnel are deconcentrated but not financing, are commonplace in developing countries (Olowu, 2001, Osaghae, 2004, Erk, 2014, Santos, 2018).

Olowu describes how decentralisation (in anyone of or a mix of the models described above) in Africa has passed through four phases since the end of the Second World War (WWII). The "golden age" (1945 to early 1960s) was marked by the establishment

of local government (LG) systems, triggered by several factors, such as a reward to the colonies for assisting in the War; the growing number of educated elites pushing back against colonisation; and rebellions from corrupt traditional rulers. This was followed (1960s to 1970s) by dismantling of by post-independent leaders to attempt to build powerful economic nation states, through single party mechanisms. LGs existed mainly for the maintenance of law and order, and the implementation of centrally determined objectives. Decentralisation was commonly partial, and mainly de-concentration of administrative responsibilities, rather than full devolution, due to a lack of will to transfer the power to act from the centre. These decisions would later lead to the governance and economic crisis of the 1970s. In the third phase (late 1970s to late 1980s), structural adjustment programmes (SAPs) were instituted because of the economic crisis. To cut down on spending, the centres devolved responsibilities, but not resources, and so decentralised structures were really extensions of the central government. There was no clear distinction between de-concentration and devolution and there was no real commitment to shifting the power base from the centre to the localities. In the fourth phase (from the 1990s onwards), although past practices continued, there was a renewed interest in decentralisation, triggered by a number of factors: i) pressures for local reforms as a result of the failure of centralised public sector management; ii) pressure from external donors, whose assistance African countries were heavily dependent on, and who consider democratic decentralisation as one of the key elements of good governance; iii) growing urbanisation, leading to sophistication and intolerance for old forms of domination by central and local elites; and finally, iv) conscious use of decentralisation as a political mechanism to resolve or diffuse conflicts in many parts of the African continent. Again, these exercises were skewed to de-concentration than full devolution, especially with resource control (Olowu, 2001).

Key challenges to the realisation of full decentralisation through these phases were that: i) the preconditions for popular democracy (high literacy levels, communication and education, secure middle class, vibrant civil society) did not yet exist in Africa, as they did in developed countries; and ii) the low levels of economic development in many African countries did not foster local autonomy. Other identified dilemmas

were: political – the unwillingness of political leaders to share monopoly power partly due to fears of secession, which was not unfounded; economic – the high costs of decentralisation which were not available to many African countries; and management – institutional and policy design issues and sustainability, for instance, how to allocate responsibilities between central and local governments and between different tiers of local authorities; the balance between financial powers and/or resources and allocated responsibilities, amongst others (Olowu, 2001).

In federal countries, the powers constitutionally assigned to health care vary in forms. While some countries assign very clear and watertight health roles to the different levels of government, other countries may ignore health care responsibilities as a standalone category and it is generally inferred; and in yet others, health care responsibilities are assigned to two or more levels of government concurrently, such that responsibilities are either shared or managed in parallel by the different government levels (Marchildon and Bossert, 2018) and Nigeria falls into this last design (FGoN, 1999). The capacity of constituent units (states, provinces, etc.) to carry out their decentralised health responsibilities, also depends on their level of dependence on central transfers in their federal design. In some cases, constituent units have enough fiscal capacity to carry out their health responsibilities. This is seen more in the developed countries (De Pietro et al., 2015, Ireys et al., 2018, Marchildon and Bossert, 2018). In other cases, predominantly in LMICs, sub-national units may be entirely reliant on central fiscal transfers or this may vary from one constituent unit to another (Erk, 2014, Marchildon and Bossert, 2018). In other cases, "*the central government establishes a right of access to health care that may create an obligation that the constituent units only have limited capacity to deliver – what some might call an unfunded or underfunded mandate*" (Marchildon and Bossert, 2018-p3). The details of how this last scenario played out in the MNCH policy implementation in Nigeria will be discussed later.

Over the past four decades, developing countries have embraced the decentralisation of health system governance, with disparate experiences. Factors which have contributed to tensions and inadequacies of decentralisation reported across developing countries are either due to inadequate fiscal transfers to sub-national

governments (Abdullah and Stoelwinder, 2007, Abimbola et al., 2015), or weak governance and accountability structures in managing funds and other resources (Arredondo and Orozco, 2006, Oosterveer and Van Vliet, 2010, Abimbola et al., 2015), institutional and policy designs, and the actors relationships across government levels (Santos, 2018, Ribeiro et al., 2018).

In Africa, in both federal decentralised and unitary decentralised countries with multi-tier health systems, some of these factors have been identified as having influenced the policy processes. In the health sector decentralisation in Tanzania (Frumence et al., 2013), and in a national government dissemination policy in South Africa, a bottom-up approach of central government in policy design, facilitated increased autonomy in local resource mobilisation and utilisation, and health workers' accountability, respectively. A multi-phased implementation of the Reproductive Health Voucher Programme in Kenya allowed for the adaptation of lessons learnt to local contexts during the implementation (Abuya et al., 2012). In Malawi, adequate engagement with relevant stakeholders during agenda setting and policy formulation, and steps taken to ensure legal enforceability across government levels and stability across transitional governments, strengthened the implementation of a resource allocation policy for universal health coverage (UHC), although it was noted that a more bottom-up approach could have been used to generate epidemiologic evidence for the process (Twea et al., 2020).

In Ghana, the policy process and early implementation of the free National Health Insurance Scheme (NHIS) coverage for pregnant women was perceived as a political initiative with limited actor engagement and insufficient evidence for policy (Witter et al., 2013).

In federal countries, the inadequate sub-national fiscal autonomy and capacity to implement policies, and hence an overdependency on central funding has been more common (Frumence et al., 2014, Kredo et al., 2017, Santos, 2018), and constrains sub-national autonomy during implementation. In Tanzania, the late disbursement of funds by central government interrupted district level implementation of their health sector responsibilities, which led to this lower tier instituting a number of informal

coping strategies (Frumence et al., 2014). Conversely, where constituent units independently command adequate fiscal capacity, as seen in the Western Cape Province in South Africa, it reflects in their governing capacity and other competencies, unlike those that are heavily dependent on the centre (Erk, 2014).

Increased sub-national decision space was reported in Kenya following devolution, but this was initially plagued by actor contestations across government levels as a result of political interference and lack of clarity in roles of national and country level actor in the health system functions, especially in devolving human resource management, commodities and health financing (Tsofa et al., 2017a, Oraro-Lawrence and Wyss, 2020). It has been proposed that resource allocation, priority setting and financial management functions between central and decentralised units be guided by considerations around decision space, organisational structure and capacity, and accountability, to enhance benefits of decentralisation (Tsofa et al., 2017b). In decentralising environmental management to district and county levels in Uganda, which also indirectly impacted on the health sector in Uganda, there were reported horizontal and vertical tensions among political and administrative actors which constrained implementation (Oosterveer and Van Vliet, 2010).

Specific to MNCH policy processes in LMICs, which contribute the larger burden of global MNCH morbidity and mortality, multi-governance structures have contributed to varying outcomes as a result of sub-national variations in contexts, disease burden, and divergent goals of political leaders and other actors (Barros et al., 2010, Daire and Khalil, 2010, Samuels et al., 2014, Smith, 2014, Deller et al., 2015, Koduah et al., 2016). It has worked more in some contexts than others. Brazil, despite its decentralisation challenges over the years, attributes some of its progress in improving MNCH in the last three decades to various health reforms of which decentralisation was key. Decentralisation enabled policies and programmes to be tailor-made to the needs of the North and Northeast states which had the poorest socio-economic status and consequent poor MNCH indices (Svitone et al., 2000, Barros et al., 2010). In India, where states have primarily been responsible for health policy implementation and also for funding a greater proportion of health services, variations in outcomes of sub-national MNCH policy implementation have been

attributed to decentralisation reforms, though causal links are said to be unclear (Smith, 2014).

Decentralisation has worked less in Guatemala and Peru, where inadequate vertical and horizontal coordination, planning and decision-making structures at the municipal, regional and national levels constrained implementation of a nutrition initiative (Pelletier et al., 2012a).

According to Erk (2014), decentralisation, it would appear, has come to stay in the African continent. It has however, extensively mutated and evolved over the last two decades or more, such that the original institutional and constitutional designs may not be adequate in trying to understand the changes. One common evolutionary pathway observed in developing countries is the symmetrical recentralisation, where large-scale national programmes are designed with national goals, in a paternalistic manner such that with time, central government starts meddling into policy areas which formally belonged to sub-national units. Another pathway is the differentiated performance, because of wide within-country ethnic and demographic diversity, varying governing capacity (fiscal, political, legislative, administrative, and intergovernmental) of regional units. These differences lead to a variation in their performance, irrespective of the constitutional or institutional blueprints (Erk, 2014).

3.4.1 Federalism and decentralisation in Nigeria

In addition to what has been briefly described in Chapter 2, this section outlines the key federalism and decentralisation processes of the present entity known as Nigeria. Historically, after the amalgamation of the northern and southern protectorates of Nigeria in 1914, Nigeria was administered with provincial arrangement until 1946, when features of federalism in terms of devolution of fiscal powers surfaced (Ali and Ahmed, 2019). Subsequently, the nation has adopted various forms of federalism since, as summarised below (Table 3.1), varying revenue allocation formula and creation of more sub-national government units of states and local governments (Khemani, 2001, Abe and Adetoye, 2014).

The first phase (1948–1953) of federalism in Nigeria was marked by a centralised financial arrangement in which the excess in the budget of the central government

was allocated to regional governments on the principle of derivation (Khemani, 2001, Banwo, 2012). The Richards Constitution of 1946 set up a central legislative council for the country and divided the country into three regions – north, west, and east (Khemani, 2001, Ali and Ahmed, 2019). The Constitution also recognised the formation of regional legislatures for the sub-national governments. After the McPherson Constitution of 1951, the country became a quasi-federal state in 1951, and was fully federalised in 1954 when yet a new constitution gave limited fiscal autonomy to the regional governments (Khemani, 2001). While the national government took charge of international affairs, defence, the police, etc., the regions were responsible for primary and secondary education, agriculture, public health services and local government administration (Khemani, 2001, Scott-Emuakpor A., 2010b). The judicial arm of government, civil service commission and marketing boards were all regionalised. Responsibility for socio-economic development, labour matters and tertiary education were shared between the central and the regional governments. After independence from Great Britain in 1960, Nigeria became a sovereign Federation of three provinces – Western, Eastern and Northern Regions – under the umbrella of a central government often referred to as the Federal Government of Nigeria (FGoN) (Olowu, 1991).

Nigeria became a Federal Republic in 1963, a republican constitution emerged and an additional region, the mid-western region, was created. The regional arrangement was abolished in 1967 and 12 states emerged. Today, the country is divided into 36 states, one Federal Capital Territory and 764 local governments. Local and regional/state governments have always been allowed to raise revenue, undertake spending decisions, and receive allocations from the federal purse, even under military rule (Olowu, 1991, Banwo, 2012, Ali and Ahmed, 2019). An additional attempt to adapt federalism to the country's diverse ethnic and socio-economic sub-national context is the further division of the country into six non-administrative regions, referred to as geo-political regions (Northcentral; Northeast; Northwest; Southwest; South-south and Southeast). This was mainly for political and not fiscal reasons, as it was proposed that the presidency be rotated through the six regions to ensure equity. However, this has not been strictly adhered to due to the faulty political system which

ensures a game of numbers along ethnic lines. As a result, one of the regions, the South-East region has not produced a president since the end of the civil war (1967–1970).

Table 3.1: Key federalism and decentralisation processes in Nigeria, 1914 – present

Political/Historical Period	Process
Pre-independence 1914–1946	British colonialism, bringing together components to amalgamate into the entity known today as Nigeria under the Lugard Constitution (1914), a new **constitution (Clifford's, 1922**) with new legislative councils
First phase of Federation 1946–1953	Marked by centralised financial arrangements, excess budget of central government allocated to regions. **Richards Constitution** (1946) set up a central legislative council and divided the country into a federation, with creation of three provinces/regions (north, west, and east). **McPherson Constitution** (1951) – Nigeria became a quasi-federal state.
Full Federation, pre-independence 1954–1960	**New Constitution,** fully federalised (1954), giving limited fiscal autonomy to regional governments.
First Republic 1960–1966	Gained independence (1960), became a sovereign Federation of three provinces/regions under the umbrella of central government (Federal Government of Nigeria). Became a Federal Republic (1963), with a new Republican **Constitution** and an additional region (mid-western) created (1963).
Military rule 1967–1979 (decentralisation reforms)	Regional arrangement abolished and 12 federating units (states) emerged (1967), attempted secession of southeastern and ensuing civil war (1967–1970). **Further division of federating units into 19 states and LG reforms, making LGs third tier of government (1976), 1979 Constitution.**
Second Republic 1979–1983	Democratic elections in 1979 was truncated by a military coup in 1983
Military rule 1984–1993	Further LG reforms (1988) providing autonomy to LG as a third tier in the Federation; federating units increased to 30 states and the federal capital territory (FCT) (1993).
Third Republic 1993	Interim democratic government (August–November 1993).
Military rule 1993–1999	Thirty-six federating states, FCT and 774 local governments (1996).
1999–present	New Constitution and return to democracy (1999), Constitutional conference, recommended to scrap the LG tier, not yet adopted.

Currently, some regions, including the Southeast Zone, are calling for a restructuring of the country towards true federalism and reducing the power at the centre (Lalude, 2020). Opinions on this are outside the scope of this study.

Fiscal federalism is a major factor in sub-national administration and policy implementation. In contrast to the early experiences in Brazil outlined above, Nigeria has not achieved true federalism, due to inadequate fiscal decentralisation as a result

of the central government holding onto rents from oil revenue (Aiyede, 2009, Banwo, 2012, Ugoh and Ukpere, 2012, Majekodunmi, 2015). This impacts on health policy implementation across government levels (McKenzie et al., 2014, Eboreime et al., 2019), as states remain heavily dependent on the centre for fiscal transfers; what some federalism scholars have also referred to as " feeding bottle federalism"(Osondu and Okeke-Uzodike, 2013, Rufus and EYO, 2019, Abada et al., 2020). About 89% of states' revenue are transferred from the centre (Marchildon and Bossert). This fiscal centralism, it is argued, has resulted in the current over-bloated federalism, because having more sub-national units is seen as a method of increasing fiscal decentralisation. Within three decades after independence, Nigeria grew from three units to a 36 unit Federation, with 774 local governments (municipalities/sub-counties) (Osai and Amugo, 2019). With this, comes different levels of autonomy, such that sub-national units are not merely implementers of national policies. States also make state level health policies and are at liberty to adopt or not adopt national policies (Okeibunor et al., 2010, Onoka et al., 2013, Uzochukwu et al., 2015a). Resource allocation at sub-national levels (from states/regions to lower levels of government) have received less focus (Abdullah and Stoelwinder, 2007, Albuquerque et al., 2015), and requires more evidence, especially its impact on primary health care services. As stated in Chapter 2, in Nigeria, LGA allocation is routed through State Joint Local Government Accounts (SJLGAs) (Eme et al., 2013). Every state has a Joint Account Allocation Committee (JAAC), which oversees the SJLGA and determines financial allocations for each LGA, based on certain criteria, including population size, social development indicators, and internal revenue efforts. Inadequate allocation of funds by the state limits LGAs from successfully executing their assigned responsibilities (Udah and Ayara, 2014).

3.4.2 Challenges of decentralisation and federalism in MNCH policy implementation in Nigeria

In Nigeria, about 30 MNCH policies and guidelines have been introduced since the development of the National Health Policy in 1988. These policies eventually formed a baseline for developing the IMNCH Strategy in 2007 (FMoH and Jhpiego, 2011, FMoH and NPHCDA, 2012, Kana et al., 2015b). Although, the IMNCH Strategy

development was greatly inspired by the MDGs, it owes its roots to the ongoing health sector reforms in the country that had been initiated in 2004, and was built on the principle of improving health care services provided by a skilled workforce using the PHC platform (Fatusi, 2012). However, the PHC management has been left to the weakest tier of government – the LG tier (Aregbeshola and Khan, 2017). This chronic weakness is as a result of poor fiscal autonomy and governing capacity of the LG tier (Abimbola et al., 2015, Khemani, 2001). Outcomes are that decentralisation in policy processes have been constrained by weak stakeholder engagement across government levels (Omobowale and Omobowale, 2011, Okpani and Abimbola, 2016, Onwujekwe et al., 2016, UNICEF, 2016b, Okeke et al., 2017, Eboreime et al., 2019), contentions of perceived inadequate fiscal decentralisation (Banwo, 2012, Onwujekwe et al., 2016, Uneke et al., 2016, Eboreime et al., 2017), and inadequate accountability mechanisms (Abimbola et al., 2015, Onwujekwe et al., 2016, Eboreime et al., 2017, Eboreime et al., 2019). In Chapters 5, 6 and 7, further findings are presented on how this governance disjuncture and the inadequate collaboration, specifically impacted the IMNCH policy processes through its national programmes.

3.5 SUMMARY

This study adopts the hypothesis that large implementation gaps and outcomes are a result of the contradictions of centralised fiscal policy and decentralised health care responsibilities, across government levels without adequate collaboration. Assumptions made at the national level, do not necessarily find easy implementation at sub-national levels in the existing fragmented structure. Because local governments are directly responsible for PHC (the bulk of MNCH care), an effective collaborative functioning of the tripartite relationship between the government levels is crucial. This study will contribute to the literature by taking a historical (rather than cross-sectional) perspective of how the federal structure in a multi-level government (MLG) in Nigeria has impacted on MNCH policy processes. Improving MNCH remains a country priority, given its contribution to the global MNCH morbidity and mortality burden (World Health Organization, 2005, Uzochukwu et al., 2020). It looks at how the dynamics of MLG change along the continuum of policy formulation to policy implementation, and what challenges have been observed in Nigeria.

CHAPTER 4

METHODS

4.1 INTRODUCTION

This chapter is divided into two sections. The first section (4.2) discusses existing frameworks and presents the conceptual framework that has been developed to guide the analysis in this study. Section 4.3 presents the methods used for data collection, analysis, rigour, and ethical issues.

4.2 FRAMEWORKS

4.2.1 Overview of frameworks

A number of frameworks for analysing the policy process have been developed over the years (Walt et al., 2008a). One of the earliest and most enduring has been the stages heuristic, which in the health policy context is prominently represented by Sabatier (2007) among others. While this framework is commonly criticised as being too linear (Buse et al., 2005a, Sabatier, 2007b), it nonetheless enables us to discretely order policy processes in our minds and to shine the light on specific stages of interest at different times. Hence, the space between policy formulation and implementation can be critically examined, employing relevant theories and frameworks to explain it.

Berlan et al. (2014), built on the stages heuristic by adding other stages that may exist between agenda setting and policy formulation (generation, consultation /deliberation; advocacy; lobbying and negotiation of policy alternatives), and between policy formulation and implementation (drafting/enactment and guidance/influence on implementation), and elaborate how these stages impact on the four discrete domains of the heuristic (Berlan et al., 2014).

Context and actors are key influences on these stages. Unpacking context allows us to examine the environmental, constitutional, governing, and social structures and how they influence the policy space. The analysis of actors' ideas, interests and their decisions will enable policymakers and implementers to better understand these

stages of the policy process, and the complex interactions and relationships between these factors in policy processes (Buse et al., 2005b, Heller et al., 2007, Sabatier, 2007a, Smith, 2014, Eboreime et al., 2017).The Policy Triangle provides a basic heuristic, to better understand this phenomenon. It highlights the central role of actors as individuals, groups, or organisations through the policy process in a given context (Walt and Gilson, 1994b, Buse et al., 2005b, Walt et al., 2008b).

Policy implementation has been defined as the process of turning a policy into practice (Buse et al., 2005a), and also as what happens between policy expectations and policy results (DeLeon, 1999, O'Toole, 2000). Various approaches have been used to frame the concept of implementation over time. Top-down understandings to policy implementation are said to appeal more to central government (Sabatier and Mazmanian, 1979, Nakamura, 1987, Sabatier, 2007b). Bottom-up understandings appeal more to health care workers and middle-ranking officials, as they emphasise the role of implementers and recognise their importance in shaping policy implementation (Lipsky, 1980, Hjern and Porter, 1981, Erasmus and Gilson, 2008, Erasmus, 2014). With the principal-agent theory, popular with economists, decision-makers as principals delegate implementation responsibilities to mid-level managers and frontline staff, as agents (Walt, 1994, Figueras et al., 2005, Busse, 2012).

Relationships between the centre and sub-national groups, and the level of control of sources of funds and other resources by each group, are key determinants of the success of implementation or of narrowing implementation gaps, which are in turn, to an extent influenced by the characteristics of the policy (Grindle and Thomas, 1989). Grindle and Thomas (1989) noted that this stage has historically been left unexplained due to the fact that it was viewed as a mechanical process, rather than a political process; so much so that a policy can be significantly diverted during implementation with outcomes very different from those initially intended by decision-makers (Grindle and Thomas, 1989). While these frameworks have their origins in developed countries, they have been successfully adapted and employed in studies carried out LMICs (Kamuzora and Gilson, 2007, Gilson and Raphaely, 2008, Walt et al., 2008b).

4.2.2 Analytical framework

To understand the factors and processes that influenced sub-national implementation of national level MNCH policies, they have been conceptualised as how national and sub-national policy actors take decisions to formulate and implement policies in changing contexts and changing policy spaces.

In multi-level governance settings, where policies are made at one level and transferred to another for implementation, the degree of participation and inclusivity during the various stages of the policy process will impact on the adoption and implementation components of the process, and subsequently on the implementation outcomes. The overarching framework for this study is based on this model of policies formulated at the national level for sub-national implementation, and how actors, context and policy characteristics influence these mediations (Walt and Gilson, 1994a, Hill and Hupe, 2006a). During data analysis, the study also draws further from two other frameworks. The Shiffman framework (Shiffman and Smith, 2007), as adapted by Walt and Gilson (2014) , was useful in identifying and organising factors that influenced the agenda setting stage at international and national levels, but in this study also included the policy formulation stage. Following that, the Berlan et al. (Berlan et al., 2014), framework was used to highlight distinct activities during the policy adoption stage, after formulation and pre-implementation. Berlan et al. (2014) describes these as the "*bit in the middle*". For policies developed at one government level and transferred to another for implementation, identifying these activities and how they influence the implementation stage, is crucial (Berlan et al., 2014).

The analytical framework, adapted from the Policy Triangle and multi-level governance frameworks (Walt, 1994, Hill and Hupe, 2006b) starts with an assumption that various factors affect the policy space at the national level, which culminate in policies prioritised and formulated at the national level; and are transferred to the state (middle) level for implementation. Because the states are not legally bound to adopt the policy and because they are shaped by their own contexts and imperatives, their actions or inactions may directly shape policy implementation and outcomes. As will be seen, the central role of state-level actors is a key component in this process.

The influence of multiple levels of government on the policy process in developed and developing countries shows that the relationship amongst actors in both directions of government levels, the ability of the governing structure to adapt to the context, and the range of choice over different functions of the policy process, are key influences in implementation outcomes. (Bossert and Beauvais, 2002b, Touati et al., 2007, Pelletier et al., 2012b, Samuels et al., 2014, Touati et al., 2015).

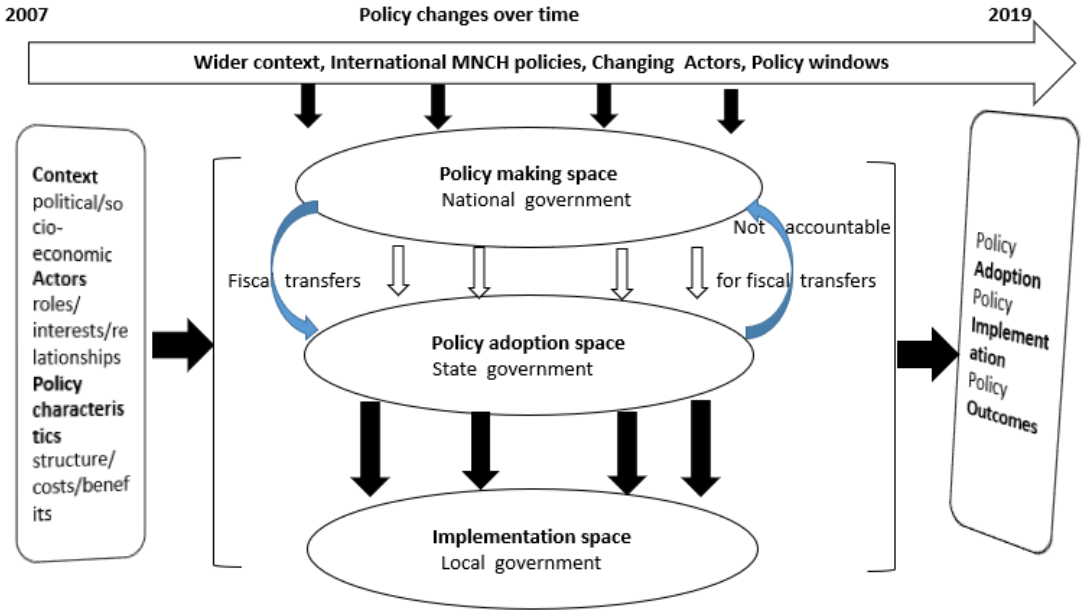


Figure 4.1: Analytical framework for MNCH Strategy (adapted from (Walt, 1994, Hill and Hupe, 2006b)

The fundamentals of health policy analysis emphasise the importance of understanding the beliefs, interests, and powers of different actors in the policy process, (Brugha and Varvasovszky, 2000, Buse et al., 2005b, Koduah et al., 2015, Barasa et al., 2016), yet governance arrangements and policy processes often neglect this insight, leading to misalignments, conflicts in government and poor policy outcomes (Koduah et al., 2016).

4.2.3 Power and power practices

To further understand the impact actors and their roles had on the MNCH policy processes, it is important to briefly describe how actor power has been conceptualised over time and adopted for this study. Power is defined as: i) the ability or capacity to do something or act in a particular way and ii) the capacity or ability to direct or

influence the behaviour of others or the course of events (Soanes and Stevenson, 2003). In the field of social science and politics, which has resonance for health policy and systems research (HPSR), power has been defined as the capacity of an individual to influence the actions, beliefs or conduct (behaviour) of others (Barnett and Duvall, 2005). Other hybrid definitions exist (Mintzberg, 1983), the commonality being the possession of a certain level or type of capacity to act or take decisions.

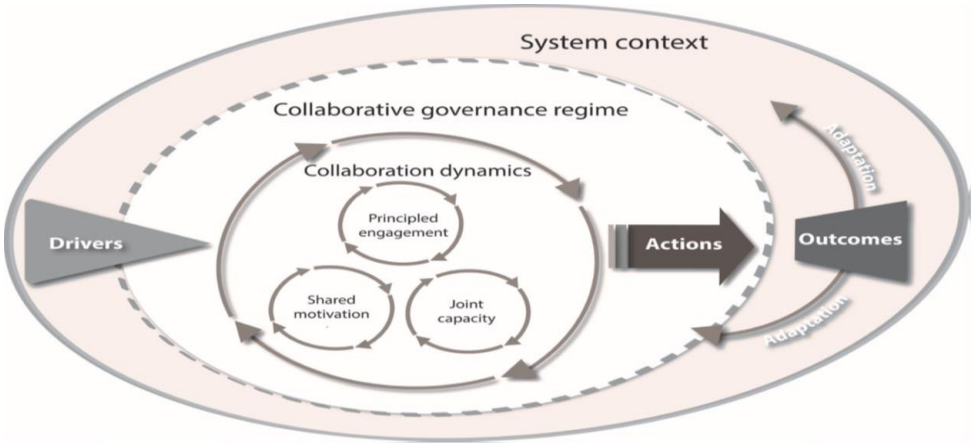
To guide the conceptualisation of power for HPSR in LMICs, a number of theories and frameworks have been concisely summarised and proposed (Sriram et al., 2018), to approach the understanding of power through the concept of dimensions and sources of power. Important to our study are the dimensions of compulsory (authoritative) power, the direct control of actors over the condition of existence and actions of another (Barnett and Duvall, 2005), and discretionary power, from the implementation perspective, where Lipsky (1980) describes frontline workers as street level bureaucrats whose decisions and actions shape, determine or become the policy outcomes themselves (Lipsky, 1980). Sources of power include technical expertise (from knowledge, skills, or information); political power (from political authority which may be legitimate, traditional, or charismatic); financial power (accessibility to financial resources); bureaucratic power (knowledge and authority of bureaucracies and administrative machinery); networks and access (for example, issue networks derived from collective knowledge); and personal attributes (exceptional personal attributes). As authors have also noted, these power concepts are continuously conditioned by existing context and hence remain fluid (Buse et al., 2005b, Erasmus and Gilson, 2008, Dalglish et al., 2015). In our study, we focus on technical expertise, political and financial sources of power.

Practices of power are pivotal in the policy process and largely contribute to the size of the gap between policy as prescribed and policy as implemented (Erasmus and Gilson, 2008). Power practice implies different actors employing different forms of power (authoritative or discretionary) at their disposal to take implementation decisions (VeneKlasen and Miller, 2002). At the interface, these result in various forms of power relationships (control, domination, contestation, collaboration, resistance, or negotiation). The consequences of these may either strengthen or constrain policy

intent or lead to other unintended consequences. Drawing on the above guiding concepts and frameworks, this study also explores the types of actor interfaces, the power practices observed at the interface sites, and how these influenced implementations. We apply these power understandings in our analysis of actor roles, relationships and their influence on the IMNCH policy process (Chapter 7).

4.2.4. Collaborative governance

The IMNCH Strategy and programmes under study, in their design, all aspired to a collaboration across the three government levels. Collaborative governance (CG) principles have been outlined in Chapter 3. In our discussion, we superimpose an integrative collaborative governance framework over our analytical framework, to identify where collaboration worked and didn't work. For this we apply the Emerson et al.'s CG framework (Figure 4.2), looking at to what extent prevalent system context and drivers influenced collaboration dynamics and actions (Emerson et al., 2012).



Source: (Emerson et al., 2012).

Figure 4.2: Integrated framework for collaborative governance regime

CG comes about through a collaborative governance regime (CGR), which requires one or more of the drivers (leadership, consequential incentives, interdependence, or uncertainty) within the system context to be initiated. The more drivers present and recognised by participants, the more likely a CGR will be initiated. The form and direction of the CGR is shaped initially by the drivers that emerge from the system context; however, the development of the CGR, as well as the degree to which it is

effective, is influenced over time by its two components: collaborative dynamics and collaborative actions (Emerson, 2018, Emerson et al., 2012). We apply this framework in Chapter 8 to discuss how collaborative the IMNCH policy processes were, between the government levels.

4.3 STUDY DESIGN, DATA COLLECTION, ANALYSIS, RIGOUR AND ETHICAL ISSUES

4.3.1 Study settings

The study was in two sub-national settings (Anambra and Ebonyi states) in the South-East geo-political zone of the country. These settings have been described in Chapter 2. In addition, data was also collected from Federal capital Territory (FCT), being the federal seat of power where national policy making is domiciled.

A further detailed description of the sub-national context in both study states is given in Chapter 6.

4.3.2 Study design and case selection

A qualitative case study research design was employed, in that the researcher undertook to investigate in-depth a phenomenon (MNCH policy) over time and in its real life context (Yin, 2009a). Case studies are empirical research strategies that depend on collecting ongoing evidence from multiple sources in a given context where the phenomenon exists, and it is especially useful when influences of the context on the phenomenon, and the fuzzy boundaries between phenomenon and context, need to be better understood (Robson, 2002, Flyvbjerg, 2006, Cresswell et al., 2007, Yin, 2009b, Gilson, 2012). It is particularly relevant in health policy and systems research (HPSR) because this form of research is concerned with experiences, and these are in turn, strongly influenced by contextual factors, which then also become an important focus of inquiry (Gilson, 2012).

This case was selected because MNCH remains a priority on the national health agenda in Nigeria and it is hoped that the analysis will provide insights that enable better understanding of these and other policies, and the development of strategies that can lead to better policy outcomes. The use of qualitative data in this study was considered appropriate because its narrative nature and thick description has a strong

potential to reveal content, context, processes, and the complexities of relationships and interactions (Crowe et al., 2011). Efforts were made, at the different stages of the methodology for this study, to align with Consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007).

4.3.3 Selection of study states

Within the Southeast Zone, Anambra and Ebonyi states were purposively selected, to compare sub-national adherence to the various national MNCH programmes on a background of variations in their socio-economic and MNCH contexts, but with similar sub-national governance and political structures.

The three programmes investigated were premised on improving MNCH quantity and quality of service delivery through several interventions, the outputs of which formed the criteria in the selection of study states (Table 4.1). At baseline in 2008 (prior to the MSS programme) the national DHS, outlined below, showed Ebonyi state consistently performing worse than Anambra state in MNCH service delivery indicators, but also progressively improving in several indicators. Although this is not a study of attribution, in Chapter 6, factors which may have contributed to these outcomes are explored.

Table 4.1: MNCH service delivery outcomes in Anambra and Ebonyi states

Indicator (%)	Anambra			Ebonyi		
	2008	2013	2018	2008	2013	2018
ANC from Skilled provider	97.7	88.0	93.3	75.7	85.0	70.3
Facility Delivery	87.8	84.6	90.4	40.7	59.6	56.5
Skilled assistance during delivery	95.2	87.6	92.5	46.3	62.1	91.5
Family Planning (any method)	34.4	35.0	44.6	6.1	15.7	8.2
Birth Registration (age under-5)	71.3	61.2	58.0	25.5	36.8	28.5
Malnourished children	4.5	n/a	n/a	13.5	n/a	n/a
Neonatal Mortality*	-	-	17*			35*
Under-5 Mortality*	-	-	58*			91*

Source: NDHS, 2008; 2013; 2018. * Estimate of 10 years preceding the survey (NDHS, 2018, p. 169).

4.3.4 Sampling and data collection

Two methods of data collection were used – review of documents and in-depth interviews with selected respondents. An initial review of key documents and pilot exploratory interviews (3) between October and November 2018, guided the development of the key interview guides. However, these were continuously adapted

to new information and to the respondent category. The initial round of data collection also helped build a picture of relevant themes for analysis. Further documents and respondents were then identified through literature searches, references, and snowballing, in an iterative manner. Study respondents were drawn from the national level, zonal level and sub-national (study states) level. Sampling was purposive of those who had been or are still involved with the various stages of the IMNCH policy process, to include policymakers, legislature, national programme managers, development partners, civil society organisations (CSOs), non-governmental organisations (NGOs) and media. At the zonal level, respondents who had oversight of the two study states and were in a position to give a comparative view, were sampled. In the study states, the following respondents were sampled, commissioners for health, MNCH programme managers, other key respondents in the SMoH and parastatals (State Primary Health Care Development Agency (SPHCDA), State Health Insurance Agency (SHIA), Ministry of Finance (MoF), local government MNCH coordinators, and state level development partners. All respondents were either involved in policy development, implementation, or advocacy for MNCH. A summary of the data sources is given in Table 4.2 below.

Table 4.2: Summary of data sources

Source	Description	Number
Documents	Policy documents before and during the study period, national and state strategic health plans, national and state level health reports MNCH and PHC programme implementation guidelines, National Council on Health (NCH) deliberations, government legal documents and frameworks, other relevant published, and unpublished articles at both state and national levels	69
Interviews (national)	FMoH (4), NPHCDA (5), development partners (2), independent MNCH consultants (4), CSOs/NGOs (2), academia (1), legislature (1)	19
Sub-national	Zonal level respondents (3), SMoH (12), SPHCDA and other parastatals (3), development partners (2), programme managers (2), local government PHC coordinators (2), academia (1)	25

The aim of the document review was to extract relevant information and triangulate this with information gathered from interviews. The process of document review involved tracing and mapping how MNCH policies have evolved over the past

decade, with a focus on background, contextual factors and their changes over time, actors, and their relationships, and how these shaped the policy process. In-depth interviews of key informants were conducted at the national and sub-national levels to enable the researcher to adequately triangulate findings and make linkages which may or may not be causal. At both levels, a significant number of respondents have worked in more than one of these respondent categories over the long study period and this enabled them to give information from more than one perspective, which further enriched the study. Interviews were conducted between May and August 2019. Efforts were made to ensure comparability between the two states by interviewing similar numbers and cadres of respondents. Question guides were used, but respondents were encouraged to lead the discussion, to allow for in-depth and rich responses of each respondent's experience. The researcher probed and prompted as necessary to further enhance the richness of the interviews. All interviews lasted between 40 and 70 minutes, and all were conducted in the English language. Interview guides were constantly refined as interviews progressed to accommodate emerging concepts or issues that required further exploration.

4.3.4 Data analysis

Document reviews, interviews and analysis ran concurrently in an iterative manner. Document reviews involved extraction of information using a template. Interviews were transcribed verbatim, and transcripts were organised with the help of NVivo qualitative analysis software Version 11. Using a framework approach, content and thematic analysis, which involved the examination of communication messages, searching for patterns and themes from multiple sources of evidence was used to extract and code information from transcripts (Gale et al., 2013). Data analysis employed both inductive and deductive approaches, initially exploring participants' views and perceptions. Familiarisation with the data was followed by organising the data sets into codes and themes. Initial content analysis enabled the arrangement of the volumes of text into categories and sub-categories, and to examine them for emerging themes (Stemler, 2000). The themes that emerged were then used to code the dataset from subsequent interviews, applying new themes as they emerged. Phrases and sentences which were related to the MNCH policy process, context,

implementation, lessons learnt, constraints, actors, relationships, and recommendations, were all extracted and coded into themes. Rich descriptions of the meaning of information obtained and triangulated from these sources formed the basis of the report. These were triangulated with information gathered from sub-national and national level documents.

4.3.5 Reflexivity, rigour, and validity

The researcher is an "insider" having been involved in the early implementation and evaluation of one of the interventions (SURE-P/MCH) under study in one of the study sites. This enabled in-depth exploration of key questions but was also balanced out by the "outsider" curiosity in the other study sites to minimise bias. More importantly, the researcher maintained a constant awareness of her positionality in explaining and constructing knowledge from the data. The convergence of information from continuous triangulation of data during analysis, which involved comparing data across interview transcripts and information from documents, enhanced the validity. A portion of this work was presented at a meeting of national level MNCH stakeholders in January 2020 and comments and confirmation of findings were obtained. Presentations have also been made at national and international conferences, journal club and PhD seminars, all with useful feedback that have further validated and enriched the study. Member checking with key informants further contributed to achieving a rigorous study.

4.3.6 Ethical considerations

First, ethical clearances to conduct this study were obtained from the Biomedical Research Ethics Committee, University of Western Cape and the Research Ethics Committee, University of Nigeria Teaching Hospital. Following these, permission to carry out the study was sought and obtained from the Federal Ministry of Health (FMoH), Abuja, Nigeria, and the State Ministries of Health (SMoH) in Anambra and Ebonyi states. Respondents were either physically approached where feasible or through e-mails and phone calls to sensitise them to the study, using a study information sheet and then appointments were secured for an interview date. Written informed consent was obtained on the day of the interview. Participation in the study

interview was fully voluntary. Participants were assured that interviews were confidential and that their identities would be anonymised. Participants were also made aware that they could withdraw from the study/interview at any stage. Following the attainment of written, informed consent from participants, interviews were recorded, and recordings were only accessible to the researcher and the research assistant who transcribed the interviews. Anonymised transcripts were stored with identifier codes in a passworded computer, only accessible to the researcher. Names and positions of respondents were not used in the analysis or report.

CHAPTER 5

HISTORICAL OVERVIEW OF THE ROLE OF MULTI-LEVEL GOVERNANCE ON THE INTEGRATED MATERNAL NEONATAL AND CHILD HEALTH (IMNCH) POLICY PROCESSES

5.1 INTRODUCTION

This chapter gives an overview of the development and implementation of MNCH policies, and the factors that impacted their implementation as intended, and outcomes at state level. It employs a multi-level governance (MLG) lens to understand how different stages of the policy process unfolded, particularly at the interface between national- and state-level government.

It starts by describing the 2007 framework policy, the IMNCH Strategy, and outlines its three programmes and characteristics. The next section (Section 2) adopts the Walt and Gilson (2008) adaptation of the Shiffman and Smith framework (2007), as outlined in Chapter 4, to summarise the findings of the policy process elements namely, policy focus (target and content); context (international and national); ideas (external and internal framing); actors (international, national, and sub-national) during agenda setting and policy formulation. In addition, two other elements – sources of funding and implementation responsibilities are included, as these were found to be key influencers of sub-national implementation. Section 3 borrows elements from the Berlan (2014) framework, outlined in Chapter 4 to analyse factors that guided implementation after policy enactment, while the section 4 presents a summary of sub-national implementation experiences. It weaves in the context and actors along the process. Detailed accounts of sub-national implementation in the two study states and the roles of actors in the process, are presented in subsequent chapters.

5.2 SUMMARY OF KEY CONTEXTUAL EVENTS ALONG THE POLICY PROCESS

The key international context was the Millennium Development Goals (MDGs) era and the push for Nigeria and other high MNCH burden countries to achieve MDGs 4

and 5, as depicted in Figure 5.1 below. At the national level, structural and situational factors, mainly political and economic, steered the policy process, the key factor being the four-year election cycles with changing political actors and interests; international debt relief and petroleum/oil subsidy removal.

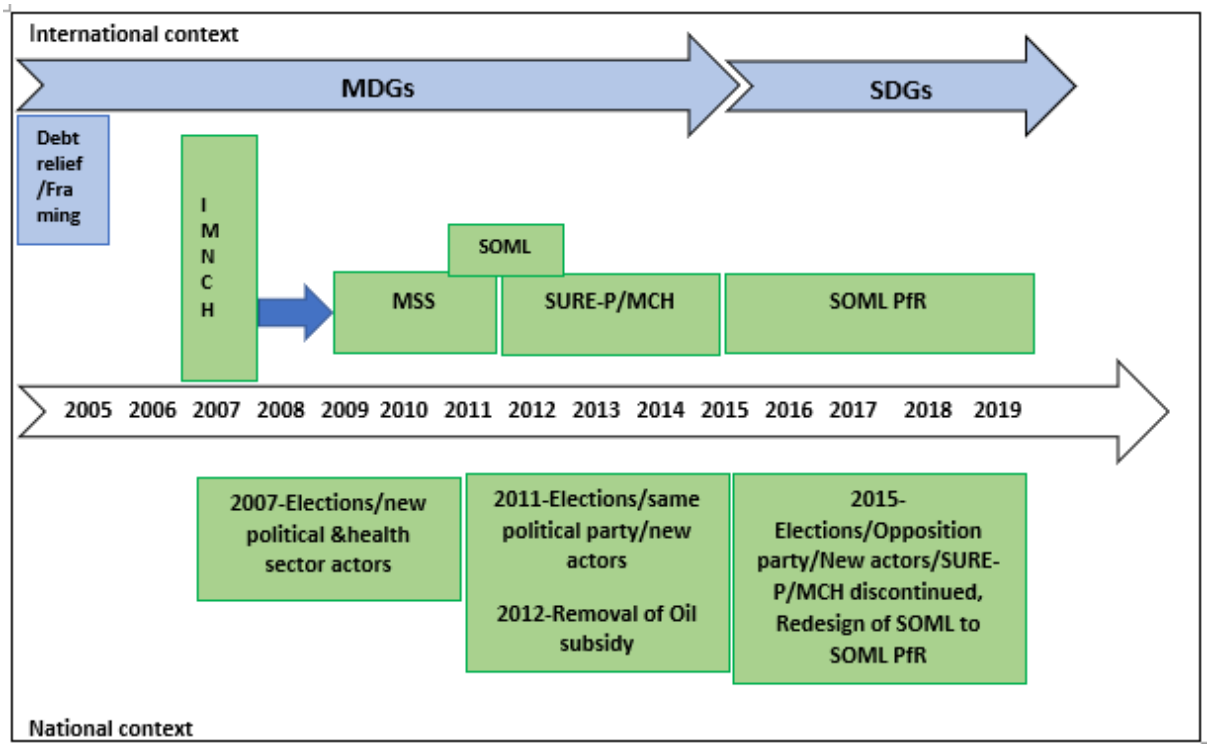


Figure 5.1: Contextual factors along the policy process

Across these cycles, MNCH was maintained high on the Nigeria's health agenda, and this was believed by stakeholders, to be in response to external pressures from the international context. The debt relief (2005) and petroleum/oil subsidy removal (2012) provided the extra economic stimuli to embark on this policy. Another key international economic influence was the entry of the World Bank in 2015 to provide financial support for the SOML PfR. These contexts were constantly interacting with multiple and changing actors to bring about actions (and inactions) which resulted in the policy process, because actors and actor roles changed every four years with the national elections.

5.3 THE IMNCH STRATEGY – "THE STRATEGY" (2007)

The IMNCH Strategy was developed midway into the MDGs, when it became clear that Nigeria was not making adequate progress towards meeting its maternal and child health targets (MDGs 4 and 5). It was founded on the principles of (FMoH, 2007):

- A continuum of care,
- Integration,
- Women's and Child's Rights,
- Equity,
- Multi-sectoral collaboration, and
- Partnerships.

Building on, aligning and integrating a host of pre-existing policies (maternal, child, reproductive health, adolescent health, health promotion, Human Resources For Health, etc.) (FMoH, 2001, FMoH, 2002, FMoH, 2005, FMoH, 2006), the Strategy aimed to design ways in which selected MNCH services that had been proven to be cost-effective, could be re-packaged and delivered in an integrated manner, within the framework of the National Health Sector Reform Programme (2003–2007) (FMoH, 2004a), as described in Chapter 2. Selected strategic approaches for implementing the Strategy included (FMoH, 2007):

- Advocacy to promote, implement, scale-up, and allocate resources to achieve the internationally agreed goals and targets.
- Strengthening of the health system by building capacities at all levels of the health sector and reducing the bottlenecks for access, availability, continued utilisation, and quality service delivery, to achieve high population coverage of MNCH interventions in an integrated manner.
- Empowering communities and families, especially the poor and the vulnerable, to improve key MNCH practices.
- Organising operational partnerships to take promising interventions to scale with government in the lead, and donors, NGOs, the private sector, and other stakeholders engaged in joint programming, co-funding of activities and technical reviews, and

- Mobilising resources at international, regional, national, state, LGA and community levels for MNCH interventions. To scale-up proven MNCH interventions, resource mobilisation and allocation relied on state and LGA capacity to plan, implement, and use monitoring results as a strong advocacy support for leveraging resources.

These strategic approaches were intended to be collaboratively owned and implemented by all three levels of government, with roles and responsibilities as outlined in Table 5.1 below. It was also described as a decision framework for the country and suggested that each state spell out clearly the level of investment they were willing to commit and the acceleration towards the impact it would have on achieving the MDGs goals in their states (FMoH, 2007). Accounts of the implementation of the offspring programmes (MSS, SURE-P/MCH and SOML PfR) later in this chapter and the next, show that this level of multi-level collaboration as intended by the Strategy was not attained during implementation due to misalignments of the existing multi-level governance structure. This will be picked up again in the discussion chapter to see how lessons learnt in the last decade could be applied to improve future programmes.

The overall objective of the Strategy was to reduce maternal, newborn and child morbidity and mortality in line with MDGs 4 and 5, and beyond. It intended to:

- Improve access to good quality health services,
- Ensure adequate provision of medical and laboratory supplies, drugs, bundled vaccines, reproductive health (RH) commodities, Insecticide Treated Nets (ITNs), and the provision and maintenance of basic equipment,
- Strengthen individual, family and community capacity to take the necessary MNCH actions at home and to seek health care appropriately,
- Improve capacity for the organisation and management of MNCH services,
- Establish a financing mechanism that ensured adequate funding, affordability, equity, and efficient use of funds from the various sources,

- Strengthen monitoring and evaluation systems, including quality assured laboratory services, to report on progress towards achieving the maternal and child health MDGs, and
- Establish and sustain partnerships to support the implementation of IMNCH Strategy (FMoH, 2007, Onuekwusi, 2007, FMoH and Jhpiego, 2011).

The Strategy included a structure for collaboration and partnerships with other sectors and health parastatals (agencies, donors, medical profession, organised private sector) and for the transfer and roll-out to sub-national levels for implementation through the national Core Technical Committee (CTC), who were responsible for targeted advocacy and the development of guidelines and plans for states and LGAs (Onuekwusi, 2007). Table 5.1 shows a summary of proposed responsibilities (FMoH, 2007).

Table 5.1: Proposed structure for roles and responsibilities of the government levels

Stakeholder/ Government level	Roles and responsibilities
Federal level	NPHCDA and other agencies of the FMoH to scale-up stewardship role to support service coverage and quality. Support secondary and tertiary facilities to manage emergency obstetric care (EOC).
State level	Must offer comprehensive essential obstetric and newborn care with the necessary drugs, equipment and skilled staff to manage such complications through the secondary health facilities.
LGA level	Responsible for households, community and PHC to facilitate access to MNCH services at PHCs through timely decisions to access care; well-equipped PHC facilities which are the point of access and ensure availability of 4–5 midwives per facility.
All levels	Partnerships for MNCH to be established at state and LGA levels with the support of the national Core Technical Committee (CTC).
Private sector/ Development partners	Improve the working arrangements between the public and private sector to increase the involvement of the private sector in financing and provision of IMNCH services. Develop new partnerships and strengthen existing ones to ensure that MNCH interventions are fully integrated in national, state and LGA health systems in a sustainable way.

Source:(FMoH, 2007, FMoH et al., 2009)

The Strategy was designed to be implemented in three phases as follows (FMoH, 2007):

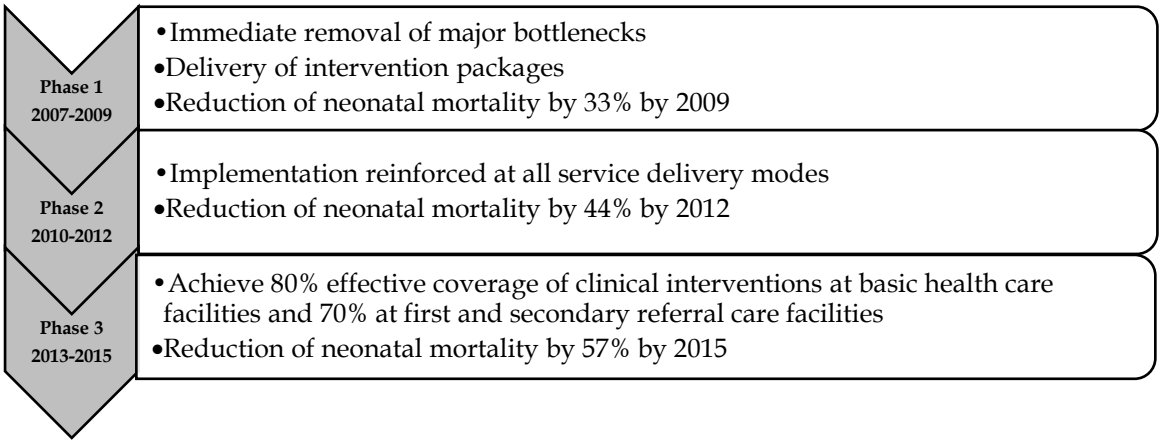


Figure 5.2: Proposed implementation phases of the IMNCH Strategy

The key services included in the intervention packages include immunisation, newborn care, antenatal care, family planning, childcare, etc. Evidence for the Strategy was reported to be predominantly from the *Lancet* series for maternal, neonatal and child survival and national level evidence on poor MNCH indices and weak HRH (FMoH, 2005, FMoH, 2007, Mbachu et al., 2016).

The Strategy development was led by the FMoH with wide consultation (professional health associations and stakeholders, private sector, parastatals and agencies of the FMoH, state commissioners for health, and state directors of primary health care) and technical and financial assistance from various groups, particularly UNICEF, PATHS/DFID, and WHO (FMoH, 2007). Although MNCH interventions were costed and budgeted in the Strategy document, it states that:

> *"It is not possible currently to determine the resource gaps because of the absence of information on health expenditure from states, LGAs and development partners. In order to develop an investment plan with realistic investment case scenarios, it will be necessary to list the potential sources of funding..."* (FMoH, 2007).

These potential sources of funding to implement the Strategy from 2007 to 2015 were (FMoH, 2007):

- Government sources (federal, state and LGA through, e.g., tax revenue, VAT, Custom Tariffs, Debt Relief Fund, dedicated tax, etc.),
- Donor financing and other external sources of funding,
- Direct employer financing,
- Compulsory Insurance (NHIS, Public–Private Partnerships, private health insurance, pre-payment mechanisms),
- Voluntary insurance (community health insurance, community self-help/solidarity, subsidy, deferral and exemption, philanthropic sources),
- Faith-based organisations,
- Out-of-Pocket payments, and
- Other special funds (FMoH, 2007).

The need to meet the MDGs clearly set the agenda for the development of the Strategy and is considered the key international influencer. In addition, there was the pressure from the World Health Assembly and the United Nations on Nigeria to improve its MNCH outcomes. Furthermore, there was also the international debt relief in 2005, which it was hoped, would provide funds needed for overall growth and poverty reduction in the country and improve MNCH, and hopefully meet the MDGs (4 and 5), given Nigeria's contribution to the global burden (Centre for Global Development, 2006).

A key enabler for the policy initiative at national level was the ongoing health sector reform initiative, which auspiciously was led by Prof. Eyitayo Lambo, a renowned public health expert, who would go on to become the Health Minister and championed the development of the Strategy (FMoH, 2004a, FMoH, 2007). He initiated a wide stakeholder engagement and consultation process across the government levels, as acknowledged in the Strategy document and attested to by respondents:

> *"He had that outlook…you have to do very broad consultation to both primary and secondary stakeholders, because any stakeholder that will either benefit or be injured by*

your policy ought to be heard during the policy formulation, and that is what we were doing. It was tiring!" (NL06_national level policymaker/technocrat).

Sub-national stakeholders also attested to having been engaged in the Strategy development:

> *"...Yes, as the Director of Public Health I represented the state. There were other representatives from the state...We participated effectively in developing the policy..."* (SLE01_sub-national policy maker).

It was thought that these early deliberate activities of stakeholder consultation facilitated the transfer of the framework strategy to sub-national levels and formed a guiding framework for the development of guidelines and plans required for sub-national implementation, as noted by this respondent:

> *"...and you know for state to implement, they didn't need to change because the states were also part and parcel of development, when we were developing it, all the state people came, the commissioners were all there, the directors of the state health care board were there with all the members, everything that happened within that strategy, they were all part of it, so even when we did a lot of state visits, they were there, that momentum was everywhere, even at the state level"* (NL11_National devt. partner).

The sub-national levels were to take ownership of the programme from this point and roll-out interventions in their respective states and LGAs. As noted in the Strategy document:

> *"When states indicate readiness to commence implementation of the IMNCH Strategy, the National Technical Team will provide them support for the formation and training of a Technical Team which will be responsible for rolling out the process to the LGAs, wards and communities. Each State Technical Team will guide the development of LGA (including wards and communities) implementation plans. The national IMNCH Strategy document will provide an excellent resource for this purpose. It is however clearly understood that each state has its own peculiarities and different levels of health care delivery, hence the need for state specific plan"* (FMoH, 2007-P.65).

States rolled-out implementation at different times, no set time was fixed by the national level. An annual evaluation survey of the Strategy in 2009 showed that only 23 states had requested implementation support from the FMoH, and at the time of the evaluation, the FMoH had visited 18 of these (FMoH et al., 2009).

As the development, approval and launch of the Strategy was happening, Nigeria was also involved in national elections (April 2007), which ushered in new actors – ministers, governors, commissioners, etc. A key informant (KI) believed this may have contributed to the delay (or not at all) in the roll-out and pre-implementation activities of the Strategy in the states:

> *"There were visits to most of the states and one on one meetings with the governors, but the problem was that there was a new administration (following the elections), so when new people come on board, that advocacy and momentum was not there to sensitize and even if some were sensitized, they felt that it wasn't their mandate, because they had their own arrangement of what they are supposed to do. So, it was based on that some states bought into it, but some states did not buy into it"* (NL11_National devt. partner).

Of the two study states, a KI from Ebonyi state recalls the national level advocacy visit following the development of the Strategy:

> *"…I want to say that even after that, there was a follow-up advocacy to the honourable commissioner, I can remember also when this Federal Ministry of Health team would go round the states, they came to Ebonyi and made a summary presentation to the commissioner and it was well accepted"* (SLE-01, subnational policymaker/technocrat).

Although there was no similar explicit report of this advocacy visit to Anambra state from key informants, the state Strategic Health Plan (SSHDP) (2010) clearly stated that the IMNCH Strategy was introduced in the state as follows,

> *"...the aforementioned programmes are the components of the recently introduced Integrated Maternal Newborn and Child Health Strategy that is ongoing in the state though not yet in an integrated manner"* (SMoH, 2010-P.18).

A second thing that happened was that, following the development of the Strategy, it was soon realised from surveys, and in line with the ongoing HSR framework, that the issue of human resources needed to be addressed first in the course of implementing the Strategy (FMoH, 2007).

5.4 THE PROGRAMMES

National programmes towards implementing the IMNCH Strategy since its launch in 2007 include the NHIS-MDG-MCH Programme (2008–2015), institutionalisation of a bi-annual National MNCH Week (2010); the Midwives Services Scheme (MSS) (2009–2011); the Subsidy Reinvestment Programme for Maternal and Child Health (SURE-P MCH; 2012–2015) and the Saving One Million Lives Programme for Results (2015–to date).

The NHIS-MDG-MCH is briefly described here to bridge the space between the launch of the Strategy and the MSS but is not included in our analysis because it was not implemented in every state. The NHIS-MDG-MCH was initiated in 2008 and started as a pilot in six states, one state in each of the six geo-political zones, addressing regional equity rather than disease burden. The programme strategy was to improve access to MNCH services through a fee exemption scheme. The benefit package covered all services at the primary care level. The programme was scaled-up in three more phases after the pilot by including additional states in each phase, and eventually it came to an end across the country in 2015. There has been no national impact evaluation nor implementation process research of the programme. However, two regional assessments concluded that coverage was low, and identified similar challenges to the programme implementation, mainly: lack of adequately skilled personnel, poor infrastructure, political interference, non-payment of state counterpart funds, alleged corrupt practices, and management bottlenecks (Omobowale and Omobowale, 2011, Onwujekwe et al., 2016).

The National MNCH Week was introduced in 2010 following the recognition at the National Council on Health meeting (March 2010) that the country's progress towards MDGs 4 and 5 remained slow; with the intention of providing improved access to quality MNCH services, in line with the objectives of the 2007 IMNCH Strategy; through improved service delivery (UNICEF, 2016a). The MNCH Week is held bi-annually nationwide, usually in May and November, with a focus on creating awareness and add-on of MNCH activities. This programme has been embedded in the health sector and is still ongoing. It is also not included in this analysis as it is

designed differently from the selected study programmes, which are now described below.

5.4.1 The Midwives Service Scheme (MSS) (2009–2011)

The need to address the HRH gap in the implementation of the IMNCH Strategy birthed the first national programme of the Strategy that was implemented nationwide at the same time – the Midwives Service Scheme (MSS). The NPHCDA, which has direct responsibility for PHC, noted that there was a dearth of HRH across PHC centres and these facilities were also short of other requirements to meet the WHO/PHC Minimum Service Package (NPHCDA and WHO, 2007). The 2008 Nigeria Demographic and Health Survey (NDHS) also showed that progress towards improving MNCH was insufficient (NPC and ICF Macro, 2009). One respondent noted as well that,

> *"...surveys showed that there were health workers (HW) but no funded HW positions, and so there was a need to first create funded positions, it was quickly realized that the issue of human resources had to be addressed first and foremost in order to have adequate staff for other proposed interventions ... this formed the thrust of the MSS, and a fiscal space was mobilized towards this"* (NL02_National policymaker/technocrat).

The MSS is not a shift away from the Strategy, rather a deliberate focus and prioritisation of the HRH component of the Strategy, as it was felt that this will then enhance the delivery of other interventions of the Strategy,

> *"So, Midwives Service Scheme was an intervention to demonstrate over a period of two years to states that if you have qualified midwives in health centres, it will improve the system and results"* (NL06-National policymaker/technocrat).

The Midwives Service Scheme was developed and launched in 2009, primarily aimed at improving human resources for MNCH. It was initially designed as a two-year pilot programme (2009–2011), to demonstrate that availability of qualified midwives offering skilled birth attendance at designated PHC centres would improve MNCH outcomes. It engaged newly graduated, unemployed, and retired midwives to work temporarily in rural areas and provide skilled birth attendance in rural facilities. It deployed 4,000 midwives and 1,000 Community Health Extension Workers (CHEWs)

to 1,000 PHC centres in the neediest areas of the country, to close equity gaps in underserved areas (NPHCDA, 2010a, Abimbola et al., 2012b, Okpani and Abimbola, 2016). The concept document states that:

> *"The scheme being implemented by the National Primary Health Care Development Agency is a public sector initiative based on wide consultation, networking and consensus building among stakeholders. The hallmark of the scheme is that it is conceived as a collaborative effort between the three tiers of government based on shared roles and responsibilities formalized by signing a Memorandum of Understanding (MOU) between the federal, state and local governments; supported by strategic partners..."* (NPHCDA, 2010a).

The next chapter will show how implementation deviated from this policy intent because of non-adherence to the MOU.

The MSS had eight strategic thrusts, as shown in Figure 5.3 below:

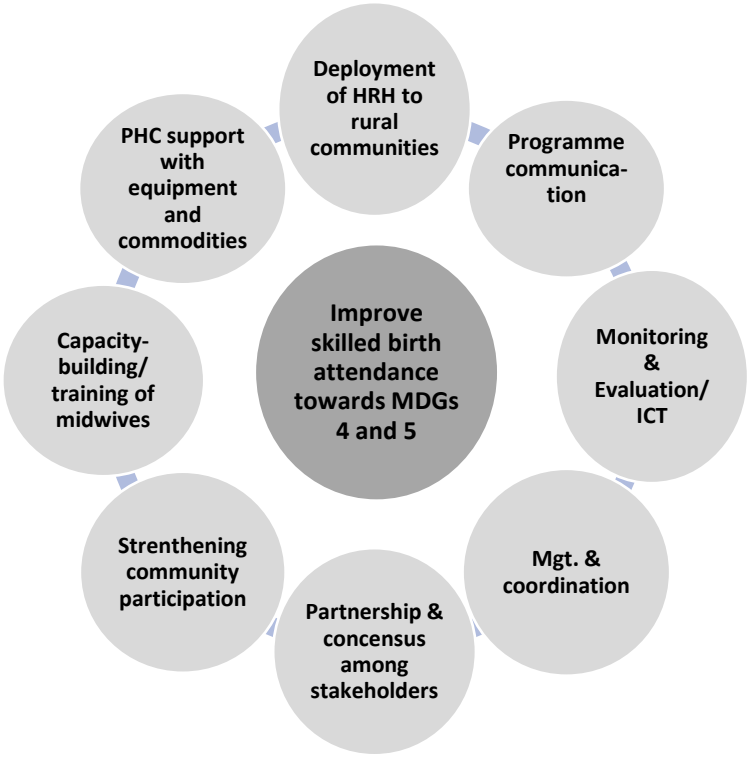


Figure 5.3: Strategic thrusts of the Midwives Services Scheme

Each thrust was seen as an important strategy in improving skilled attendance at delivery and accelerating progress in the attainment of MDGs 4 and 5 (centre circle). There is no national end-of-programme evaluation of the MSS, yet. However, a mid-term evaluation and a number of studies show that during implementation these

policy thrusts thinned out and focused mainly on recruiting, training and deployment of HRH to selected Primary Health Care facilities (NPHCDA and WHO, 2011, Abimbola et al., 2012a, Okpani and Abimbola, 2016, Ikpeazu, 2018).

Remuneration of these midwives was designed along a splintering formula which proposed that in the MOU, the three tiers of government pay the midwives stipulated amounts and also provide living accommodation (NPHCDA, 2010a-Appendix 2, p111-120). Individual midwives were supposed to be paid from three different sources, national, state and local government, paying N30,000 (USD204), N20,000 (USD136), and N10,000 (USD68), respectively. The national level portion of the salary (N30,000) was to be paid directly to the midwives by the NPHCDA, as per the MOU, but there was no explicit mechanism outlined in the MOU to ensure that the sub-national levels paid their portions (NPHCDA, 2010a-pp112-116). This remuneration design became problematic during implementation, as will be shown in the next chapter.

In direct contrast to what the MSS document stated and also in contrast with the parent strategy document, besides the signing of MOUs, there was no explicit sub-national stakeholder engagement in the early stages, and respondents reported this at both national and sub-national levels, *"I can't remember being involved in the design of MSS, and the fact that some of us at the state level were not involved in the planning introduced some kind of disconnect in the execution of that whole thing..."* (SLA03_Subnational policymaker/technocrat), whilst a national level stakeholder also noted,

> *"Looking back now, I will say that the state was not totally involved. If it is now, I would involve them more. It was later, and it was almost like a done deal. We did go for advocacy visits and all that, but it wasn't that intensified in MSS..."* (NL03_National level implementer).

The national level also intended that after the two-year pilot phase, MSS would be taken over, owned, and sustained by the sub-national level. But, although some programme objectives extended to 2015, there was no explicit design in the document as to how this was going to happen and how it was going to be funded. As a KI reflects:

> *"The plan was for the most part wishful thinking on the part of the federal government. Part of the founding idea of the MSS was that the federal government would pull out and the state government would take control, that was the rhetoric, and it continued until SURE-P materialized. But if SURE-P hadn't happened, it [MSS] would have died a natural death in the name of handing over to state government"* (NL01_National implementer/academic).

In conclusion, the MSS design process was not as inclusive of multi-level stakeholders as the parent strategy. In addition, the MSS policy elements did not incorporate adequate accountability mechanisms to ensure commitment of the sub-national stakeholders. Later in this chapter and in a subsequent chapter, it will be shown how this negatively impacted on adherence to the policy design during implementation.

5.4.2 The SURE-P/MCH (2012–2015)

A key contextual issue in Nigeria in late 2011 was that the new government (following elections in April 2011) was considering removing subsidies from petroleum products and ploughing this back into poverty alleviation projects, targeting mainly rural areas. This later came to be known as the Subsidy Reinvestment and Empowerment Programme (SURE-P), after the subsidy removal was announced on 1st January, 2012 (FGoN, 2013). It was designed as a multi-sectoral poverty alleviation programme and the funds for the health sector were allocated to maternal and child health, hence the name SURE-P/MCH.

The federal government hoped that this project would put Nigeria on track to achieving MDGs 4 and 5 by 2015 (FMoH and NPHCDA, 2012). The SURE-P/MCH intended to build on the MSS. Hence, in addition to providing adequate human resources, it was designed to strengthen other health system building blocks and also included a demand-side intervention (Conditional Cash Transfers), which was intended to stimulate and drive increased demand and utilisation of facility-based MNCH services (FMoH and NPHCDA, 2012). There were new actors (after the 2011 elections), besides Dr Muhammed Pate (MP) – the Executive Director (ED) of NPHCDA, who had driven the MSS but had now been moved to the FMoH as the Deputy Health Minister after the elections,

> *"So, SURE-P came about because it was a new government ... from the policy perspective was the fact that the Minister of State for Health, felt that health needed to have a seat in the overall national development agenda, and so we had to make a case for it"* (NL02-national policymaker/technocrat).

The SURE-P/MCH, like the MSS, also intended to be a collaborative effort across the three government tiers. However, this was not the case. State and local government stakeholders were not adequately consulted during the programme design. In this case, the short time available for the conceptualisation meant that the programme was designed quickly, by only national level actors, as acknowledged in the SURE-P/MCH concept document (FMoH and NPHCDA, 2012-P.5). The SURE-P/MCH was an unexpected opportunity (following the oil subsidy removal) for the national level to carry on with MSS activities, "*So, transiting to SURE-P (MCH) was like a soft landing but it was supposed to learn some lessons from MSS so that it will be tidier...*" (NL05_national implementer). A case in point is that similar MOUs were drawn up for both programmes, although states and LGAs had not honoured the initial MOU for the MSS. The SURE-P/MCH was officially launched for implementation in October 2012.

5.4.3 Saving One Million Lives Programme for Results – SOML PfR (2015–2019)

Soon after the SURE-P/MCH was designed, the junior minister began to conceptualise the Saving One Million Lives (not the SOML PfR) as an umbrella concept (rather than a programme/policy) to house the MSS, SURE-P/MCH and other MNCH activities/programmes, which it was hoped would collectively save one million lives by the end of the four year tenure of the government at the time (2015), and hopefully, meet MDGs 4 and 5 (Ohiri, 2012, UNICEF, 2012b, World Bank, 2014b). It is mentioned here to lay the foundation for, and at the same time distinguish it from, the Saving One Million Lives Programme for Results (SOML PfR). As one KI reflected,

> *"SOML was not a policy. SOML was set up as a platform to engender the implementation of MNCH. But now, it has become a programme, because the government was able to get five hundred million dollars for the states to implement what we call PforR – Programme for Results"* (NL10-national policymaker/technocrat).

The SOML was more of a country commitment to save one million lives of mothers and children by 2015 (the end of the MDGs), as captured in this quote by a key actor, the then Minister of Finance,

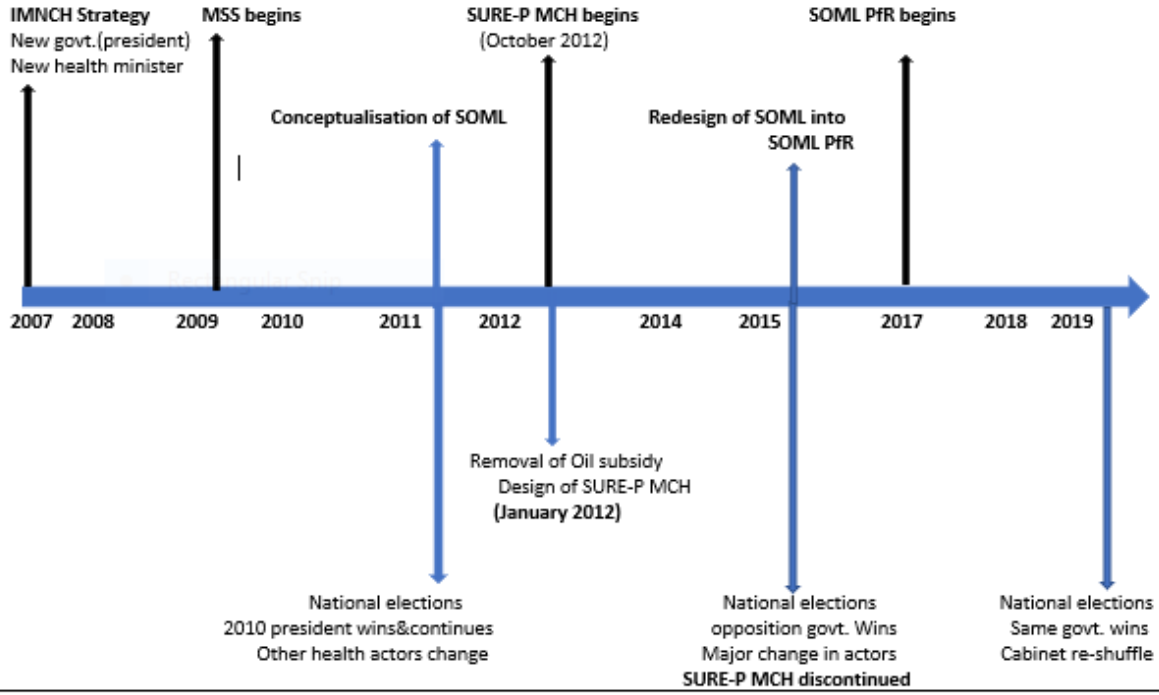
> *"Saving One Million Lives builds on growing international momentum behind child and maternal survival...and the recently concluded Abuja Conference on Essential Commodities. The Commodities Commission recommendations and implementation plan – issued in New York on 26 September – stated that with increased supply and demand, as well as correct use of 13 specific commodities, more than six million lives of women and children across the world could be saved by 2015. Today in Abuja, Nigeria took the bold step of announcing an official commitment to lead the way and save one million lives by 2015"* (UNICEF, 2012b).

So, SOML became this big idea to strengthen ongoing MNCH activities and other activities that impacted on MNCH, like malaria prevention, and thereby harness all the gains under the concept of SOML by 2015 (World Health Organization, 2012, World Bank, 2014b)

Figure 5.4 below shows a summary of the timeline of the policy development processes from the Strategy through to the SOML PfR, using information from the strategy documents (FMoH, 2007, FMoH et al., 2009). It also outlines prior key policies which fed into the Strategy in 2007.

Pre-2007 policies with direct or indirect MNCH components

- NHP (1988)
- Revised NHP (2004)
- NRHPS (2001)
- WMHCP (2001)
- NPFN (2001; reprinted in 2005)
- NHIV/AIDS/ PMTCT PSP (2003)
- HSRP (2004)
- NPAFN (2004)
- NPIYCFN (2005)
- NCHP (2006)
- CSD: SFPA (2006–2010)
- MDGs Roadmap for Maternal and Newborn Health (2006)
- PHDAYPN (2007)
- HRHP (2004)



NHP-National Health Policy (1988); Revised National Health Policy (2004); NRHPS-National Reproductive Health Policy and Strategy (2001); WMHCP-Ward Minimum Healthcare Pac e, 2001; NPFN-National Policy on Food and Nutrition, 2001 (reprinted in 2005); NHIV/AIDS/PMTCT-PSP-National HIV/AIDS and PMTCT Policy and Strategic Plan, 2003; HSRP-Health Sector Reform Programme, 2004; NPAFN-National Plan of Action on Food and Nutrition, 2004; NPIYCFN-National Policy on Infant and Young Child Feeding (IYCF) in Nigeria, 2005; NCHP-National Child Health Policy, 2006; CSDSFPA-Child Survival and Development (CSD): Strategic Framework & Plan of Action, 2006–2010; The Roadmap for Accelerating the Achievement of MDGs Related to Maternal and Newborn Health, 2006; PHDAYPN-Policy on the Health and Development of Adolescents and Young People in Nigeria, 2007; HRHP-Human Resources for Health Policy

Figure 5.4: Timeline of the IMNCH Strategy and programmes

How the SOML then evolved into the SOML PfR was that at the end of the MDGs in 2015, Nigeria did not achieve MDGs 4 and 5 (United Nations, 2015). On the international scene the Sustainable Development Goals (SDGs) gained importance. At the national level, Nigeria had its four-yearly national elections and there was a change in government. The new government (new actors) discontinued the SURE-P/MCH Programme in October 2015, although it still claimed to have MNCH high on the health agenda. Having worked with the World Bank before he became the ED of NPHCDA and later the Junior Minister of Health, he was said to have also started thinking of how to progress the SOML concept, but this time as a funded programme, *"The ED of NPHCDA had also talked about this Save One Million Lives and how else he can find a way of getting money to start doing more things around Save One Million Lives..."* (NL03_National implementer).

The federal government (through the FMoH) requested support from the World Bank for its intention to extend the original SOML concept for another five years (2015–2019) as a funded programme. The readiness of the World Bank to support a performance-based programme in the health sector underpinned the design of the SOML PfR (World Bank, 2015), because having not achieved the MDGs, a new approach to addressing MNCH Programme issues was desired (this is elaborated on later in this chapter). The SOML PfR was designed to shift focus from inputs to results and was aimed at strengthening six MNCH pillars: MNCH services – antenatal, etc.; HIV/AIDS; immunisation; malaria; nutrition; and essential medicines. Whereas the programme funds in MSS and SURE-P/MCH were targeted at inputs (supply of midwives, drugs and consumables, health facility upgrade, CCT), the programme funds in SOML PfR (after the initial start-off funds) were targeted at rewarding improvement in given indicators (see Table 5.2). In addition, through the experiences of the federal level with the MSS and SURE-P/MCH, it readily recognised that it could not adequately influence implementation at sub-national level within the existing constitutional political structure. It therefore incorporated levers in the SOML PfR design to influence implementation, which included recognition and rewards, and technical assistance (World Bank, 2015). Funds were provided to states based on a set of disbursement-linked indicators (DLIs). In the programme design, engaging states

to produce state level plans for achieving reduction in maternal, perinatal and under-5 mortality rates was one of the DLIs. So there was a high level of engagement of sub-national stakeholders early on in the programme design (World Bank, 2015). Table 5.2 below summarises the key components of the Strategy and its programmes.

Table 5.2: Key components of the MNCH Strategy and programmes

IMNCH Strategy (2007) components and content	Programme components and content
• **Improve** access to good quality health services • Ensure adequate provision of supplies • **Strengthe**n individual, family and community capacity to take necessary MNCH actions • **Improve** capacity for organisation and management of MNCH services • **Establish** adequate financing mechanism that ensures affordability, equity, and efficient use of funds • **Strengthen** monitoring and evaluation systems • **Establish** and sustain partnerships to support policy implementation	**MSS (2009–2011)** • **Deployment** of human resource to health facilities in rural communities to improve the coverage by skilled birth attendants, capacity-building/training of midwives • **Multi-level** responsibility for remuneration of health workers • **Building** partnership and consensus among key stakeholders • **PHC support** with basic equipment/commodities and supplies • **Strengthening**/Institutionalising community participation
	SURE-P MCH (2012–2015) • **Build** on MSS • **Recruitment**, training and deployment of additional human resources (midwives, CHEWs, village health workers (VHWs) • **Multi-level** responsibility for remuneration of health workers • **Conditional** cash transfers to pregnant women, VHWs and traditional birth attendants (TBAs) • **Activation** of Ward Development Committees (WDC) • **Upgrade** of health facility infrastructure
	SOML PfR (2015–2019) • **Specific pillars** (six) of intervention: MNCH and others • Results (output) based on increasing quality and utilisation of high impact MNCH interventions • Clear **disbursement-linked indicators** (DLIs) for assessing performance • **Involvement** of the private sector

Sources:(FMoH, 2007, FMoH and NPHCDA, 2012, FMoH, 2016b, NPHCDA, 2010a)

5.4.4 Policy elements across the Strategy and programmes

Table 5.3 below shows key cross-cutting elements in the agenda setting and development of the Strategy and programmes across the multi-level governance structure (federal decentralised).

Table 5.3: Elements of agenda setting and policy development of the IMNCH Strategy and programmes

Elements	Description	IMNCH (2007)	MSS (2009)	SURE-P/MCH (2012)	SOML PfR (2015)
Policy focus	Content	Delivery of integrated MNCH interventions	Focus on HRH shortage targeted in rural areas.	All HS blocks + demand side incentive scheme	Results-based programme in 2015
Context (Environment, policy windows)	International	WHA and UN call on Nigeria to address MNCH	MDGs global agenda to reduce maternal and child deaths	Approaching end of MDG/need to meet goals	Post-MDGs Launch of SDGs
	National	High MNCH burden Desire to meet MDGs/ new health reforms	Critical HRH shortage with wide north/south and urban/rural disparity	Removal of oil subsidy and re-investment into poverty alleviation schemes	Post-MDGs Targets not met
Actor power (organisations/ individuals	International	UN, DFID, WHO			World Bank support
	National	FMoH (Minister), MDAs, HERFON leadership	FMoH (Nursing & Midwifery), Presidency (MDG office), NPHCDA	NPHCDA, ED-NPHCDA, Presidency	FMoH (Minister)
	Sub-national	**SMoH (technocrats and political office holders)**	**Not involved at this stage**	**Not involved at this stage**	**SMoH/ SPHCDA/ programme managers**
Funding sources		Govt. tax revenue, donor funding, insurance schemes, OOP, others; MoF	Funds from MDGs **Held by the NPHCDA**	Proceeds from removal of oil subsidy **Held by Presidency/SURE-P**	Grant from World Bank **FMoH sends directly to states MoH**
Implementation responsibilities (fiscal and service delivery)	Remuneration of health workers	Aligned with govt. Budget across health tiers	**Splintered across tiers - earmarked funds only at national level**	**Splintered across tiers – earmarked funds only at national level**	**Pay for performance with earmarked funds**
	Service delivery/ oversight	**Aligned with National Health Policy**	**LGA – oversight from national**	**LGA – oversight from national**	**LGA/state –oversight from state/national**

The key cross-cutting elements include the policy content (design); context (international/national and sub-national); actors at various levels; source of funds; and control of funds (fiscal autonomy). These factors are organised in Table 5.3 using the adapted Shiffman framework (Shiffman and Smith, 2007). The table shows how these elements begin to change after Strategy development; the similarities in the MSS and SURE-P/MCH; the level of involvement of sub-national stakeholders and how they influenced pre-implementation activities; and adherence to implementation at sub-national levels. The key international influences across the Strategy/programmes were the MDGs and SDGs, being driven by the UN and other global actors (WHO, DFID, World Bank). However, all programmes were domestically designed. Following the Strategy, key actors at the policy development stage were mainly at national level and again in the SOML PfR when sub-national actors gained prominence.

Notable factors which influenced all programmes, were sources of funds and where programme funds were domiciled (elaborated upon later). As outlined in Chapter 2, and earlier in this chapter, the Strategy envisaged multiple sources of revenues to be pooled and disbursed centrally through the Federal Ministry of Finance, Budgeting and National Planning (FMoFBNP). However, as will be shown when the programmes are described, different sources of dedicated national level funding (MDG; SURE-P) directly allocated funds to the MSS and SURE-P/MCH in the health sector. The design of these two programmes (splintered staff remuneration) was premised on the assumption that states would also allocate state-level earmarked funds to these programmes, but there were no accountability levers to ensure that they did, given the existing MLG power structure. These inadequacies played out during implementation, and the lessons learnt from these inadequacies influenced the design of the third programme (SOML PfR) and the funding arrangements, which were ring-fenced at the FMoH (described in Chapter 6).

5.5 PRE-IMPLEMENTATION ACTIVITIES

This section describes the pre-implementation and roll-out activities of the three programmes across the government levels, followed by a summary table (Table 5.4 below). The pre-implementation activities, following policy development of all health policies include approval by the National Council on Health (NCH); enactment by the national legislature (Federal Executive Council – FEC); signing of MOUs; preparation of programme guidelines; and other pre-implementation and mobilisation activities.

The Strategy and three programmes were all approved by various NCH assemblies (NPHCDA, 2010a, FMoH and NPHCDA, 2012, FMoH, 2016b). The NCH as described earlier in Chapter 2, is the highest health policymaking body in the country. However, policy approval by the NCH has been known not to translate to automatic sub-national implementation (Abimbola et al., 2014, Okpani and Abimbola, 2016, Eboreime et al., 2017). Following the approvals, signing of MOUs was the first explicit collaborative activity across government levels in the programme designs.

With the IMNCH Strategy, following NCH approval, the launch was followed by several consultations with various groups, at national and state levels to set up different coordination platforms (Onuekwusi, 2007, FMoH et al., 2009). A national Core Technical Committee (CTC) was set up to oversee the IMNCH implementation and this Committee was also replicated at the state level. The CTC was responsible for developing the guidelines by which the Strategy could be translated into action. This national-sub-national linkage created by the CTC facilitated initial sub-national implementation take-off of the Strategy: *"…when we now went to the states, because we established the CTC in most of the states, so it was the member of the CTC that supported their different states to develop their strategic plan…"* (NL07_National level devt. partner).

The coordinating team also conducted capacity-building for sub-national actors for the rolling-out of the Strategy, and this was said to have created positive momentum and ownership. Because states were to be the primary implementers, roll-out and pre-implementation activities happened at different times and rates in different states (FMoH et al., 2009). Table 5.4 below shows how pre-implementation activities were overseen when it came to the programmes.

With the MSS, NCH approval was followed by signing of MOUs by the three levels of government (NPHCDA, 2010a). However, following this, other pre-implementation activities either remained at the national level or were dominated by the national level. The national Technical Working Group (TWG) was made of national level actors and there is no record of a replication of this group in the states (NPHCDA, 2010a). The Programme Implementation Unit (PIU) was at the national level, and recruitment and training of midwives was also done at national level (NPHCDA, 2010a). The next chapter describes how this impacted on the implementation of programme activities.

The MSS was followed back-to-back by SURE-P/MCH and there appeared not be adequate time to incorporate lessons learnt from MSS implementation into the SURE-P/MCH design. MOUs across the MSS and SURE-P/MCH were almost identical (NPHCDA, 2010a, FMoH and NPHCDA, 2012) and were passively signed by sub-national actors, having not been actively engaged with earlier policy processes. As one KI explained:

> *"...whatever you do at the national level and send it across, no state will reject it; there is one of the documents that I have where all the 36 state governors signed including the President and the Vice-President. I treasure that document because I use it to teach how much you can get the chief executives of the states to do something and then at the end of the day, it doesn't still work...we all know. So, signing of MOU or going into agreement doesn't translate into the desired action because we don't have accountability mechanisms in place in Nigeria, where people are held accountable for anything they sign..."* (SLE04_Subnational academic/policy broker).

As seen in Table 5.4 below, following signing of MOUs, formation of a national TWG for MSS and SURE-P/MCH was not explicitly replicated at sub-national levels; and other key pre-implementation activities (staff recruitment and training, identification of intervention facilities) and programme funds remained with the national PIU, domiciled at the NPHCDA and SURE-P Secretariate, respectively.

Table 5.4: Policy adoption activities towards sub-national implementation

	Activities (Actors)	MSS	SURE-P/MCH	SOML PfR
Guiding implementation	**Signing of MOUs**	**All tiers**	**All tiers**	**All tiers**
	Pre-implementation roll-out activities/Sensitisation	Remained at national level (NPHCDA)	Remained at national level (SURE-P Secretariat)	State MoH/SPHCDA (Commissioners, LGA public health, programme managers)
	Pre-Implementation core technical groups	TWG formed of national level actors and development partners	Not clear	National CTG State CTG
	Identification of intervention facilities	**Overseen by national PIU**	**Overseen by national PIU**	**One functional PHC per ward concept overseen by state**
Implementation	**Staff recruitment/ Training/Deployment**	**National – NPHCDA (PIU)**	**National – SURE-P (PIU)**	**State – where required**
	Health worker remuneration	Splintered across the three tiers	Splintered across the three tiers	As per govt. revenue budget (MoH) - align with tier
	Oversight for service delivery (M&E)	**National – NPHCDA (PIU)**	**National – SURE-P (PIU)**	**State**
	Staff accommodation	**LGA (not consulted)**	**LGA (not consulted)**	**Not applicable**

5.5.1 Summary of Strategy/programme development

Whilst the parent strategy had a wide, multi-level stakeholder engagement, the MSS and SURE-P/MCH policy development only started to consult sub-national actors during the pre-implementation activities. Hence, there was poor commitment and ownership at the sub-national level, and this was not followed through and mitigated through advocacy by the federal level. As reflected by a KI above, this was a lesson learnt from the MSS and some effort was made to improve on this in the SURE-P/MCH, although inadequate, due to the same constraints of poor sub-national stakeholder engagement at the design stage of the programme. This, and other lessons from the poor adherence of the MSS and SURE-P/MCH policy during implementation, and overall poor MNCH outcomes at the end of the MDGs, are thought to have partly influenced the design of the third programme. Key lessons were summarised by the Minister of Health in the SOML PfR implementation manual as follows:

> *"We have observed that solutions focused on improving inputs have not worked in the past but the availability of many of the needed inputs (such as health facilities and trained workers) suggest that governance broadly defined, is the binding constraint. As a response to that, the FMoH introduced an innovative financing mechanism which we hope will address the challenges observed...This PfR will help with setting technical standards and establishing protocols, as well as providing technical guidance and support to States and service providers. Furthermore, the PfR will help strengthen fiscal federalism and encourage the Federal-State relationship to become a results based relationship"* (FMoH, 2016b).

This changing mindset was also corroborated by other national level stakeholders who felt that health system governance and programme activities required a different approach, in which health system performance was measured by outcomes, rather than inputs. As exemplified by this quote from a stakeholder,

> *"If you were to run a business, and you wanted to judge how a company or say, for example GTB (Guaranty Trust Bank) was successful, you will look at the financial statements that will tell this was the revenue, this was the profit... Never will anybody tell you that GT Bank is the best bank because they have 500 computers and 120 desks and 50 million employees, those were all inputs. So, how was it that in the health sector when we ask people what they achieved, they will tell you the number of hospitals they*

refurbished, how many beds they bought, and the consumables they used? So, what should be the currency by which we appraise success in the health sector?" (NL02-National policymaker/technocrat).

Thus began the re-imagining of the health system, with a shift in focus from inputs to outputs (results).

The design of the SOML PfR facilitated a bottom-up approach, given that the activity of states developing their own specific programme guidelines was one of the programme output indicators, with an attached incentive (FMoH, 2016b). As a sub-national KI reflected,

"We had to start at the state level to get the work done, we were asked to meet severally, we were able to put down something as a work plan and sent to the national and there were a lot of corrections, they even sent us program support unit, they were here to make us know how they really want SOML, that is performance for result. There were a series of meetings with them, we developed a work plan, sent to national, and finally when it was approved, that was when we were then qualified to receive the said money" (SLA01_subnational implementer).

However, as further explained in Chapter 6, this programme also faced implementation challenges of non-adherence, albeit different from the MSS and SURE-P/MCH, but also due to inadequate intergovernmental accountability structures.

5.6 POLICY IMPLEMENTATION

For completeness of this chapter on the overview, key issues during implementation are presented here. The next chapter then presents the programme's implementation in detail and a comparative analysis of implementation experiences in the two study states.

The MSS and SURE-P/MCH were designed in such a way, that the recruitment, deployment, and part payment of the programme staff was made the primary responsibility of the NPHCDA. This meant that the national level, against its mandate, would be involved in the implementation space. Recruitment and training of midwives and other programme staff were carried out by national implementers, and thereafter they were posted to facilities.

Having not been adequately consulted during the programme design, these pre-implementation activities initiated by the national level, served to further alienate state-level actors, who then resisted certain implementation activities, like the identification of PHC facilities for the programme intervention. One national implementer explained:

> *"...selection of facilities to be used for this programme... were done by the states. We gave states the criteria for them to select those facilities. The only thing we did was, when they gave us the list of facilities, we sent people to go and check. Those that did not meet the required criteria/population were identified and the states were advised/convinced to change it. We, however recommended that they change those ones; but you find out that in some few places where we asked them to change the facilities, they did not. Instead, they will tell you that the powers that be want it to be there. In that case we don't fight. We try to convince them and some of them will change it at the end of the day, some will not*" (NL04_National implementer).

As explained earlier, remuneration of programme staff according to a splintering formula (50%; 33%; and 17%) of their total salary was to be paid by the national, state, and local governments (LGs), respectively. This was also poorly received by states: "*...during the drafting of MOU we invited them...but the problem is when you now talk about the financial implication nobody wants to be part of it"* (NL04_National implementer). The result was that states did not pay adequate attention to the programme implementation and the sub-national counterpart payments were haphazard or not paid at all:

> *"We were not very much involved, they don't report to us, we hardly knew what they were doing…the coordination mechanism was not completely streamlined to ensure that the states are aware so that they can equally monitor the midwives, and I think there were some payments that were supposed to be made by the state which the state did not do"* (SLA_07_Sub-national policymaker).

Monitoring and Evaluation (M&E) was also led nationally, even where there were already existing state-level M&E structures:

> *"...in one of our monitoring, integrated supportive supervision (ISS) we went at U (facility), I saw people who introduced themselves as SURE-P staff. I asked him what he does, he said he is a health educator. I saw another person, he said he is a SURE-P staff and he is working with the primary health centre there with our own CHEWs and*

> *the CHEWs will say that they have one SURE-P staff, and the SURE-P will be just like a corps member, so that is how I saw them. So, just like the MSS, I never really knew the impact of that. MSS was even more specific because all the people there were midwives. But for SURE-P, we don't know who they were or what their professional qualifications were and the work they were supposed to do"* (SLE01_Subnational policymaker/technocrat).

In other words, SURE-P/MCH employed programme staff that managed the implementation activities from the national level and directly deployed them to facilities.

Although the SOML PfR was designed to run from 2015–2019, implementation did not commence across states until March–April 2017. As a result, the programme was extended to end in 2021 (FMoH, 2019b). This study reports findings up until 2019. The SOML PfR attempted to address some of these shortcomings, but its implementation was also constrained by sub-national contextual factors. The states now had control of the funds, but expenditure still required the consent of the executive governors. It was up to the health commissioners to adequately sensitise and mobilise the governors to align with the SOML PfR goals. The next chapter shows that in both study states programme funds were not adequately utilised to implement the programme's performance indicators, although for different reasons.

5.7 CONCLUSION

The IMNCH Strategy was developed as an integrated framework for delivering proven cost-effective MNCH interventions in Nigeria. Analysis of three national programmes that were designed and implemented based on the framework, show the influence of changing contextual factors over a decade, the design of the policy goals, and the existing political structure (national and sub-national) on the entire policy process. The first two programmes were perceived as not adequately consultative of sub-national actors and did not build in adequate mechanisms in the design to ensure sub-national adherence during implementation, given the existing governance structure. These two programmes hoped to achieve the maternal and child MDGs by 2015, but this did not happen (United Nations, 2015). Lessons learnt contributed to a

different approach in the design of the third programme, which then became more consultative of a wider stakeholder base.

The key collaborative activity across the government levels was the signing of MOUs, but these were not honoured during implementation. The next chapter presents how all these factors impacted on adherence to programme goals during implementation, by comparing the experiences in two states.

CHAPTER 6

THE ROLE OF STATES AS SUB-NATIONAL MEDIATORS OF THE INTEGRATED MATERNAL, NEONATAL AND CHILD HEALTH (IMNCH) STRATEGY IN NIGERIA

6.1 INTRODUCTION

States are the federating units of the country and are the units of analysis for health care outcome evaluation. States and their local governments (LGs) are responsible for implementing national health policies. However, the existing MLG structure is such that states are at liberty to adopt or ignore national policies, and can also formulate and implement state level policies, as will be discussed later in this chapter. As outlined in Chapter 1, the LGs, the third and lowest tier, has actually never operated as a true third tier in the governance structure of Nigeria (Alao et al., 2015) as a result of the absence of a legal framework that recognises the local government as a third tier of government (Khemani, 2001, Alao et al., 2015, Babalola, 2015, Ali and Ahmed, 2019). Hence, formal decisions on health policy implementation are made at the state level and handed down to the LGs for execution, although the LGs have primary responsibility for PHC services.

In trying to bring to action the goals of the national IMNCH Strategy, the two study states (Anambra and Ebonyi) implemented the three consecutive programmes (MSS, SURE-P/MCH and SOML PfR) between 2009 and 2019. Anambra and Ebonyi states were purposively selected for the study, the purpose being to explore experiences of sub-national MNCH policy processes in two south-eastern states, under the same governance structure but with different socio-economic and MNCH contexts, as briefly outlined in Chapter 4, and further explored in this chapter.

This chapter presents a brief historical overview of the south-east region of Nigeria, in which both study states are located. It then outlines the contexts of the two study states, highlighting commonalities and differences, followed by a section on individual state implementation experiences and then a comparative analysis of the

policy process elements (Walt, 1994). Actors' roles and relationships during the policy process are explored in the next chapter.

6.2 SUB-NATIONAL CONTEXT OF THE SOUTH-EAST (SE) ZONE

Historically, the Southeast (SE) Zone was one of the 12 states of Nigeria, then known as East Central State (ECS) up until 1976. Since then, it has gradually been split, as shown below (Figure 9). The SE Zone is presently made up of five states – Abia; Anambra; Ebonyi; Enugu; and Imo states. Its population in the 2006 census was 16,395,555, contributing approximately 12% to the national population. Although occupying a comparatively smaller land mass than other zones, the SE Zone has the second (Anambra) and third (Imo) most densely populated states per square kilometre in the country; the first being Lagos state in the South West Zone (NPC and ICF Macro, 2014).

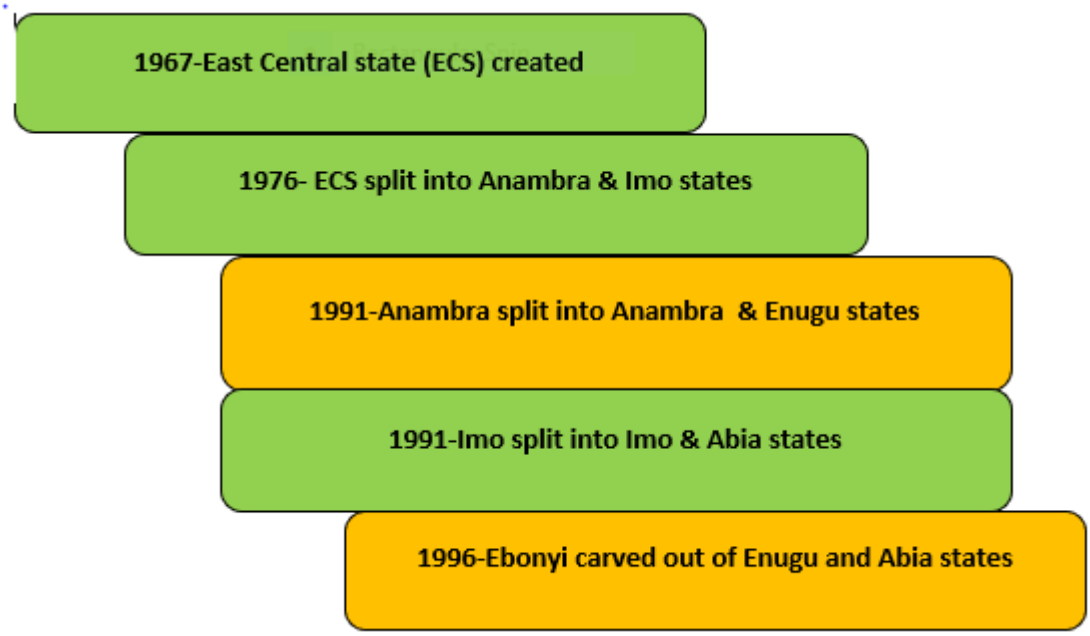


Figure 6.1: Evolution of the states of the South-East Zone, with the yellow boxes being the study states

6.2.1 Sub-national governance structure

The sub-national governance structure is described early on here, before the individual contexts, as this applies to all states. Four yearly elections are held to elect the state governors. The governors then appoint commissioners into different sectors,

including health. The governors are the ultimate decision-makers at the state level. They confer with the State Executive Committee (SEC), which is made up of all the commissioners, the secretary to the governor and the deputy governor, all appointed by the governor. Decisions of the SEC are presented to a state legislative arm for ratification. This sub-national political and decision-making structure overrides any national level decisions taken at the National Council on Health (NCH) meetings (SMoH and FHI 360, 2013, Eboreime et al., 2017, SMoH, 2018). So, even if and where sub-national stakeholders are consulted in national level policy processes, the governor retains executive powers at the state level and his/her commitments to policy implementation is crucial. However, the state still depends on the national government for the bulk of its multi-sectoral expenditure, including health (Uzochukwu et al., 2015b, Marchildon and Bossert, 2018). The inherent tension in this structure is that funding health and other sector policies, are at the discretion of the governor, hence his/her support will need to be adequately mobilised. This has implications for the study programmes, as shown later.

The State Ministries of Health (SMoH) are responsible for state level health policies, norms, and protocols in the health sector. This may be in the form of domesticating national policies and/or initiating state level policies. In addition, they provide oversight for secondary health care service delivery and support their LGs in delivering effective primary health care (PHC) services. The LGs are responsible for managing the bulk of Service Delivery Points (SDPs), with fiscal allocations from the state level (Ozohu-Suleiman and Chima, 2015, FMoH, 2016a).

Sub-national health care financing has also evolved over time, from when the LGs had some level of fiscal autonomy, prior to the institution of the State Joint Local Government Account (SJLGA) (Khemani, 2001). About this time a key informant (KI) recalls,

> *"…for me is that it was like a historical trend, when I started as a young medical officer, I actually started heading health facilities...every month, I had resources to run my facility...So, there were a lot of things I could do. And at different levels, the different officers had resources to do what they needed to do. Now, we have gone from that stage to a stage that we are now, where every resource that you require, the governor has to*

> *actually approve, even the commissioner doesn't have any approval authority"* (SLA09-Subnational policymaker/technocrat).

Presently, all fiscal resources (for all sectors) are held by the State Ministry of Finance and disbursed as approved by the executive governor and his legislature. Presently, the state-LGA fiscal relationship, is that local government funds are being appropriated by the state government, and LGs can only access their funds at the governor's discretion (Oranekwu, 2017). Overall, there has remained a very low budgetary allocation to the state health sector, as shown in Table 6.1 below, and as one KI stated,

> "*They will tell you it (health) is their priority, but it is never their priority. The only problem in Nigeria now is that what is a priority to our government is security and roads and physical infrastructure. If you are made the Commissioner of Works, you have arrived. But if you are made the Commissioner for Health, you are struggling with partners. What about budgetary allocation? We have never crossed five percent, but the WHO or AU or what other organization said fifteen percent and we signed it"* (SLE-01-Subnational policymaker/technocrat).

The units of health care delivery at the LG level are Primary Health Centres. States exercise an oversight role because the Constitution sees the LGs as integral components of the states (Federal Republic of Nigeria, 1999). In practice, the boundaries are fuzzy, and implementation has at times, been carried out by all levels, sometimes independently, with little coordination and accountability across them (FMoH, 2007, NPHCDA, 2015, Eboreime et al., 2019).

6.2.2 Socio-economic, demographic, and political context of study states

Anambra state (Case 1)

The current Anambra state emerged from the restructuring of the old Anambra, following the state's creation in August 27, 1991 (Ukiwo and Chukwuma, 2012). According to the 2006 national census, it had a population of 4,453,964, and an annual population growth rate of 2.21% per annum (SMoH, 2010). The indigenous ethnic groups are Igbos (98% of the population) and a small population of Igala (2% of the population), who live in the north-western part of the state (Anambra Igbofocus, 2013). The predominant religion in Anambra state is Christianity, dominated by

Roman Catholic adherents (Ukiwo and Chukwuma, 2012). This has implications for family planning uptake in the state, as shown later.

The potential economic drivers in the state are agriculture (farming, fishery, pasturing and animal husbandry), markets (trade and commerce), transportation (good road networks), natural resources (crude oil, natural gas, bauxite, ceramic and almost 100% arable soil), security, tourism, numerous other industries, and stable governance institutions. Anambra has two very commercially vibrant cities, Nnewi, with a number of manufacturing industries; and Onitsha, reputed to have the biggest market in West Africa (SMoH and FHI 360, 2013). Commercial activities form the mainstay of the economy and contribute to the state GDP and Internally Generated Revenue (IGR). However, subsistence agriculture remains the predominant occupation in rural areas, engaging more than 70% of the population.

As with other states in the country, Anambra is largely dependent (about 80%) on the revenue allocated from the federal account (NBS, 2017, NBS, 2019), which is augmented by IGR (less than 20%) from taxes, fines and fees, licenses, earnings and sales, etc. (Ukiwo and Chukwuma, 2012, NBS, 2017). However, it receives a higher allocation from the federal account than Ebonyi state, in line with the criteria outlined in Chapter 2 – it has a larger population and a higher IGR, amongst other things. For instance, in the first half of 2020, the IGR for Anambra state was N9,546,712,182.69 [USD2,328,466.39] while Ebonyi state internally generated N6,331,208,837.88 [USD1,544,197.28] (NBS, 2019).

Anambra has 21 LGs and 330 political wards (SMoH, 2010). Each LG is administered by an elected LG chairperson. However, LG elections were not held in Anambra state throughout the study period. LGs were administered by caretaker chairs, appointed by the executive governor. The state was governed by the same political party (All Progressive Grand Alliance) throughout the study period (2007 – to date), and a different political party from the two national governing parties in the same period (Peoples Democratic Party [PDP] and All Peoples' Congress [APC]). This is not known to have overtly impacted on MNCH policy implementation in the state:

> *"…anytime we go for anything national, Anambra state is usually outstanding. They use us as an example, so at that level most of the ministers, they don't talk politics...and when it comes to issues about maternal mortality or anything that has to do with health, their concern is for the general indices to improve. So, I think the politics does not affect any state that is doing well"* (SLA07_State executive/technocrat).

Ebonyi state (Case 2)

Ebonyi is the youngest of the five SE states, carved out from Enugu and Abia states in 1996, and is also largely of the Igbo ethnic group and Christian-dominated. It had a population of 2,176,947 in the 2006 national census, and a population growth rate of 3.3% per annum (NPC, 2006). The main occupation of the people is subsistence farming and husbandry. It has several solid mineral resources, including lead, crude oil, and natural gas, but few large-scale commercial mines (SMoH, 2018). There has, however, been very rapid improvements in education and infrastructure:

> *"...as the time goes, we are moving from purely agrarian to a more multi-economic state. We now have civil servants forming a core, the farmers are still there, we now have business group that was not there before, we now have the political group who have been empowered politically...Economy has also permeated the local governments through appointments and recruitments..."* (SLE_01, senior executive/technocrat).

Ebonyi is also largely dependent (more than 80%) on revenues from the Federation Account, although it receives the least federal allocation in the SE Zone ((NBS). 2016, SMoH, 2018, NBS, 2019). However, federal allocation to states also fluctuates according to the national macro-economic environment, hence between 2013 and 2017, federal allocation to Ebonyi state ranged from 65–90% of the total state revenue, whilst in the same time period, the health budget as a percentage of state budgetary revenue was only between 3% and 6%, and actual health spending was between 2% and 5% (Eneze et al., 2020).

Politically, Ebonyi state is divided into 13 LGAs and 171 wards. The state has been governed by the same political party (Peoples Democratic Party [PDP]) since its creation (SMoH, 2018). It holds elections for the LG chairperson as prescribed, the most recent being in April 2020. All elected chairpersons are from the same political

party as the state government, although there are other opposition parties (Premium Times, 2020).

6.2.3 Health system and MNCH context

Table 6.1 summarises key socio-demographic and health system/MNCH characteristics in both states.

Table 6.1: Socio-demographic, health system and MNCH context of Anambra and Ebonyi states in 2008

Contextual characteristics		Anambra	Ebonyi
***Socio-economic Demographics**	Total Population	4,177,628	2,176,947
	Female Population	2,059,844	1,112,791
	Women of child-bearing age (15–49 years)	1,137,559	567,757
	Literate women (15–49 years) n (%)	1,066,845 (93.7%)	384,269 (67.7%)
	Local government areas	21	13
	IGR (Billions): 2011–2016†††	6+ – 14+	2+ – 11+
Health system**	Public health facilities Primary Secondary Tertiary	685 560 123 2	567 516 48 3
	Private health facilities	1,532	119
Health financing	Health budget as % of state budget (2015)	3.5%‡	3%‡‡
MNCH Service delivery (2008/2018)***	ANC from skilled provider	97.7/93.3	75.7/70.3
	Facility delivery	87.8/90.4	40.7/56.5
	Skilled assistance during delivery	95.2/92.5	46.3/91.5
	Family Planning (any method)	34.4/44.6	6.1/8.2

Sources: *National Population Census, 2006(National Population Commission, 2006); **(SMoH, 2019, SMoH, 2018); ***NDHS Survey 2013 (NPC and ICF Macro, 2014); (NPC and ICF Macro, 2014, NPC and ICF Macro, 2019) ††† (NBS, 2017); ‡(SMoH, 2019); ‡‡(Eneze et al., 2020).

Table 6.1 shows that at baseline (2008, prior to the onset of MSS, the first study programme), Ebonyi state had poorer indices than Anambra state, but improved relative to Anambra, over time. Another key feature to note from Table 6.1, is that both Anambra and Ebonyi states had similar numbers of public PHC facilities (516 and 560 respectively), which is where these national programmes (MSS, SURE-P/MCH and SOML PfR) are implemented. However, there is a very wide gap in the presence of private facilities between both states. The implication is that since MNCH indicators are evaluated as state level aggregates, Anambra state continually performs better in

MNCH service delivery outcomes (ANC, SBA etc.) than Ebonyi state, despite the public PHC facilities in both states suffering the same deficiencies (chronic staff shortages, ill-equipped facilities, etc.), as noted in Chapter 5 (NPHCDA, 2010b).

In 2016, in preparation for the SOML PfR programme, a national health facility (public and private) survey was carried out to assess facility baseline capacity and readiness for implementation. Results showed that Anambra state had the highest national score for skilled birth attendance and the highest zonal score for immunization (FMoH, 2017b). There is also evidence from consecutive national demographic and health surveys (DHS) that MNCH services are accessed more from private than public facilities, although the level of access varies across states (NPC and ICF Macro, 2014) (NPC and ICF Macro, 2019).

In Nigeria, the private sector provides about 60% of health services (FGoN, 2018b). Despite this, the private sector was not explicitly mobilised in the MSS and SURE-P/MCH. The SOML PfR engaged the private sector during the design stage, but their role during implementation is not documented. There are also several donor MNCH Programmes (in both states) and state level MNCH Programmes (Ebonyi state), as outlined in Table 6.2 below. These programmes significantly impact MNCH in each state (FGoN, 2018b), as will be shown later in the chapter. For these reasons, improvements in MNCH during the period of these national programmes are not directly attributable to the programmes beyond the specific facilities where the interventions were carried out.

Table 6.2: Other MNCH activities in study states

State	MNCH Activity/Description	State Govt.	Donor
Anambra	HIV/PMTCT (FHI 360/USAID)		√
	MNCH Services/Family Planning (SFH)		√
	Association for Reproductive & Family Health (ARFH)		√
	Family Planning (public sector)/Marie Stopes		√
Ebonyi	Free Maternal Service Programme (2008–2015)	√	
	Rural Health MNCH Programme (2008–2015)	√	
	Maternal And Child Survival Programme (MCSP)/JHPEIGO (2015–2018)		√
	HIV/PMTCT (FHI 360/USAID)		√
	MNCH Services/Family Planning (SFH)		√

Despite the importance of the private sector, donor, and state level MNCH programmes, PHC, which is responsible for first line MNCH services, remains public sector policy driven. The later discussion will interrogate the impact of this misalignment between formal policy processes and governance arrangements within the federal space and the presence of international donors as key actors.

Under the description of each state's MNCH context below, further descriptions of these programmes and how they may have impacted the study programmes are given. This is more so in Ebonyi state where there were two large state level public sector MNCH programmes before and during the national MNCH programmes under study.

Anambra (Case 1)

Anambra state has the largest number of women of childbearing age and has the largest number of literate women in the Southeast Zone. Although the state has adequately trained health workers per capita, there are inadequate public sector funded vacancies, due to poor budgetary allocation to the health sector (SMoH, 2019). In addition, there is also migration of health workers from the sub-national health institutions to the national level in search of better remuneration, as explained in Chapter 2. So progressively, qualified staff continuously seek to move away from the LGs to the state or national level employment, for hospital employment or to the private sector (SMoH, 2010, SMoH, 2019). Despite these public health sector constraints, Anambra state continues to record high MNCH indices nationally and in the SE states, due to the high rate of access and utilisation of MNCH services from private facilities, as already outlined above. Prior to the SOML PfR, Anambra was the national leader in the provision of skilled birth attendance (97%) and the SE Zone led in immunization coverage (88%) (FMoH, 2017b, FGoN, 2018b).

Ebonyi (Case 2)

Ebonyi state is a smaller state in terms of population, with less than half of the women of child-bearing age and less than a third literate women, compared to Anambra state (Table 6.2). It also has about a quarter of the total number of facilities compared to

Anambra, with the widest gap being in the number of private facilities. This should potentially place a higher demand and pressure on public health services, but there is reportedly low patronage, due to a lack of skilled staff and the poor quality of health services (SMoH, 2018). Human Resources For Health (HRH) are in short supply in Ebonyi State (SMoH, 2018), due to an absolute lack in the early years of the state, and presently due to not employing adequate numbers in the public facilities, "*…When Ebonyi started, we started with thirteen medical doctors in the whole state, nine from Afikpo axis and three from Abakiliki axis and myself...*"(SLE_01_senior executive/technocrat).

Concerted efforts were made to address this, first by upgrading the general hospital to a state teaching hospital and recruiting and training, for free, indigenes who were qualified to train as medical doctors. They also attracted non-indigenous medical personnel from other states by providing attractive and competitive remunerations and working conditions. Despite this, there remains a critical shortage of person power in the health sector in the state.

During the development of the first State Strategic Health Development Plan (SSHDP), it was noted that, as at 2008, there were a total of 27 doctors and 142 nurses in the public facilities, with ratios of 6/100,000 and 9/100,000 population respectively, and a similar pattern for other cadres of health workers, whilst the minimum number of these cadres required to implement the state minimum health care package was 39 doctors and 520 nurses (SMoH, 2009). The second SSHDP (2018) noted that this human resource gap remained in place, because there has not been any employment of person power (doctors and nurses) in over 13 years despite the retirements of existing staff, because of no budgetary funded vacancies for HRH. Consequently, most PHC facilities are staffed by community health workers. Over 95% of the existing specialist medical staffs are concentrated at the tertiary facilities in the state (SMoH, 2018).

A second factor why public health facilities are poorly patronised for MNCH services is poor health seeking behaviour for MNCH services in the state. Low literacy rates and certain cultural practices (early marriage, female genital mutilation, home delivery) persist and constrain MNCH services. Skilled birth attendance remains low

(38%) due to the cultural context, "*Our people still believe that you have to deliver at home for you to be a strong woman, if you deliver in the hospital, you are a weakling...*" (SLE_06-subnational programme officer). The consequences are high rates of under-reported maternal mortality and morbidity (MCSP, 2017, SMoH, 2018).

The Maternal and Perinatal Death Surveillance and Response (MPDSR) policy was adopted in the state in 2015 (Shittu and Kinney, 2017), to raise awareness about the importance of reporting maternal and perinatal deaths, to inform future management. The opportunity was seized to re-sensitise the populace and embark on education and changing old ways of practice, although the policy did not explicitly aim to improve quality of MNCH services. An evaluation of the policy in 2017 showed that there was still a low level of awareness and use of the MPDSR guidelines to integrate mortality and morbidity data (MCSP and USAID, 2017, Shittu and Kinney, 2017). However, chronic staff shortage and ill-equipped public PHC facilities also do not incentivise utilisation of public health services.

As a result of the above factors, for a long time Ebonyi state has had very poor MNCH indices, some worse than others and some lower than national averages (NPC and ICF Macro, 2009, NPC and ICF Macro, 2014, NPC and ICF Macro, 2019). However, through a number of state level MNCH programmes (the Rural Health Programme and free Maternal and Child Health programme) and donor driven programmes (key is the Maternal and Child Survival Programme – MCSP), discussed in the following section and <u>not</u> part of the cluster of policies driven from the centre (i.e. the FMoH), the state has made appreciable progress and surpassed national averages in some MNCH indicators (FMoH, 2017b). This again raises interesting questions for the configuration of policy processes and governance arrangements, which will be discussed further on and picked up in the discussion chapter.

As stated earlier, Ebonyi state receives the least revenue allocation of all the South-East states from the national Federation Account. This poor revenue allocation has consequent implications for funds allocated to the health sector in the state (Eneze et al., 2020). One consequence of this health sector funding deficit is the high level of donor dependency in the state: "*...programs are struggling to survive or to make it with the*

help of partners, but any program that has a partner, that program will thrive. But when that partner goes, it goes down" (SLE_01, senior executive/technocrat). Later in this chapter, if and how outcomes of a large donor programme impacted on the study programmes, is explored.

6.3 POLICY PROCESSES IN ANAMBRA AND EBONYI

6.3.1 Anambra (Case 1)

Policy development

State level actors in Anambra were well-sensitised and consulted during the development and early implementation of the components of the parent Strategy, the key one being the Integrated Management of Childhood Illnesses (SMoH, 2010). A KI recalls his involvement:

> "*Like you have mentioned IMNCH, I am aware that the state also implemented those programs. In fact, I attended the facilitators course for that program (IMCI), and we trained a lot of health workers in the state*" (SLA09_State policymaker/technocrat/implementer).

However, as KIs reflected (in Chapter 5), there are no reports of any clear involvement of state stakeholders during the development of the MSS and SURE-P/MCH Programmes, but with the SOML PfR, there was a wider stakeholder engagement, including sub-national actors and the private sector (FMoH, 2016b).

At the adoption stage, the major activity was signing of MOUs and setting up state implementation committees. Having not been involved in the development of the MSS and SURE-P/MCH, Anambra state, and all other states still felt compelled to sign the MOUs,

> "*The issue in Nigeria is that whatever document that is given, is accepted, there is no state that will reject a national guideline, national instructions, national policies, when it comes to the implementation of the content of the policy, that is a different ball game*" (SLE04, Academic/knowledge broker).

Policy implementation

Sub-national stakeholders conceded that the programme goals of MSS and SURE-P were evidence-based and important to implement to improve the MNCH indices. However, they also pointed out that the programme logistics (in MSS and SURE-P) were difficult to implement sub-nationally because of the design. These components included: i) the cost of remunerating health workers by state and local governments; ii) provision of accommodation to the midwives and CHEWs (in SURE-P/MCH); iii) support to PHCs; and iv) the retention of health workers after the initial phases of the programmes (MSS and SURE-P/MCH), as outlined in the programme MOUs.

In addition, there was no sub-national level programme implementation unit (PIU) or committee to oversee programmes, as this was not provided for in the programme design (NPHCDA, 2010a, FMoH and NPHCDA, 2012). So, while there was agreement with the policy intent, inadequate stakeholder consultation, as well as poor content and process design, undermined chances for implementation success.

States and LGs were required to pay programme staff a proportion of their monthly salaries, but this was not backed up by any dedicated programme funds and was not provided for by states in their health budget. Hence these were either not paid at all (states) or paid haphazardly (LGs), as some KIs reflected,

> *"I cannot vouch to what extent either party kept to these agreements especially at the state level, I think they were getting the national part of their remuneration, but that of the state was not very regular, or maybe they were not paid at all"* (SLA_03, state executive/technocrat).

A national level implementer also buttressed this, "*Anambra state did not pay a dime, it was only local government that paid*" (NL_04_national implementer).

The MOU furthermore required LGs to provide accommodation for the programme staff. Some LGs and communities made attempts to provide accommodation, but this was not uniformly implemented across LGs:

> *"We tried to give them accommodation but not necessarily the ideal accommodation that was envisaged because at times we had to pair two in a room...Also, in AN (LG), with the SURE-P/MCH, I know about one or two that were like that in the MSS too.*

A few will accept and others will say no, but we were not able as the local government to provide accommodation" (SLA_10_LG executive/technocrat).

As a result of inadequate accommodation in some intervention facilities, the staff deployed to rural areas took turns to work, rather than work together as per programme design: two midwives were supposed to run a shift together but worked alternate days because they had to commute long distances to the health facilities. At the health facilities where programme staff were accommodated, they felt comfortable to work and delivered services which improved access and utilisation of MNCH services (Ebenso et al., 2020).

Lastly, health workers were not automatically retained at the end of the MSS and SURE-P/MCH, as proposed in the MOU. However, during subsequent state recruitments, some of the programme staff were only offered employment after going through the usual state recruitment process. Whether or not their being previous programme staff influenced their recruitment, was not explicit, as this respondent states:

*"...the state government in Anambra I'm aware absorbed some of them but I don't think it was direct absorption because they still had to go through the interviews other people who applied for the job went through then. Maybe they were successful because they were already in the state, and they seemed to know their way better. I never saw anyone that said, 'I was taken because I was doing MSS'...so, beautiful programme, poor continuity...you sign an MOU, but you are not enabled" (*SLA_10_LG executive/technocrat).

Studies and reports would later confirm that poor staff remuneration, lack of adequate accommodation and poor staff retention, amongst other challenges, constrained the MSS and SURE-P/MCH in Anambra state (Adogu, 2014, Okoli et al., 2014, Christian Aid, 2015, Nsofor et al., 2015, Oduenyi et al., 2019, Ebenso et al., 2020, Etiaba et al., 2020).

With the SOML PfR, the design aimed to strengthen the capacity of existing facility staff to improve quality of care and achieve results, hence issues of additional staff remuneration, staff accommodation and staff retention were not in contention. Secondly, the programme had earmarked funds, and this influenced the acceptance

of the programme by stakeholders at the sub-national level. The programme objectives were also time bound and tied to incentives (FMoH, 2016b). A state level, a Core Technical Group (CTG), also referred to as the Steering Committee, was formed in Anambra state, inclusive of the state programme managers, executive secretaries of the SPHCDA and Anambra State Health Insurance Agency (ASHIA), LG health officers, and a few others, including representatives of the private sector and community representatives. As reported by a KI:

> *"...there is integration with the local government level for whatever we are doing at the state level. In fact, SOML is being implemented at the local government level and community level, and the local government officers are part of what we are doing..."* (SLA-01, State level implementer).

Although, Anambra stakeholders were of the opinion that, the SOML PfR policy design was more consultative, they perceived the assessment criteria as unfavourable to the state. They argued that since they were already highly performing in a number of the performance-linked indicators, they would not be eligible to receive adequate financial incentives in the next tranche of disbursement, as this was based on improvements (FMoH, 2016b, FMoH, 2017a). The following quote by a KI exemplifies how implementation of the programme was perceived in the state:

> *"...now if somebody improves by 0–10%, he wins the extra money but if you are already 93%, like in Anambra state immunization you get nothing...some other states like for instance in immunization, Kebbi state, the other time improved from 5% to 55% and they were awarded the best in the country. Of course, you know that to move from zero to the first 50 is very easy but when you begin to score excellently...it becomes very difficult and that was what we were not very happy about from the beginning. We complained... "*(SLA07_State executive/technocrat).

With this mindset, Anambra state did not adhere to implementing some of the key DLIs, because they felt there was inadequate room for effective improvement to be able to get the subsequent performance incentives, *"...for Anambra, we selected few facilities, gave them seed money but we didn't really continue because it wasn't like we expected, we were not getting the outcomes we needed from them"* (SLA_01, subnational implementer). So, they initially started to implement the DLIs, although they feared they would not meet the required upward change in the indicators, and later deviated

from the programme DLIs. To buttress this, a World Bank mid-term independent evaluation report of the SOML PfR in 2019, also acknowledged that Anambra state initially started off well, and already had, *"Well advanced implementation and wide range of innovative and standard solutions as well as good evidence of impact at the local level"* (World Bank, 2015), but declined, to the extent they had a negative sum total of -4.1% from their 2016 baseline (FMoH, 2019b, Bridges and Woolcock, 2019). Consequently, they did not receive any indicator-linked performance-based funds for the implementation period of 2017–2018 (FMoH, 2019a).

Challenges

The Anambra state experience of the first two programmes (MSS and SURE-P/MCH) was that of national level actors coming to the state, and sometimes directly to the facilities, to initiate and oversee primary care level implementation in Anambra state. Midwives were directly recruited and deployed by national level actors but were expected to be integrated into the state health system and be integrated into the communities by the local government actors. Where possible, LGs provided accommodation for programme staff. However, these challenges, and the reason for national level intervention, have been partially attributed to a fundamental lack of state level commitment, which is reflected in not prioritising health in budgetary allocation:

> *"...there was a time in this state when the commissioner said that if partners are coming, there are those who require counterpart funds and there are those who don't require it. We will choose those who don't require counterpart funds. So, it gives you the mindset that government seems not seem willing to invest resources in health...So, it is a very serious issue where the other tiers of government do not want to contribute, and I think that is also a big challenge"* (AN09_State policymaker/technocrat/implementer).

6.3.2 Ebonyi (Case 2)

Policy development

Following the launch of the IMNCH Strategy at the national level, there was subsequent advocacy by the national Core Technical Committee (CTC) to the state commissioner, and this was said to be very positive. As a result of this advocacy, the

commissioner and the director of public health became part of the team for the state implementation. However, with the MSS and SURE-P/MCH, like Anambra state, key sub-national stakeholders do not recall being involved in the development of these programmes, except one stakeholder who was a political appointee during this period and, also held a national role at the NCH:

> *"...as the regional vice chairman and the national secretary...at the point of development or formulation of this policy, we were involved. So, we (NCH) were convinced, we were committed to this policy of MSS and SURE-P"* (SLE_05, Subnational policymaker).

Another KI who had been in the public sector throughout the span of these programmes reflected on the SOML PfR:

> *"It was quite different. For SOML, I think we started with the development of the work plan. It was in Nike Lake Resort, Enugu. It was well-attended, it was for Southeast only and each state had a team of doctors then where relevant programs – Nutrition, Immunization, Family Planning, Safe Motherhood, HIV and Immunization were discussed. I was in the team, and incidentally when Ebonyi state team started to produce their own (workplan), I was the team lead…"* (SLE_01, Subnational policymaker/technocrat).

Policy implementation

Although majority of respondents in Ebonyi state stated that they were not actively involved by the national level in the design of the MSS and SURE-P, they too passively accepted implementation of both programmes, after the signing of MOUs. Ebonyi state's experience in implementing the three key components of the MOUs for which the states were assigned responsibilities (part remuneration, provision of accommodation and retention of programme staff) are as follows:

Ebonyi state did not pay the programme staff their assigned portion (33%) of their salaries, but the LGA paid (17%) haphazardly, as was reported. As a national level implementer observed:

> *"None of them (Anambra and Ebonyi states) paid. It is only the local government that paid N10,000 from the Ministry of Local Government and Chieftaincy Affairs. The local government no doubt is more responsive to PHC than the state, but the problem*

is, currently their (LG) money is now getting stuck at the state and I don't know what they are doing in that area to get their money back..." (NL04-National Implementer).

Ebonyi state and LGs were more responsive than Anambra state in the provision of accommodation. However, because these were more rural communities, it was reported that a large number of programme staff in Ebonyi, especially the younger women did not find this suitable and either left their posts or did not report for duty at all (Ikpeazu, 2018). Dissatisfaction with accommodation facilities was a contributory factor to this attrition as reported in an MSS impact evaluation study (Okeke et al., 2017), and as a KI also said:

"...some of the midwives that came on MSS and even SURE-P were really young girls and then where we really needed the manpower was in the very rural communities, with very minimal basic infrastructure, so it took only the ones that are very determined...to stay long" (SLE_03, senior executive/technocrat).

Midwives, who during the MSS were attracted by the pay package and potential capacity-building opportunities, soon lost motivation, due to unpaid salaries and incentives, inadequate accommodation, and difficulty with transportation to the health facilities. As a result, a number of them in Ebonyi state exited the programme, mainly to private facilities, even before the programme ended (Okeke et al., 2017, Ikpeazu, 2018).

As in Anambra, there was no explicit retention of the MSS or SURE-P/MCH midwives and other programme staff at the end. The state was already not committed to paying partial remuneration during the programme and was not going to retain staff they could not pay. As a result, staff were disengaged, and some left the programmes before they ended due to poor conditions of service (Ikpeazu, 2018). The negative impact of the national role in the recruitment of health workers was aggravated by the fact that the state had not had any HRH recruitment for years, even before the onset of these programmes (SMoH, 2018):

"...and then from the government perspective, you cannot have many people from your state that are unemployed, and you retain people from all over the place. So, I think that was a political issue about MSS. The recruitment procedure was a bit faulty. They just

get the list, fly in, at times they will even post them from Abuja to facilities where they don't know if they exist" (SLE_03, senior executive/technocrat).

Like Anambra, respondents reported that SOML PfR was more accepted in Ebonyi state than the MSS and SURE-P MCH because of its design. One KI explained:

> *"The difference is that for MSS and SURE-P, the design was packaged by NPHCDA and implemented like that. For SOML, we were given guidelines, there is a pen and a pad, but each state is allowed to design and implement activities that will yield results. So, it's a bit more flexible, because I don't remember during the MSS and SURE-P ever sitting down to develop a work plan"* (SLE_03, subnational implementer).

Stakeholders uniformly agreed that this is a more bottom-up programme in design, as they were involved in designing and adopting the programme. A state Programme Management Unit (PMU) was inaugurated with the commissioner as the head. They received seed grant of USD1.5 million, like other states. However, when it came to implementation, the state departed from the disbursement linked indicators (DLIs) and embarked on execution of other activities outside the programme design, such as procuring commodities outside the programme goals. It is not clear whether this was out of a lack of capacity to comprehend the underlying performance-based principle of the programme design as a KI reflects below, or just because they lacked the political will and commitment to implement the programme as designed, or both:

> *"It is different...but the problem still is that the people are not used to this method, so they are still learning it. And that is why we are talking about capacity-enhancement and development. If the capacity of the people is developed to handle projects at the state level with high level of accountability, if there is a very robust accountability mechanism that is in place, the states are at the better opportunity to achieve more success than what we see previously"* (SLE_04, academic/knowledge broker).

As a result, Ebonyi too did not receive subsequent tranches of disbursement of SOML-PfR funding:

> *"I think basically if the program is allowed to target the key indicators, it is a welcome development. But, when the money is used as an alternative source of funding for the health sector, you will find out that it is like throwing a stone into the ocean, it may not really do much, which is where we have found ourselves in the state"* (SLE_02-senior executive/technocrat).

One notable difference in the MNCH policy landscape between Anambra and Ebonyi states was the fact that Ebonyi state had two successive state level MNCH Programmes before (Rural Health Programme) and during (Free MCH Programme) the MSS and SURE-P/MCH, offering free MNCH services in the state. In contrast to MSS and SURE-P, these programmes were said to be successively implemented due to the strong political will of consecutive state governments. However, they were discontinued due to inadequate resources and a shift of priority to other sectors when there was a change in government. Apart from un-sustained political will across government periods, another factor which contributed to abandoning the policy, was that adequate sustainability mechanisms were not incorporated into the policies. As a KI reflected:

> *"It (Rural Health Programme) was quite successful, the only problem was that it nearly crippled our teaching hospital because we had a situation where people were coming from neighbouring states to deliver free and then government at a point was no more picking up the bills as it should, and the management of the hospital became overstretched. This is one of the shortcomings of laudable programmes that have not been well-thought through, and appropriate structures set up for its implementation, so at that time it was just a government pronouncement, and that was it. There was no structure to guide its implementation. So, the governor, improved upon that by picking the strategy of using mission hospitals and rolling out the free maternal health programme"* (SLE03_subnational implementer/technocrat).

The second state-based programme was the Maternal and Child Survival programme which was USAID funded and was a large MNCH programme, carrying out interventions in 50 facilities in the state (MCSP, 2017). Auspiciously, the MCSP commenced in 2015, when the state programmes (Rural Health Programme and the free MNCH programme) and the national SURE-P/MCH were folding up, so it was perceived as having bridged the gap in MNCH service provision in the state before the commencement of the SOML PfR in 2017. These programmes are mentioned here because they were as large, or larger, (MCSP) than the MSS and SURE-P/MCH programmes in terms of resource inputs, and had state commitment and buy-in (MCSP, 2017, SMoH, 2018). For example, a KI summarised the donor driven MCSP as follows:

> *"...MCSP has for example, over the last three or four years (2015–2018) changed the landscape in terms of manpower skill, in terms of capacity-building. You know, every health worker you'd ask, have you been trained on this, and he/she will say yes...have you been trained on neonatal care, yes, do you know how to use Partograph, yes. It is all because of MCSP, they have done it so well that I am sure more than 80% of the available manpower have been trained..."* (SLE01, subnational policymaker/technocrat).

Evidence of this is reflected in 2016/17 National Health Facility Survey, where Ebonyi was reported to have exceeded national averages in a number of MNCH indicators (skilled birth attendance, immunization) and even surpassed Anambra state in HRH training indicators. An example is staff knowledge of Integrated Management of Childhood Illnesses (IMCI) danger signs, where Ebonyi scored 66.7% and Anambra 63.3% (FMoH, 2017b). This finding is picked up again in the discussion chapter, as evidence to interrogate the value in national top-down policies, since the governance structure means that states can make their own policies and these programmes are evidence of ability to act when there is the will to act.

Challenges

Identified challenges are underpinned by the existing governance structure, which allows the national level to interfere in policy implementation in the sub-national space, and secondly by the skewed decision-making authority at the state level. Like Anambra state, Ebonyi state equally experienced interference from the national level during the implementation of MSS and SURE-P/MCH. The national level recruited, deployed, and haphazardly monitored programme staff. Consequently, the state level did not take adequate ownership of these programmes. Staff were not adequately accommodated and some of them exited the programme as a result. The state was also not keen to retain those staff who remained in the programmes until the end.

The SOML PfR funds were earmarked and domiciled at the SMoH, but the commissioner still needed approval from the governor before expenditure. As a KI recounts,

> *"To make the Saving One Million Lives functional...we (the PMU) ...sit down together, we develop a work plan which will be shown to the honourable commissioner, if it is*

approved, then you now send it to the national; if national approves then it is returned, then you start implementing. But then you'd find out that occasionally you might now send a program like that, and it may not go down well with the governor, and he will slot in his own program which was what happened to us" (SLE02, Subnational policymaker/technocrat).

So, at the initial stages of the programme, Ebonyi state embarked on a number of mis-procurements (tri-cycle ambulances and electricity generators) that were not direct components in the programme design:

"When we got our own (seed money), instead of applying them in these indicators, we went and bought keke na pepe *(tricycle), at the end of the day, our indicators did not change, we lost the money because we decided to boil our own seed and eat...if we are honest, that we are not paying a priority attention to maternal and child health..."* (SLE_09, senior executive/technocrat).

These issues will be picked up again in the discussion chapter. Table 6.3 below summarises policy process experiences of both states, as described above.

Table 6.3: Summary of factors that influenced policy processes in Anambra and Ebonyi states

Policy Elements	Anambra	Ebonyi
Programme characteristics (content)		
Policies internally (state) or externally (national and international) developed as perceived by stakeholders	MSS and SURE-P MCH as externally developed with little or no sub-national involvement. SOML PfR as internally developed by the stage, acknowledging the support of the national level in providing a guiding framework and other technical support.	
Costs of intervention other than available resources	Major costs of MSS and SURE-P MCH states were staff remuneration. SOML PfR funds earmarked and domiciled at SMoH to reduce bottlenecks.	
Accountability: External (national) strategies, guidelines, mandates, benchmark reporting, pay for performance	Guidelines and mandates for accountability provided for the MSS and SURE-P/MCH were not adequately implemented. In SOML PfR, selected DLIs needed to be improved from baseline for states to qualify for more funds.	
Accountability: Competitive pressure from other states to implement an intervention	None in MSS and SURE-P MCH, national performance league tables in the SOML PfR.	
Context		
Structural characteristics: Health system context (human resources, financing, etc.)	Fairly vibrant economy, though large dependence on federal allocation, Health sector inadequately funded. High MNCH uptake from private facilities. Human resource shortage.	Agrarian economy, least federal allocation in SE. Critical human resource shortage, heavily dependent on donors, large state level MNCH policies/programmes.
Cultural factors: Beliefs, norms	High literacy, poor family planning uptake due to a large Roman Catholic population.	Low literacy, regressive MCH beliefs and practices.
Actor characteristics		
Knowledge and attitude of sub-national stakeholders towards intervention	Limited knowledge of MSS and SURE P MCH Programmes until adoption stage, passive resistance during implementation. Fully involved in SOML PfR. Believed in their capability to execute all three programmes if involved from the beginning and given control of some components of the programme resources.	
Implementation processes		
Degree to which the programme goals are broken down and implementation activities are specified on local level	MSS and SURE-P MCH Programme goals were largely determined by national level. For the SOML PfR, states were provided with framework of goals to adapt to state level needs and context.	
Formally appointed state programme leaders	National-level appointed state programme managers for MSS and SURE-P MCH. SOML PfR programme manager was appointed by the states.	
Accomplishing the implementation according to plan	Programme goals not achieved in MSS and SURE-P/MCH. In SOML PfR, both states initially did not meet the required benchmark for any of the DLIs, but improved over time.	

6.4 SUMMARY

In conclusion, despite the contextual variations across both states (Table 6.3, highlighted in blue), they had similar outcomes to the three national programmes, irrespective of the design, however through different pathways. This path dependence as a component of complex adaptive systems, will be further explored in the discussion. Although, programme design and sub-national stakeholder engagement were perceived as inadequate, there is an underlying disconnect which lies in the existing political and MLG structure, which may explain why state-owned programmes appeared to have performed better than the national programmes. States' policy autonomy clearly impacted MNCH services in Ebonyi state. The level of, and the need for intergovernmental collaboration in the existing MLG constitutional set-up, will also be explored. In the next chapter, the role of actors and different relationships and their consequences during these programmes, will be explored.

CHAPTER 7

ACTOR ROLES AND INFLUENCE ON THE INTEGRATED MATERNAL, NEONATAL AND CHILD HEALTH (IMNCH) STRATEGY

7.1 INTRODUCTION

In preceding chapters, the experiences of developing the IMNCH Strategy was outlined – its programmes and implementing them in two states over a decade (2009–2019). This chapter trains the study's lens on actors (their interests, priorities, power, positions, and relationships) as one of the key forces of complex adaptive systems (CAS). The first part of the chapter draws information from documents and interview respondents to identify and describe key actors and their roles in the policy processes discussed in the previous chapters. For the purposes of our analysis, actors can be institutions and organisations, such as the Federal Ministry of Health (FMoH), or they can be individuals or units within organisations.

Actor relationships within and across the levels of government are then analysed by applying the concept of actor interfaces and practices of power, to provide an interpretive synthesis of our findings (Erasmus and Gilson, 2008, Lehmann and Gilson, 2013, Parashar et al., 2020). Power practice implies different actors employing different forms of power (authoritative or discretionary) at their disposal to act (or not); and when actors interface, these interactions result in various forms of power relationships (such as control, domination, contestation, collaboration, resistance or negotiation) (VeneKlasen and Miller, 2002). This chapter will explore how power practices and relationships in the implementation of IMNCH Programmes, in the context of Nigeria's MLG arrangements, shaped policy intent and implementation, frequently leading to unintended consequences, such as deviation from programme design during implementation and not honouring activities outlined in signed memoranda of understanding (MOUs).

7.2 IDENTIFICATION AND DESCRIPTION OF ACTORS

This section gives an initial general overview of actors (organisations and individuals) and then focuses on those identified as key actors in the process. At the initial phase of the IMNCH policy drive, as Nigeria began to think of how she could improve her MNCH indices in the context of the MDGs, international actors played a central role in driving the policy agenda through political pressure and support. Nigeria was highlighted in the World Health Report 2005, among countries where MNCH indices were either stagnating or in reversal (World Health Organization, 2005). The UN supported the FMoH in the development and production of policy documents (FMoH, 2007, FMoH, 2009). During the agenda setting, further international support was provided through scientific evidence from a series of findings by the Lancet Group, while other key international actors, including UK Department for International Development (DFID), WHO, UNDP, UNICEF and the World Bank provided technical and financial support at various stages (Lawn et al., 2005, FMoH, 2007, Hill et al., 2007, Mbachu et al., 2016).

DFID played a key role in the early years of health sector reform in Nigeria (2003–2004), by coordinating the initiation and funding of the health sector reforms (FMoH, 2004a). This was driven through the Health Reform Foundation of Nigeria (HERFON), led by a Nigerian health economist, Eyitayo Lambo, who had been working with WHO and would go on to become the Minister of Health from 2003–2007. The IMNCH Strategy was developed under his leadership. The WHO and UNICEF provided technical and financial support at different stages of the IMNCH Strategy policy process. Other development partners who were involved in the IMNCH journey through technical support, financial support, or direct involvement in policy/programme development, include the USAID and UNDP (World Bank, 2010, United Nations, 2015).

After this early role in agenda setting for the IMNCH Strategy and provision of financial and technical support, international actors were not actively involved in subsequent programme design, development and implementation of the MSS and SURE-P/MCH but remained involved in some parallel MNCH Programmes in the

country. With the beginning of the third programme – SOML PfR, a key international actor, the World Bank, became actively involved in shaping policy once again, by funding the programme through a performance-based mechanism (FMoH, 2016b).

National level groups and organisations involved in agenda setting, formulation, enactment or implementation, include HERFON, Federal Executive Council (FEC), the National Council on Health (NCH), FMoH, the National Primary Health Care Development Agency (NPHCDA) – a parastatal of the FMoH, given oversight for PHC services, National Council of Nursing and Midwifery (NCNM) – in designing the MSS, and a national Core Technical Committee (CTC) (FMoH, 2007, FMoH et al., 2009). The NCH gives final approval for all national health policies, while the FEC gives final approval for enactment of all sector policies. The others include the office of the MDGs and the SURE-P Secretariate at the presidency (NPHCDA, 2010a), where all MDG and SURE-P funds were pooled for all sectors, and these offices also had oversight for disbursement of programme funds for the MSS and SURE-P/MCH. Once they released funds to the NPHCDA, they did not play any other key role in the policy processes.

Individual actors include the presidents, health ministers across the span of the study, the executive director (ED) of the NPHCDA, technical advisers to the ministers and ED, and national level programme directors. While the presidents actively supported the MNCH policy process to varying degrees, usually in response to global momentum, they did not play any other key role in the policy process. Amongst the national actors, the FMoH, NPHCDA, Prof. Lambo (Minister of Health, 2003–2007) and Dr M Pate played key roles at various stages of the policy process as will later be shown.

The Nigeria (State) governors' forum is a non-partisan platform that was created to enhance collaboration among the executive governors of all Nigerian states. It serves as a forum for consensus-building among the governors on common national issues (NGF, 2021). It is also seen as an advocacy forum, to sensitise governors to enhance commitment and buy-in to policies, since they retain executive powers at the sub-national level. National health policies are usually presented to governors at this

forum, as a way of sensitisation, before being forwarded to the FEC (FMoH and NPHCDA, 2012, FMoH, 2016b). As was discussed in the previous chapter, the support and commitment (or lack thereof) of the governors to the study programmes, impacted sub-national implementation in both states.

At the sub-national level, actors in Anambra state were two executive governors (2006-2014/2014–2022), three commissioners for health, the State Ministry of Health (SMoH), the State Primary Health Care Development Agency (SPHCDA), State Health Insurance Agencies (SHIA), and their executive secretaries, local government (LG) primary health care (PHC) directors, state programme managers and health workers. In Ebonyi state there were also two governors, two commissioners, the SPHCDA, LG PHC directors, programme managers and health workers. The governors, commissioners, SMoH and health workers, are key in the analysis of the sub-national experiences of the policy processes.

7.3 ROLES, INTERESTS AND POSITIONS OF KEY ACTORS IN THE POLICY PROCESSES

Figure 7.1 summarises roles of the international, national, and sub-national actors, respectively. Blue arrows are used to depict involvement of actors in the Strategy and programme development, whilst black arrows depict roles in implementation. In both cases the thickness of the arrows correlates with level of involvement, as interpreted, and triangulated from literature and respondent interviews. Blue arrows from the sub-national space going into the national level depicts where sub-national actors were involved in policy development, and this would be seen only explicitly for the parent Strategy (IMNCH) and the SOML PfR. A high convergence of blue arrows in the development of SOML PfR indicates a wider stakeholder engagement, as outlined in Chapter 5. The figure also shows that international actors were more involved in the initial stages of the Strategy development, either by contributing evidence to the external framing of the MNCH issues in Nigeria, or by providing technical and financial assistance to the strategy development. In subsequent programmes, international influence is not explicit in the policy process until the third programme, SOML PfR, when the World Bank played a key role in providing the programme

funds and technical assistance with the performance-based financing component of the design.

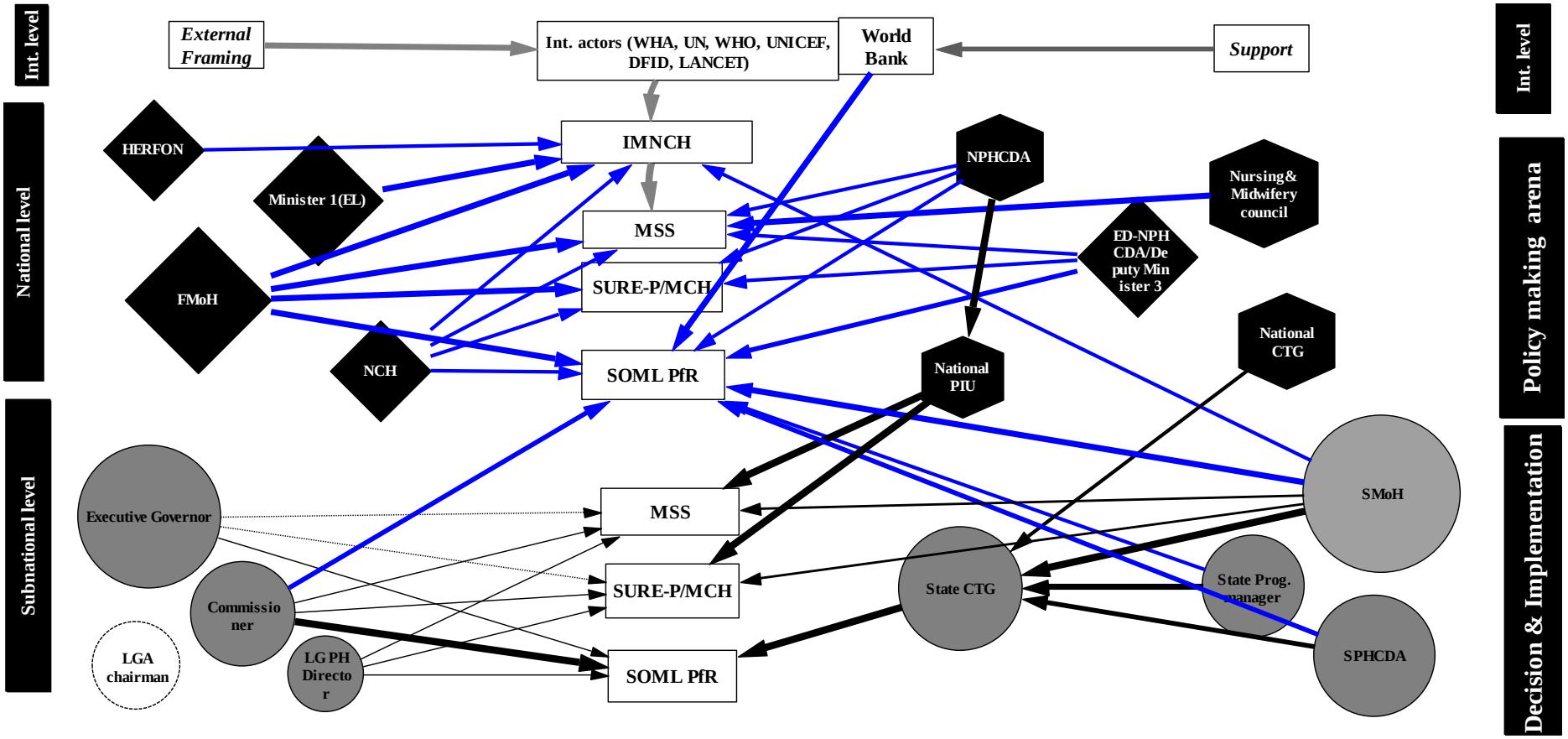


Figure 7.1: Key actors and their roles in the policy processes

Key: ◆ Black diamonds- key national level actors (organisation & individuals) who influenced policymaking ⬢ Black hexagons- Key national actors during implementation; ● Circles-subnational actors; Blue arrows-actor influence during policymaking; Black lines-actor influence during implementation; Thickness of arrows approximates level of influence

National actors

Although the **presidents** in office during the time span of the Strategy and its programmes were not directly involved in policy development and implementation, they had a keen interest in achieving the MDGs (health MDGs and others). The MNCH burden had been profiled on the international agenda, as noted in Chapter 5. In their position, the presidents gave impetus to the programmes (MSS and SURE-P/MCH) by providing dedicated funding towards their implementation, up until 2015, the end of the MDGs. Funding from the MDG office of the presidency was made available directly to NPHCDA for implementation of MSS. Similarly, the SURE-P Secretariate at the presidency also allocated part of the SURE-P funds to the health sector for the SURE-P/MCH (NPHCDA, 2010a, FMoH and NPHCDA, 2012, United Nations, 2015).

National Council on Health (NCH): In its position as the highest health policymaking body in Nigeria, the NCH approved the Strategy and all three study programmes for implementation and coordinated the multi-level proposed collaboration on programme implementation, through the signing of MOUs. However, although they hold this key position at the national level, once policies are enacted and transferred to the sub-national space for implementation, the NCH does not have any statutory role within which they can influence sub-national adherence during implementation. A review reported that less than half of policies approved by the NCH have been adhered to by the sub-national level (Eboreime et al., 2017).

Key national level organisations are the FMoH and the NPHCDA. The **FMoH**, with national stewardship for health and health policymaking was also aligned with the national interests of achieving maternal and child MDGs, hence were fully mobilised. The FMoH was the key driver and coordinator of strategy and programme development, whilst engaging its agencies, parastatals, other sectors (Ministry of Finance), as well as key developmental partners (WHO, UNICEF). After overseeing the policy developments, the FMoH ceded oversight for implementation for MSS and SURE-P/MCH to the NPHCDA, as these were core PHC interventions. However, with the SOML PfR, the FMoH retained oversight throughout the process, because

there were other programme components, besides MNCH, which were the responsibilities of other agencies, besides the NPHCDA, for example, the HIV/AIDs component was under the National AIDS Control Agency (NACA) (FMoH, 2016b). SOML PfR funds from the World Bank were domiciled at the FMoH and disbursed in annual tranches to states on a pay for performance basis after the initial seed grant to all states (World Bank, 2015).

The **NPHCDA,** a parastatal of the FMoH, which has oversight for PHC service delivery, had primary oversight for MSS and SURE-P/MCH Programme implementation and had custody of the programme resources for MSS and SURE-P/MCH, because these programmes were core PHC programmes (FMoH, 2016b, NPHCDA, 2010a). As a focal point for overseeing the implementation of these PHC-based services, they had high interest in, and support for, the programmes. The NPHCDA also directly implemented programme components in the sub-national space through the national Programme Implementation Unit (PIU). They were also engaged in the development of SOML PfR but did not have a direct influence on its implementation.

Although individuals *"cannot be separated from the organisations within which they work…"* (Buse et al., 2005b-p.9), there are a few notable individuals who were key in the process. During the agenda setting and development of the Strategy, on the background of a global push to achieve MDGs, Prof. Eyitayo Lambo championed these activities, having already been at the head of ongoing health sector reform (HSR), as the then Minister of Health (2003–2007). As noted in Chapter 5, he facilitated a wide multi-level stakeholder consultation during the development of the IMNCH Strategy. His previous work with WHO and DFID, and his wide national and international network, and engagements nationally with the HSR and health policies, afforded him tangible resources (members of his organisations) and intangible resources (expertise and legitimacy, access to decision-makers). These contributed to his key influence on the IMNCH Strategy processes. He also recognised the importance of collaboration across government levels for successful policy implementation. As he (Lambo) explicitly noted during the revision of the national

health policy in 2004, "*I wish to emphasize the need for all interest groups and actors to collaborate with my ministry and health authorities at the state and local government levels to ensure the successful implementation of this policy....*"(FMoH, 2004b).

This wider outlook was corroborated by key informants (KIs). As one KI reflected, Prof. Lambo attempted to breach the disconnect in the policy process between government levels,

> *"...it (Strategy) was such a beautiful document, and we actually insisted that, you know the problem we have in this country, which is still happening now, is from policy to practice, Abuja wants to do the policy, Abuja wants to do the practice...that has not improved. We did a lot under the minister to break that barrier..."* (NL06_National policymaker/technocrat).

Lambo's role as the key actor driving the IMNCH policy agenda was cut short with the 2007 national elections, which brought a new national government to power. Lambo had been Health Minister for four years (2003-2007) and handed over after the elections to a new minister, who, auspiciously, had also been one of the core actors in the development of the Strategy. So, there was hope for a smooth transition. However, the new minister was replaced after a very short tenure (8 months; July 2007 to March 2008) due to other organisational events in the FMoH, which is outside the scope of this study.

As summed by a KI,

> *"...we had said to her, 'Thank God you are now the minister, and you need to help us push this (the Strategy) to the floor' but unknown to us that being a minister is a different ball game altogether, you know their hands are full all the time with so many other things. It was difficult for her to focus, much as she tried. Anyway, eventually she was relieved of her job...and that was when everything began to just fall apart and it has been so sad that we were only able to get to a few states to advocate that they begin to implement and to set up similar platforms like we did at the national level"* (NL10, National policymaker/technocrat).

Another minister was then appointed, who coordinated the development of the MSS Programme (NPHCDA, 2010a). Although the shortage of HRH was identified as a priority component of the Strategy (FMoH, 2007), implementation of the Strategy was

designed to, initially, follow the replication of state level CTCs as a foundation for commencing the implementation of strategy components. As noted in Chapter 5, an evaluation of the Strategy in 2009, prior to the commencement of the MSS showed that only 24 out of 36 states had inaugurated state CTCs (FMoH et al., 2009). The 2007 elections were a key contextual factor – this will be picked up later as contributing to the path dependency of the strategy journey.

The new government (2007–2011) also saw the appointment of Dr Muhammed Pate, from the World Bank, to head the NPHCDA as the ED, and with that, presiding over the development and implementation of the MSS, and later (2012–2015), as the junior Minister of Health, the development of SURE-P MCH and SOML/SOML PfR Programmes. While at the NPHCDA, he was responsible for rolling-out and implementing the MSS. He was then transferred to the FMoH as the junior Minister of Health where he was said to have played a key role in securing the SURE-P health sector funds for MCH and also for putting together the team at the FMoH that designed the initial SOML concept (World Bank, 2014b). According to a technocrat during Pate's tenure,

> *"...One, he was extremely persuasive at the Federal Executive Council (FEC) meetings on the social safety net agenda. Other more powerful sectors were cut off but the social safety net including MCH was protected, so that was what led to the SURE-P MCH fiscal space coming up..."* (NL02, National policymaker/technocrat).

With the hope and intent to facilitate sub-national commitment, Dr Pate advocated to the executive governors on the platform of the Governors' Forum. As a KI, who had interacted at this Forum, reflected,

> *"...at that stage, they had this Governors' Forum...and he had that grip and collaborated well with the Governors Forum on these projects. He also had the meetings behind the scenes. I have presented twice there, but health is usually not high on the agenda. They do listen but it is not usually high on the agenda"* (NL03_national implementer).

So, although Dr Pate was highly influential at the national level in designing and securing funding for two of the three study programmes, given the MLG structure, he could only employ advocacy to mobilise sub-national actors (governors). It was

clearly shown in Chapter 6, that this was not adequate to change the governors' positions in the national led programmes (MSS and SURE-P/MCH).

Sub-national actors

Roles, interests, and positions of sub-national actors are of particular interest, given that the decision to adhere and implement national policies or not, resides in the sub-national spaces, and given that they are also the units of analysis for performance evaluation. The key actors in this space are the state governors, the SMoH, the commissioners, the health workers, and at a later stage in the process during SOML PfR, the SPHCDA.

The **state governors** retain power to authorise expenditures in all sectors with support from the state legislature. National actors in the MSS and SURE-P/MCH hoped and expected governors to ensure the adoption and implementation of these national policies, through providing adequate fiscal space for the SMoH and LGs to implement the part remuneration of programme staff and other items of the MOU that they had signed. However, the governors were not adequately mobilised to shift their position and support the programmes, so national level expectations were not met.

State governors had pooled funds for MDGs and SURE-P, as outlined in Chapters 2 and 5, but since they were not required to provide expenditure reports to the national government, the national level could not influence how they managed and spent these funds. States did not explicitly align with national level in providing earmarked funds to the MSS and SURE-P/MCH, going by the budgetary allocation to health in those programme years. In Anambra state, between 2007–2013, the health sector remained the least funded when compared with the education, works, and environment sectors (Okafor et al., 2018). Similarly in Ebonyi state, health budgetary allocation to health remained as low as 3–6% throughout the programmes' period, up until the end of the MDGs (Eneze et al., 2020).

It was different with the SOML PfR. Although, SOML PfR funds did not go into the central purse (SJLGA) at the State Ministry of Finance, but was ring-fenced at the SMoH, the governor's assent was still required before expenditure of the funds in the

health sector. In Ebonyi state, as will be discussed later in this chapter, KIs believed the commissioner did not adequately mobilise the governor with evidence to change his position on disbursement of the SOML funds. This perceived "ad-hoc and personality-dependent" (Kwamie et al., 2016), solution to mobilising public sector funds is picked up again in the discussion, as it is one of the manifestations of the imbalance of power at the state level, because of the existing governance structure.

The **SMoH** is a key actor in implementing transferred national health policies and in formulating and implementing state level policies. Prior to the inauguration of the SPHCDAs, it also had oversight for LG departments of health and supervision of LGs in delivering services at PHCs. In Ebonyi state, the SMoH was implementing state level MNCH policies alongside the national MNCH Programmes. Being the focal point for state health care and evaluation, they shared the interest of improving the MNCH burden, but were poorly mobilised to shift their position, by the national level, during the MSS and SURE-P/MCH, due to inadequate engagement earlier in the process, as outlined in Chapter 5.

The **commissioner** represents the governor within the health sector and is expected to obtain the governor's support and commitment for programme implementation. To perform this key stewardship role in the health sector, within the existing political structure and narrow decision-making authority, the commissioner is also expected to adequately mobilise the executive governor's interest to give political and financial support to health sector programmes. It is also the commissioner who signs MOUs on behalf of the state at the NCH meetings. At the beginning of a regime, the executive governor appoints the commissioners across all the sectors, with input from political party stakeholders. They are screened and confirmed by the state legislature. The governor is also at liberty to reshuffle the cabinet at any time. So, the commissioner serves at the discretion of the governor. Hence, this executive power of the governor directly impacts the decisions of the commissioner and other sub-national actors. Positions and interests of governors, especially in the first tenure, are usually focused on quick wins, to win the next election for the second term. So, where a governor has not prioritised health in his/her state, national and other sub-national actors see it as

the responsibility of the commissioner to drive the health agenda. In most cases this means using resources available to him/her to alter the governor's perception of, and interest in, the health sector, and possibly shift his/her position and lend more support to health sector programme implementation. This became apparent in the SOML PfR because states had ownership of the programme and bottlenecks to accessing programme funds were critically reduced.

A national level KI summed up these reflections in the following quote:

> "*...in MDGs, we were releasing money to the state, but the governors had what they called special advisers on MDGs, so, MDGs money were in government house. The governor decides where the money goes to. Many of our priorities were in health but the governor can say, no, let me construct a dam, and he would carry the whole money and do one dam that is not cost effective. So, in this one (SOML PfR), I used my knowledge and that experience of MDGs, and I said let us ring-fence this fund within the Ministry of Health, and they (governors) will never see it again. For the first time, these funds are domiciled in the State Ministry of Health...but governors pay attention to that money, you can't say governors shouldn't give approval, mind you, the governor is chief executive*" (NL07-National implementer/policymaker).

So, the state could not veer the SOML PfR funds away from the health sector, since it was ring-fenced at the SMoH, but the governor's assent was still required for expenditure. A widely held opinion among respondents is that commissioners, irrespective of the existing political structure, should be able to skilfully engage their state governors with the resources at their disposal (for instance, evidence from available data) into shifting their positions to support adherence to implementation of programme components and appropriate utilisation of the programme funds. Other intangible resources would include a cordial personal relationship between the governor and commissioner or belonging to the same political party. As a zonal level KI, who had oversight of both states, reflected,

> *"I think in general; the decision space (of the commissioner) depends on the relationship between the commissioner and the governor...in Ebonyi state, the politicians all came from one party. So, for me, there was enough decision space for them, at that level, especially for the commissioners, why this did not translate to political commitment is quite unclear to me...."* (ZL01_zonal implementer/academic).

However, this also raises the question of the fate of a policy hanging on the soft skills of a single health system actor without any back-up with hardware, such as clear accountability mechanisms and legal frameworks. These fundamental governance issues lie at the crux of these contestations, as shall be explored further in the discussion.

The **SPHCDA** was set up to mirror the NPHCDA, to coordinate all PHC activities. States were mandated to set up and inaugurate their SPHCDAs before they could access the seed funds for the SOML PfR. Their main role was to coordinate the Primary Health Care Under One Roof (PHCUOR) reform, as outlined in Chapter 2, and the PHCUOR would go on to be incorporated into the SOML PfR as a disbursement linked indicator (DLIs) (FMoH, 2019a).

Were the LG tier to function autonomously as a third tier, **the LGA chairperson** and **primary health care director (also known as Head, Department of Health**) would have roles equivalent to the executive governor and commissioner, respectively in the LGAs. Hence, the LG chairperson is responsible for all LG public sectors, while the primary health care director mirrors the commissioner, and has direct oversight for PHC services. However, in the present structure, they have poor administrative and fiscal capacity (autonomy), and as a result, little discretionary power to influence their positions. The ad hoc attempts of some the LG chairpersons to pay their assigned portion of the programme staff salaries and provide accommodation, though haphazard, within their limited fiscal capacity, were actions which have been interpreted as a high level of interest in and support of these programmes (MSS and SURE-P/MCH). By the SOML PfR, LG health actors had been recentralised at the SPHCDA, which was highly mobilised during the SOML PfR.

Health workers were not explicitly included in the study interviews because the study is focused on the governance relationships and interactions in a MLG setting. However, health workers were at the centre of the design of the MSS and SURE-P/MCH. In the initial stage, they were fully mobilised by the incentives of the programme designs (MSS and SURE-P/MCH), in the way of remuneration, accommodation and retention by states at the end of the programmes. During

implementation, this was altered by the interests and positions of other actors and manifested in their power practices. During implementation, health workers used their discretionary power and worked alternate days instead of daily (Anambra state), or did not report to deployed facilities at all, or left their posts after initial reporting (Ebonyi state), as previously detailed in Chapter 6 and briefly outlined in the next section.

An actor evolution across the three programmes clearly shows a shift from a predominance of national level actors in the development and implementation of the MSS and SURE-P/MCH, to a greater role of sub-national actors in the SOML PfR; and a shift in positions and interests between the MSS/SURE-P/MCH and the SOML PfR. The next sections outline power practices as they individually applied to the study states.

7.4 ACTOR POWER – TYPES, SOURCES, INTERFACES AND POWER PRACTICES

To further understand the impact actors and their roles had on the MNCH policy processes, we have earlier (Chapter 4- Methodology) described how actor power has been conceptualised over time and adopted for this study. The focus is on technical expertise, political, and financial sources of power. Organisational hierarchy, control of resources and budgetary approval and release, technical expertise, and knowledge (health workers) are the key factors that influence the forms and sources of power available to different actors, which then interact with actors' positions and interests outlined earlier, within the existing context, resulting in the observed power practices and outcomes, which are described below.

Table 7.1 below summarises observed actor interfaces, power practices at interfaces, and the consequences of these. With the vertical actor relationships across the government levels, the contestations were largely because of interference by national level actors in sub-national policy implementation processes. Authoritative power of national actors (e.g., NPHCDA) resulted in top-down control, but this was repeatedly resisted by lower-level actors in the MSS and SURE-P/MCH. As will be shown below, this was ignoring assigned responsibilities. There are two underlying issues here. The

first arises from the fundamentally flawed policy design, where national actors assign and transfer responsibilities to the state level actors, who, constitutionally are not obliged to adopt and implement these. The second factor is the national level overstepping their oversight mandate and going into the implementation (sub-national) space. The mandate of the national level is to formulate policies and provide oversight functions, but repeatedly, they have formulated and partly implemented the policies. In the opinion of a KI,

> *"...what is causing some of the problem is that the national is formulating policy and implementing, that is the problem. Giving example with National Health Insurance and even the National Primary Healthcare Development Agency. They want to formulate, and they want to implement. So that is the friction between the national and the state. The state is saying no, and the state is right...."* (ZL02-Zonal level implementer/academic).

These factors have led to a clash of authoritative powers, manifesting in various contestations and consequences that limited policy goals being implemented as designed.

At policy adoption on the platform of the NCH (under the aegis of the FMoH), commissioners felt dominated and compelled to sign MOUs where they clearly did not have the power to commit to their implementation. Contestations were also rife in the implementation of programme components of the MSS and SURE-P/MCH in Anambra and Ebonyi states. States felt that identification of intervention facilities, and the recruitment, training, and deployment of programme staff, should have been domiciled with them, and consequently ignored policy stipulations to remunerate deployed programme staff and retain them when the programmes ended. Counterpart remuneration of staff by states were not adhered to, as per programme design, because state governors, who had the political authority and were in control of the financial resources, were not adequately mobilised to back the programmes. Not remunerating and accommodating programme staff, negatively impacted the achievement of programme goals.

In **Ebonyi state** specifically, there was a high level of attrition of programme staff, as a result of unsatisfactory accommodation and no incentives (training and

remuneration) (Ikpeazu, 2018). At the end of each of the two programmes (MSS and SURE-P/MCH), programme staff were not automatically retained as intended in programme design. As outlined in Chapter 6, states reported that they did not have any budgetary provisions to pay staff their counterpart salaries, let alone fully retain them. At this interface, the real power practice is the sub-national level refusing to take responsibility for staff they considered were imposed on them from the national level, even though both states clearly had a shortage of staff, although Ebonyi more so than Anambra State (FMoH, 2009). Respondents reflected that LG actors were more committed to these programmes because they were closer to the grassroots (communities) who needed these interventions but were constrained by their lack of fiscal autonomy. As a KI reflected,

> *"...the local government system is virtually collapsed, it is dependent solely on what comes from the state...they are supposed to have direct funding, but the funding was hijacked by state government"* (SLE07_subnational technocrat/academic).

Table 7.1: Observed actor interfaces, practices of power and influence on implementation

Policy implementation activity	Actor interfaces observed	Practices of power observed	Effect of power practices
Adoption/Signing of MOUs at NCH	Commissioners and national level actors	Domination: commissioners felt compelled to sign the MOUs.	Constrained implementation due to narrow decision space of commissioners.
Identification of intervention facilities	NPHCDA and SMoH **(MSS and SURE-P/MCH)**	Contestation about criteria and choice of PHC facilities. Where state and national (NPHCDA) disagreed, the state executive's (governor) choice of facilities was adopted, governor's authoritative power overriding the NPHCDA's authoritative power in the implementation space.	Some choices did not reflect programme goals but were rather politically motivated.
Recruitment, training and deployment of programme staff	NPHCDA and SMoH	Authoritative power of the NPHCDA resulted in control and domination, as these activities was entirely undertaken by national actors.	Some staff recruited were not adequately matched to state context – seen more in **Ebonyi state.**
Counterpart remuneration of staff by sub-national actors (state and LGA)	National and sub-national actors **(MSS and SURE-P/MCH)**	Contestation and resistance – states (governors) exercised authoritative powers and did not pay their portion of the salaries (33%) and also did not release earmarked funds to the LGs to pay their portion (17%).	Constrained implementation due to reported frustration, mistrust and lack of motivation amongst the programme staff.
Provision of 24-hr facility-based MNCH services in selected PHCs	Health workers and NPHCDA **(MSS and SURE-P/MCH)**	Contestation – resistance. Midwives not provided with accommodation, used discretionary power; some left their duty posts **in Ebonyi**, while in **Anambra** re-designed the programme and worked alternate days.	Constrained implementation as number of programme staff on duty were less than originally intended in programme design.
Retention of programme staff by state and LGA at end of intervention	National and sub-national **(MSS and SURE-P/MCH)**	Contestation over non-budgetary provision for states to retain programme staff – states used their authoritative power to resist automatic retention of programme staff.	Gains of programme (staff strength) dwindled.
Implementation of disbursement-linked indicators (SOML PfR)	State governors/SMoH/FMoH **(SOML PfR)**	Although funding was earmarked, state governors still had control over the release of the funds. **Ebonyi state** actors did not adequately negotiate with governor. **Anambra state** (SMoH)had a higher level of autonomy over the funds but used their discretionary power and deviated from the DLIs.	Constrained implementation as funds were diverted to other activities in the state.
Oversight of PHC activities in intervention facilities	State and local government	Control and domination as a consequence of joint state account – states had political and financial control of LG activities. No earmarked funds were released to LGs to remunerate staff (17%) and provide accommodation.	Contributed to staff attrition, leaving posts or re-designing duty rota to work alternate days due to lack of adequate accommodation.

With the SOML PfR, the key programme component was implementing disbursement linked indicators (DLIs). The commissioner had direct oversight for these programme funds, but he importantly still required the governor's consent. Unlike accessing the statutory health budget, which is held centrally at the Ministry of Finance for all health programmes, which has several bureaucratic bottlenecks, the SMoH (headed by the health commissioner) only needed the assent of the governor to access the SOML seed funds. So, it was seen as the commissioner's responsibility to adequately sensitise and mobilise the governor on the pay for performance incentives of the programme, to change the governor's position towards approval to use the funds appropriately. Some state level actors also felt the state did not adequately comprehend the concept of performance-based financing. As one KI reflected,

> "*...each state was given 1.5 million US dollars as a seed fund, you know the purpose of a seed, if you plant a seed, it germinates...the states were encouraged to go and plant the 1.5 million US dollars and the areas to plant it are the thematic areas, we call it the disbursement linked indicators (DLIs)...when we got our own, instead of applying them to these indicators, we went and bought* 'keke na pepe' *(tricycle ambulance)...At the end of the day, our indicators did not change, we lost the money because we decided to boil our own seed and eat"* (SLE09-Subnational technocrat/policymaker).

If the state had used the initial seed grant (USD1.5 million given to each state) appropriately by applying it to implement the DLIs, it would have fetched additional funds in the following programme year. Rather they applied the funds to other health sector activities. Other actors, however, felt that this was borne out of a history of prior conflicts and contestations (in MSS and SURE-P/MCH) between state and national actors, and state actors could use their discretionary powers and ignore national level guidelines. It would seem that state actors did not care about aligning with the programme design and probably thought it was *"business as usual"* (NL07_national implementer), i.e. ignoring or resisting policies, rather than a lack of capacity in comprehending the design, since all sub-national actors received training on performance-based financing design (FMoH, 2016b).

With this mindset in place in Ebonyi state, it would appear that, inadequate efforts were made to mobilise the executive governor. As a KI reflected,

> "*What happened was that it was not actually the fault of the governor. The governor is very much concerned with the health sector in Ebonyi state. So, when he came on board, he inaugurated a twenty-man committee to look into the health sector and come up with strategies that will vitalize the health sector, so the state already had a plan (before the SOML PfR), a blueprint on how to move the health sector forward. So, when the issue of this Saving One Million Lives came up, it is like let us now start implementing what these people had developed and some of these things we were now doing were the things that were in the blueprint. That was what happened. All he (the governor) needed was for somebody to explain to him very well that we were moving in the wrong direction. But meanwhile, that the program (blueprint) is good, but it is not capturing what will yield money for us (the DLIs*)" (SLE_02-subnational technocrat/policymaker).

This is probably one of the reasons why some KIs in Ebonyi state were of the opinion that the commissioner (SMoH) did not adequately sensitise and mobilise the executive governor to change his position on the SOML PfR implementation at the onset. The consequence of this was that at the interface of the FMoH and SMoH, the FMoH applied their authoritative power and denied Ebonyi performance-linked funds in the following programme year (FMoH, 2017a), in line with the programme guidelines and in agreement with the World Bank (World Bank, 2015).

In **Anambra state**, SMoH attested to an adequate decision-making authority with particular respect to the SOML PfR. However, because they felt, they were already performing highly in some of the indicators (for example 92% in immunization) (FMoH, 2017a), and were unlikely to make an appreciable difference (6% increase from state baseline), they did not adhere to implementing some of the DLIs either. As a result, they also did not receive the next tranche of performance-based funds after the initial seed grant. In their case, Anambra did not think they would receive follow-up funding and so deviated from the programme goals.

In conclusion, actors' roles, the power practices they employed at actor interfaces, and their subsequent outcomes, have been outlined. Also outlined are how cross-level actor relationships in the existing MLG structure impacts the functioning of the CAS in which policies are being implemented. Majority of actor practices were contestations (control, domination, resistance). Changing actors and interests, inadequate mobilisation of key actors also impacted the existing complexities. All this

was within the conditioning contexts of four, yearly elections, bringing with them new actors.

To carry into the discussion, two key interfaces which limited the policy intent are identified. First, is the clash of authoritative powers across government levels. A key actor interface where this clash manifested was between the national (organisations – NCH, FMoH, NPHCDA) and state (governor), within which the existing constitutional arrangement portrayed the national level as meddling in sub-national space if the governor was not adequately mobilised to shift his/her position. The second is the sub-national power imbalance between the executive governors and the commissioners, requiring skilful navigation by the commissioners, to appropriately mobilise governors' interests in the health sector. These multiple disjuncture and poor clarity of mandates that characterise the Nigeria MLG federal structure, are at the core of the discussion in the next chapter.

CHAPTER 8

DISCUSSION OF FINDINGS

8.1 INTRODUCTION

This study set out to better understand how Nigeria's federalism and decentralised multi-level governance (MLG) arrangements impacted on the development and implementation of health policies, using the policy processes of successive integrated maternal, neonatal and child health (IMNCH) policies and their implementation in two states as specific cases. The key guiding conceptual ideas and frameworks are fundamentally, understanding the Nigerian health system as a complex adaptive system (CAS), and within this, situating and viewing the challenges of federalism and decentralisation through a MLG lens. It contributes to the literature by taking a historical (rather than cross-sectional) perspective of how the federal decentralised structure in a MLG system in Nigeria has impacted on MNCH policy processes.

A key issue and common theme running through the findings, which will be elaborated on in this chapter, is inadequate collaboration, and at times contestation, across different levels of government (federal and states), despite the collaborative aspirations of the policy and programme designs. These happened for various reasons, key reason being the misalignments between the political and fiscal arrangements across the government levels within the overarching partially decentralised federal structure. Other reasons include inadequate stakeholder engagement across government levels, lack or insufficient intergovernmental legal frameworks and accountability mechanisms, frustrations of inadequate fiscal autonomy for health policy implementation at sub-national levels, especially the local governments (LGs), and inherent design flaws of the programmes, as elaborated on in Chapters 5–7.

In this chapter Emerson et al.'s Integrated Framework for Collaborative Governance Regime (Emerson et al., 2012) is used, to interrogate these factors in more detail,

starting from an understanding that federal systems (including Nigeria's) by their very nature are intended to work collaboratively across levels of government.

8.2 HOW COLLABORATIVE WAS THE IMNCH POLICY PROCESS?

We have earlier (Chapter 3), defined collaborative governance (CG), and in chapter 4, described the integrated CG framework (Emerson, 2018, Emerson et al., 2012), which will guide our discussion.

8.2.1 System context, drivers, and collaboration dynamics

Nigeria's federal decentralisation processes, prior to and after independence, have been detailed in Chapter 3. Here the identified key contextual issues and drivers and how they impacted the IMNCH policy processes, are discussed. System contexts include a multitude of factors. As Emerson et al. (2018) points out, in particular *"prior relationships and existing networks as well as the institutional context matter, as they shape opportunities and constraints, and influence if, how and when collaborative governance unfolds and operates"* (Emerson, 2018). Adapting the Emerson framework, the diagram below (Figure 8.1) is used to illustrate the different dimensions of system context (global, national, and sub-national) that shaped the IMNCH policy processes in Nigeria in the study period, followed by elaboration of these factors.

Global context

The initiating global context was the Millennium Development Goals (MDGs), followed by the Sustainable Development Goals (SDGs). At the beginning of the IMNCH Strategy, 2007, the country's poor MNCH indices, and their contribution to the global burden, informed the global push to pursue the MDGs in Nigeria to improve its MNCH indices. The 2005 World Health Assembly (WHA) and UN, clearly identified Nigeria as one of the countries whose MNCH was poor and stagnant (World Health Organization, 2005).

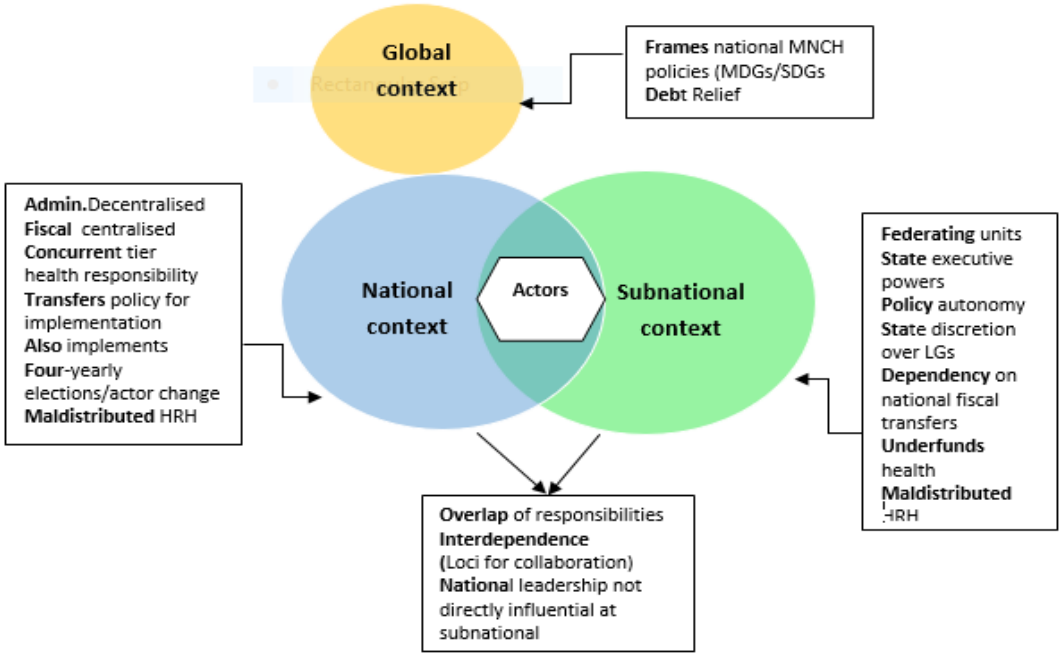


Figure 8.1: System context and drivers in the MNCH policy process

This pressure from the international community became the key driver of the desire in Nigeria to meet the MDGs, hence initiating the IMNCH Strategy process towards achieving the maternal and child MDGs (4 and 5).

Another international factor, which gave impetus for Nigeria to embark on this, was the international debt relief in 2005, linked to a commitment from Nigeria to improve its efforts towards achieving the MDGs and alleviating poverty (Centre for Global Development, 2006). Committing to the MDGs and acquiring the means to do so, were the two international influencers that were to kickstart the IMNCH Strategy process. Besides this encouragement from the global actors, there was no international prescription to Nigeria or other countries on how to navigate the task of achieving the MDGs, rather these were driven by the country contexts. During the latter stage of the policy processes, funding and technical support from the World Bank were the external drivers for the SOML PfR, the third study programme. This would be the first performance-based programme to be implemented nationally in all the states of the Federation, although performance-based designs have been noted not to be adequate drivers in weak health systems of LMICs, where other contextual constraints need to be surmounted (Miller and Babiarz, 2013, Singh et al., 2020).

National and sub-national context

The national and sub-national context will be discussed together due to overlaps as shown in Figure 13, highlighting level specific factors which drove or constrained the policy process. With the global push outlined above, the IMNCH Strategy was thought to be timely and was going to be appropriately situated within the ongoing national health sector reform (HSR) framework (FMoH, 2007), which was the key national driver at the time and formed a springboard for initiating the IMNCH Strategy. The background for the HSR initiative was firstly, Nigeria just coming out of decades of military rule in 1999 and going through multi-sectoral reforms under the democratic government; and secondly, at the turn of the millennium (2000), the declaration of the MDGs (FMoH, 2004a), as described in the detailed country context in Chapter 2.

Although the IMNCH Strategy was designed with a provision for states to adapt goals to their specific contexts, transferring the impetus and commitment to the MDGs in general, and to the MNCH in particular, at the national level, across the multi-government levels required the process to have strong incentives, a strong leadership and iterations of wide stakeholder engagement (Emerson, 2018). Prevalent system contexts at the beginning of a proposed collaboration can facilitate or constrain cooperation between stakeholders across organisations, but they are not linear substrates for initiating a CGR. Instead, they continuously and regularly shape and reshape policy contexts, and hence the collaboration dynamics.

A key driver across this study was the availability of dedicated funds to enable implementation of the first two programmes of the Strategy (MSS, SURE-P/MCH), albeit from different sources. However, disbursement and utilisation of these funds had to happen within the existing governance and political structures, some of which constrained programme intent. Lessons learnt from these meant funds were externally sought and earmarked for the third programme (SOML PfR).

Three key national and sub-national contextual issues directly interacted with the policy process interactions and collaborations. The first was the partial federal/decentralised structure, with a clash between the political and fiscal

arrangements. The central government disproportionately allocates fiscal and administrative responsibilities, such that, whilst the highest proportion of the revenues is held at the centre, the least funded LGs have the highest public sector primary health care responsibilities (as outlined in Chapter 2). The constitutional revenue allocation formula, whereby the national level retains more than half of the revenues (NBS, 2019), which are usually rents from oil, means that the 36 states, Federal Capital Territory (FCT), and 774 LGs are left with the other half, to implement a host of decentralised multi-sectoral responsibilities. The result is persistent underfunding and reduced capacity to meet certain responsibilities, especially in those states with low capacity to generate revenues internally (NBS, 2017, NBS, 2019). This mismatch between fiscal and administrative responsibilities does not only occur in Nigeria, but is common to other post-colonial LMICs, who still remain paternalistic and unwilling to share power with sub-national entities (Olowu, 2001, Olowu, 2003, Smoke, 2008, Suberu, 2009, Erk, 2014, Ssali, 2017). Ethiopia, though not colonised, is one of the big federations in the LMICs where this mismatch has also constrained the decentralisation processes (Tewfik, 2010, Assefa, 2015).

A second key issue that creates misalignments, is the arrangement of sub-national executive powers, which allows states to appropriate fiscal transfers as they see fit, and to adopt, re-shape or outrightly reject the implementation of national level policies. Sub-national executive powers potentially undermine the stewardship role of the national level for health (and other) policies. Following approval of the Strategy and Programmes on the National Council on Health (NCH) platform, the fragmentation of the existing MLG structure necessitated the signing of MOUs by the three government levels, but historically these steps in the health policy processes in Nigeria do not always translate to full sub-national implementation. Hence, only about a quarter of national policies find direct translation to sub-national implementation (Eboreime et al., 2017). However, this is not totally as a result of inadequate fiscal capacity to act, but due to lack of the will of states as federating units to shift their positions and willingly collaborate with the national level, on policies perceived as top-down – the findings of this study show that Ebonyi state (one of our study states) had elaborately implemented two state level MNCH policies (Chapter

6), as well as other states outside this study (Idris et al., 2013, Ossai and Uzochukwu, 2015, Ogbuabor and Onwujekwe, 2018).

A third factor hindering the collaborative governance processes, is the power of the state to hold on to the LG funds through the constitutional State Joint Local Government Account (SJLGA). This means that LGs receive funding for their responsibilities at the discretion of the states. Bearing in mind, as outlined in Chapter 2, that the LGs are responsible for PHC services which comprise the bulk of the MNCH services, which our study programmes intended to implement, the LGs had neither the administrative nor the fiscal capacity to implement these programmes independent of the national and state levels. In practice, this meant all three government levels were active in the implementation space at the LG level, with no clarity on the specific roles of each. Rather than fostering collaboration, this led to contestation, as will be discuss later in this chapter. The SJLGA has been a source of conflict and contestation across all sectors since its provision in the Constitution (Federal Republic of Nigeria, 1999), well before the MNCH Programmes. It has led to mistrust and a lack of synergy in the sub-national public administration, and several calls have been made for its amendment in the Constitution (Ugoh and Ukpere, 2012, Nwogwugwu and Olusesi, 2015, Ozohu-Suleiman and Chima, 2015, Oranekwu, 2017). The constitutional provisions for health as a concurrent responsibility of the three levels of government was an aspiration to collaboration, but without adequate mechanisms to mitigate the sub-national executive powers (Abimbola et al., 2015, Eboreime et al., 2017).

These contexts share similarities with India, which also has poor MNCH outcomes (also with wide interstate variations), also has a three tier (federal, state and LG) government system, and states and LGs act in line with national policies. Health is also a constitutional concurrent responsibility of the three tiers. However, given their persistent poor performance in health outcomes, in the last decade a national level policy sought amendments to empower the LGs for more active involvement in public health administration. States like Kerala and others, which have complied and taken steps to empower LGs and devolve funds and responsibilities to LGs, are reported to

have registered positive gains, while there has also been resistance from several other states to devolve funds to their LGs (Smith, 2014, John and Jacob, 2016).

The reverse was originally the case in Brazil, where fiscal decentralisation to sub-national government left the national government with funding deficits for its responsibilities, and consequently inflation, which persisted until the disjuncture were addressed through a constitutional amendment (Rosenn, 2004). Neither of these countries have managed to achieve optimal allocation of authorities to the different tiers of government that could foster adequate collaborative actions. Brazil still aspires to a cooperative federalism, but there remain challenges of inadequate fiscal and administrative capacities at the lowest tier (LGs). This means that 30 years after their Unified Health Policy, although there were regional improvements in health indices in the north-east (Svitone et al., 2000), policy outcomes have remained short of the intended goals, and inadequate fiscal capacity at the lower levels was one of the contributory factors (Santos, 2018, Ribeiro et al., 2018).

A key health system contextual factor which should have worked as a driver and incentive for collaboration, is the human resource for health (HRH) malalignments in the health sector. There is a north/south maldistribution of HRH, due to an absolute shortage in the northern part of the country. In addition, there is urban/rural and intergovernmental maldistribution. The latter is as a result of higher remuneration of nationally employed health workers than their counterparts in corresponding positions at the state and LG levels; and state remuneration higher than LGs (FMoH, 2009, FGoN, 2018b, FMoH, 2015). So, there was a clear and early recognition that the HRH issue had to be addressed first to facilitate programme implementation at the PHC (LG) level where the HRH crisis had most impact. The first programme, the MSS, for instance was reported to be the largest HRH programme in sub-Saharan Africa (Ohiri, 2012), but poor intergovernmental collaboration of the three tiers meant that the potential HRH gains of this programme were not harnessed. Instead, there were within programme staff attritions and lack of retention at the end of the programme (Abimbola et al., 2012a, Okoli et al., 2016, Okeke et al., 2017, Ikpeazu, 2018).

Cutting across all the government levels is the conditioning political context of four, yearly elections, and consequent change in actors, who are key in driving the aspired collaboration. Elections in the study period (2007, 2011 and 2015) came with change (or reshuffling) of actors, end of programmes, and initiation of new ones. Phased programme design and implementation were aligned with national election years, as captured in Chapter 5. Implications of this for programme scale-up were that programmes were either prioritised or shelved, depending on the interests and positions of incoming actors. In addition, existing cross-level collaborations, which were weak at best, were truncated, and new ones initiated with a change in government, and as a result, new collaborators, who needed time to familiarise themselves with the collaborative space.

Actors

Through these actors and their positions, the elements of leadership, shared incentives, interdependence, and shared uncertainties manifested in a proposed collaboration. *Leadership* is considered the first essential driver of a successful CGR. It *"refers to the presence of an identified leader who is in a position to initiate and help secure resources and support for a CGR"* (Emerson et al., 2012). In Chapters 5 and 7 it was shown how Prof. Lambo as the Minister of Health provided this leadership at the early initial stages of developing the Strategy, spanning the government boundaries. However, this momentum was not adequately sustained after the elections, as a new government came into power, and Prof. Lambo was replaced as Minister of Health. Furthermore, fragmentation of leadership between national and state levels emerged as a barrier to collaborative governance in the policy process. The misalignment of executive and fiscal authorities and its impact has already been mentioned in this chapter. The arrangement of executive and fiscal authorities at sub-national level further undermined leadership: the governor's extensive authority over budgets and finances meant that commissioners of health at state level had very little leverage to provide leadership and work collaboratively to develop and implement national MNCH policy initiatives. In addition, advocacy by national leaders to sub-national actors to mitigate this constraint was not always successful, as evidenced between Dr

Pate and the Governors' Forum, in the study. To get the governors' political and financial commitment to the implementation of SURE-P/MCH, Dr Pate made advocacy visits to the Governors' Forum, but as outlined in Chapter 6, these did not translate into the adoption of programme goals as they were intended.

Bold political leadership which facilitated collaboration across the entire government has been credited with the successful adoption of the universal coverage policy in Thailand (Carrin et al., 2008), the successful abolition of user fees in rural Zambia (Carrin et al., 2008, Gonani and Muula, 2015), and the reduction of the incidence and prevalence of HIV in Uganda (Parkhurst and Lush, 2004). In these cases, political leadership, like Prof. Lambo's, emanated from the national level, but was able to elicit collaboration across government levels. However, this is not always the case, as noted with Dr Pate, in this study findings. Other studies have also recognised that in some cases, leaders are not influential in other sectors or in organisations that are not familiar with them (Emerson and Gerlak, 2014, Bennett et al., 2018, Ramadass et al., 2018).

The contradictions between the above hierarchical forms of leadership and the goals of collaborative governance have been picked up by other authors. Bianchi et al. (2021), for example, argue about the importance of beginning to build the case for a model of leadership that is, *"...guided by a collective consciousness that results from learning in logic-of-practice distributed in self-organizing agents of complex adaptive systems like collaborative governance"* (Bianchi et al., 2021). This entails multiple leadership roles of the different thematic areas (science, resources, person power, etc,) within the collaboration (Emerson and Gerlak, 2014). Prof. Lambo's style of leadership was important and useful at the initiation of a policy process, as reported in the findings of this study, but to foster collaboration, authors note that distribution of leadership across jurisdictional levels, is more sustainable (Carrin et al., 2008, Emerson and Gerlak, 2014, Rasanathan et al., 2018), especially in LMICs (Nzinga et al., 2018). There are now global calls for LMICs to consider this form of leadership at the country level, to achieve the SDGs (Reddy et al., 2017, Marchant et al., 2020).

Poor MNCH indices, and external global pressures to meet the MDGs were the *incentives* at the onset. Positive incentives were availability of dedicated programme funds from different sources. These were shared incentives, which were hoped to foster cross-boundary collaboration, but which did not directly translate to the sub-national level in the same way. The challenge was that the sub-national level at the beginning was not directly incentivised by these funds since they were not earmarked for addressing MNCH, although this was then addressed in a new programme design, post the MDGs. Inadequate self-sustenance and fiscal dependency on the centre, which should also incentivise sub-national actors to collaborate with national actors, were disrupted by the sub-national power structure, where the governor could reset his/her priorities, and historically, health was not usually high on the agenda, as the study findings suggest (Chapter 6).

Where such barriers of different jurisdictional powers can be surmounted, collaboration has improved government initiatives. With rapid urbanisation in the last two decades, Indonesia quickly acknowledged the need to maintain cross-boundary collaboration in the face of full regional decentralisation, to cope with the emerging urban systems which spilled over boundaries. They embarked on different models of intergovernmental collaboration, driven by the varied regional contexts (Okitasari and Kidokoro, 2013). Authors have also found that multiple incentives (material and non-material) worked synergistically for positive results in a land and ecological conservation project in Taiwan (Tang and Tang, 2014); or were not adequate to foster collaborative actions for forest management in Nigeria (Fasona et al., 2019); and that funding as an incentive was central to the bottom-up collaboration in an environmental natural resource management project in Sweden (Eckerberg et al., 2015). Where collaboration is a mandate, rather than voluntary, the presence of adequate positive incentives become even more important in driving collaboration dynamics (An and Tang, 2020).

The fuzziness of the constitutional provisions of concurrent health care across the government requires some **interdependence**, but where the paternalistic national level can officially stray into the sub-national implementation space, and the sub-

national level can resist, within the existing structure, there is resultant contestation instead of collaboration, thereby fundamentally counteracting the functioning of the CGR. Studies have shown that interdependence directly correlates with positive collaboration outcomes (Ramadass et al., 2018). Fiscal centralisation and overdependency of the sub-national level on the centre, as seen in a number of LMICs, significantly skews the interdependence, resulting more in contestation (Oosterveer and Van Vliet, 2010, Kredo et al., 2017, Santos, 2018, Cavalcante et al., 2019), and various coping mechanisms (Frumence et al., 2014), than collaboration. Some LMICs have started addressing this through devolving health care administration to sub-national levels, as exemplified in India and Kenya (Smoke, 2008, John and Jacob, 2016, Tsofa et al., 2017b). The goals of the IMNCH Strategy were clear, which are using evidence-based and proven cost-effective interventions to improve MNCH. However, there were *uncertainties* about how to achieve the desired outcomes through a multi-level collaboration.

As stated earlier, Emerson et al. (2012) argues that the more these drivers are present and recognised by actors, the more successful a CGR (collaboration dynamics and collaborative actions) will become (Emerson et al., 2012). Actors' relationships and actions (and inactions) underpin collaboration dynamics (principled engagement, shared motivation, and joint capacity for action), and consequent collaborative actions. Figure 8.2 below is used to summarise the interactions between these elements, followed by elaboration of each element and the linkages with the study findings.

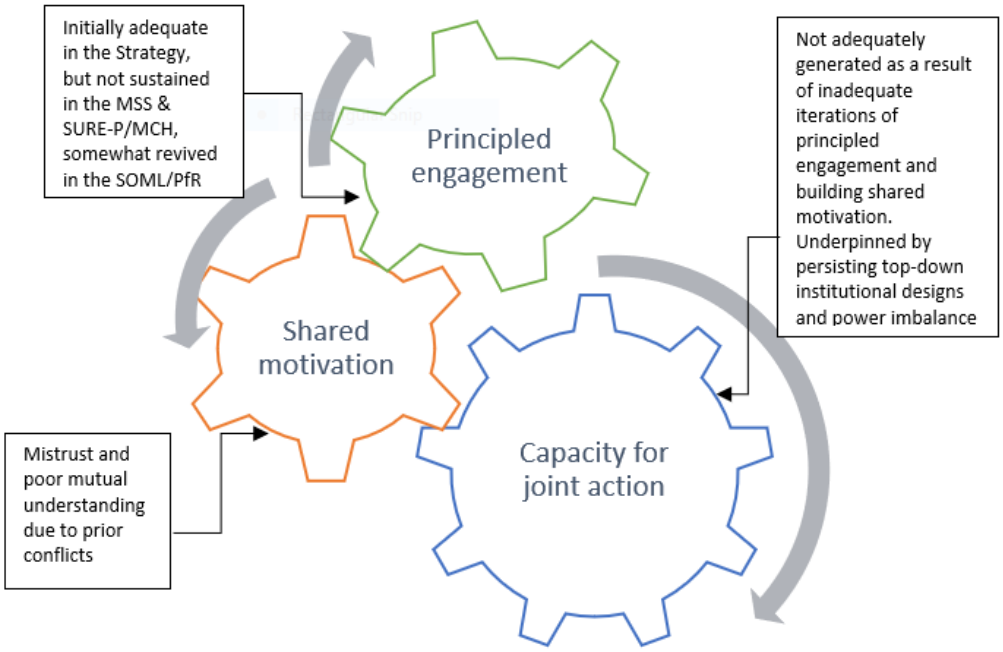


Figure 8.2: Collaboration dynamics identified from the IMNCH policy processes

Through principled engagement, people with differing content, relational, and identity goals work across their respective institutional, sectoral, or jurisdictional boundaries to solve problems, resolve conflicts, or create value (Emerson et al., 2012). This was positively achieved at the early stages of the Strategy development, during which there was an explicit attempt to achieve a balanced representation of relevant and significant interests across the levels of government. Prof. Lambo insisted on adequate and iterative engagement of all relevant stakeholders across the three government levels to enhance ownership and commitment to the IMNCH Strategy. The early successes of principled engagement enhanced the adoption of the Strategy and engagement of sub-national actors in pre-implementation activities of replicating Core Technical Committees (CTCs) in the states. However, beyond the parent Strategy, the iterations (e.g., across election cycles and changing actors) required for successful principled engagement, were not sustained with the MSS and SURE-P/MCH, due to reported time constraints in turning around these policies. Post-MDGs, and from lessons learnt, cross-level engagements were somewhat revived in the last programme design (SOML PfR), which incorporated sub-national engagement in the development of programme guidelines, as one of the performance indicators.

Other bodies of literature view issues of engagement through the lens of participatory policymaking, arguing that it requires that relevant stakeholders are all meaningfully and equitably involved in the various stages of the process in order to adequately focus on the problem and contribute to the tools and processes for implementing the policy (Wimmer et al., 2012, Boru et al., 2015, Helbig et al., 2015, Petkovic et al., 2020). Cross-boundary stakeholder engagement is fairly common practice now in developed countries, but it still faces the challenges of inadequate consultation, especially where there are systemic and cultural barriers (Alemanno, 2015, Hamilton et al., 2017, Hossain et al., 2018, Foster and Arnold, 2019). In LMICs, with already existing challenges of inadequate resources and other health system complexities, participatory policymaking becomes even more important, especially when policies are (or perceived as) top-down, and in policies that are transferred from one government level to another for implementation.

Inadequate stakeholder consultation is one of the reasons policies have remained weak in four LMICs – South Africa, Ghana, Zambia and Uganda (Omar et al., 2010). Inadequate engagement and lack of effective communication with stakeholders contributed to the implementation gaps in an MNCH policy introduced in Kenya in 2013 (Tama et al., 2018), whilst in another Kenyan study, early and adequate mapping and engagement of stakeholders led to collaboration and uptake of service referral protocols (Akwanalo et al., 2019). The degree of consultations during the design stage, and communication during implementation stages of health policies in Ghana and South Africa, were found to have influenced the policy outcomes (Ahuja et al., 2016).

Where principled engagement is successfully implemented, it can give rise to a shared motivation amongst stakeholders. The findings in this study reflect how adequate iterations of deliberations and determinations during the development of the parent Strategy resulted in an acceptable policy across government levels. There were iterations of different stages of the Strategy development. After development, time was taken to still pay advocacy visits to sub-national governments and obtain their commitment towards setting up state level implementation structures. The subsequent two programmes took a different path. In the MSS and SURE-P/MCH

Programmes, there was clearly a rush by national stakeholders to get into the implementation stages of these programmes, and feedback was not adequately incorporated in their designs.

Shared motivation is produced by a self-reinforcing cycle of the elements of mutual trust, understanding, legitimacy and commitment. Reneging on signed MOUs by sub-national actors may be because of prior lack of mutual trust, which in turn bred and reinforced further lack of trust, to the detriment of commitment to programme implementation as designed. When it came to the performance-based programme, sub-national actors probably did not trust the national level to pay them, hence their actions to ignore implementing performance-linked programme indicators. Emerson and Nabatchi (2015) argue that trust on three levels (individual, organisational and system) forms the basis for mutual understanding, which entails respecting the positions and interests of other stakeholders, even when not agreeable (Emerson and Nabatchi, 2015). Inadequate trust and mutual understanding are likely to be partly responsible for the level of actor contestations at interfaces (Chapter 7). It was noted that at key actor interfaces (national/sub-national; governor/MoH; national/state/health workers), aspired collaborations turned into contestations and resistance to programme components, key ones being recruitment and deployment of programme staff, identification of intervention facilities, and staff remuneration, during the MSS and SURE-P/MCH. Lack of shared motivation during the SOML PfR led to a total departure from programme intent by actors in both study states. Adequate shared motivation generates the capacity for joint action amongst collaborators.

Capacity for joint action, which did not exist before the onset of collaboration, is only attainable with adequate principled engagement of stakeholders towards a shared motivation. Given the poor sustainment of stakeholder engagement and lack of shared motivation, it is not surprising that joint capacity was also not adequately generated in the MNCH policy processes. This is because of the top-down institutional designs, malalignments in the federal structure, fragmented leadership, and uneven distribution of power and other resources at the sub-national level. Chapter 7 outlined

actor power practices at eight distinct interfaces (between national and sub-national actors) of which seven manifested as contestation, control, domination, and resistance; and non-confrontational discretionary power practice at one interface. These were all underpinned directly or indirectly by the existing governance and fiscal arrangements. Generating joint capacity for collaborative actions under these circumstances faced a high barrier.

8.2.2 Collaborative actions, outcomes, and adaptations

Collaborative actions are more likely to be implemented where collaboration dynamics are optimal and capacity for joint action adequately generated. They are those actions propelled by the CGR which could not have been achieved by the organisations acting alone. Collaborative actions may be carried out by all partners, their agents or individuals, but must have been agreed on by all participants in the CGR (Scott and Merton, 2021). Inadequate iterations of stakeholder engagement, insufficient trust building and shared decision-making, results in the absence of an explicit shared theory of action identified and agreed to by all partners.

The key potential collaborative actions in the MNCH policy processes were development and enactment of the policies, recruitment and deployment of programme staff and other resources, selection of programme facilities, remuneration of staff, and monitoring of programme activities. In contrast, these actions became contestational. Sub-national government did not remunerate the programme staff, for instance and the staff, in turn did not adhere to their programme responsibilities. After the parent Strategy development, subsequent policy approvals and signing of MOUs on the platform of the NCH by multi-level stakeholders, were the first collaborative actions and these were passive collaborations underpinned by a prior history of mistrust and domineering top-down power practices at actor interfaces. In the Whole of Society Approach (WoSA) Programme of the Western Cape province in South Africa, to address the social determinants of health, they quickly recognised the need to address the "long-standing mistrust between government and communities" through shared learning and distributed leaderships, amongst others (Schneider et al.,

2019). In the short-term these became important collaborative actions which lay the foundations for future positive collaborative outcomes.

More commonly, outside the health sector, high quality collaborations from different contexts have led to positive outcomes in water management (Scott and Merton, 2021), energy and environment (Clarke, 2017, Ulibarri, 2019, Fisher et al., 2020), despite complexities of the systems and costs of long-enduring institutional arrangements (Schoon and Cox, 2018). The inadequately collaborated designs of the MSS and SURE-P/MCH Programmes placed the national level government in the forefront of implementation but was not sustainable and encountered difficulties at the point of handing over ownership to states, since the initiatives did not have any accountability levers to foster adherence and lacked the constitutional powers to do so. Choice of programme intervention facilities for MSS and SURE-P/MCH, a potential collaborative activity, became a victim of a power struggle between state executives and national implementers, who should not have been implementing in the sub-national space, had the federal arrangements not been flawed. Both these programmes aspired to collaboration in their design, but in practice were more of a top-down coordination.

A similar experience occurred with Uganda's Environment Policy, which was participatory and user-focused in design, but in practice was mediated by the legal and administrative structures and procedures established for the implementation of nationally determined programmes (Brinkerhoff and Kamugasha, 1998). The process became complicated because,

> *"authority and resources were captured by either (or both) central or local actors, who had an interest in preventing them from reaching local governments, and/or because the design of local institutions and processes is frequently flawed''* (Wunsch 2001, p. 286).

The SOML PfR attempted to address these design flaws by incorporating incentives and sanctions directly, and competition across states indirectly. The SOML PfR involved the states in conceptualising core components and left the adaptable components at the discretion of the states (Damschroder et al., 2009), hence leaving

the states adequate space to prioritise implementation of their key health indicators in order to receive incentives. All these actions (and inactions) described in the study led to outcomes which were shy of the intended programme goals. Large inputs of human and financial resources in the MSS and SURE-P/MCH resulted in less than expected MNCH outcomes at the end these programmes, as outlined in Chapters 2 and 5. This feedback was partially responsible for the adaptation in the third programme to a results-based programme. The second reason was the external financial influence from the World bank, who favoured financing a performance-based programme.

Policy outcomes were far removed from intended goals: at the micro-level, staff were not adequately integrated and remunerated and not retained at the end of programmes. At a higher level, there were no appreciable improvements in MNCH and consequently MDGs were not met. Post the MDGs, based on identified outcomes and feedback of the MSS and SURE-P/MCH, and based on the external influence by the World Bank, a new, third programme design was embarked on, incorporating adaptations as noted above. Actors also changed with the elections (2015). Feedback from the MSS and SURE-P/MCH showed that existing structures were not optimal to foster the attainment of the MNCH policy goals. This contributed to a return to a certain level of collaboration across government levels in the development of the SOML PfR, as was seen in the early stages of the Strategy. There was also the unifying incentive of leveraging new funds from the World Bank for a performance-based programme. This later programme also aspired to shared learning and shared leadership, but was again constrained by sub-national governance complexities, and possible mistrust arising from prior contestations. These adaptations were reportedly partially triggered by feedback from the outcomes of the MSS and SURE-P/MCH and external stimulus from the World Bank, they were, however, not adequately guided by the collaboration heuristics, given that the sub-national executive powers were not adequately mobilised to commit to the programme in one of the study states. Efforts at controlling and containing the COVID-19 pandemic have also triggered adaptations to both intergovernmental and multi-sectoral collaborative governance (Megawati et al., 2020, FGoN, 2020).

8.2.3 Challenges of collaborative governance

The non-hierarchical structure of CG challenges the existing historical top-down structure in place in Nigeria. The sub-national executive powers further complicate this structure, as earlier outlined, leaving governance in permanent contestation.

The frequently high transactions costs of cross-boundary collaboration are another challenge:

> "*These include time, the costs of which correspond to the seniority of the parties involved, increasing as more powerful agents are required to resolve disputes; and the emotional costs of the frustration and distrust resulting from collaborating without certainty of the other parties' good will or without proof of their reliability to deliver*" (Scott and Merton, 2021).

The transaction costs of iterations of the collaboration dynamics in order to generate collaborative actions may be high in the short-term, but forms a strong foundation for sustained collaboration in the long-term (Schneider et al., 2019, Scott and Merton, 2021). Inefficiencies of time and coordination of large group sizes at times results in aspirational collaborations reverting to a hierarchical arrangement (Emerson, 2018, Bianchi et al., 2021).

Adaptation, a primary concern of complex systems, requires adaptive capacity or adaptability which "*can be seen as the ability of individuals and groups to respond to and shape change through learning and flexibility to maintain or improve a desirable state*"(Emerson and Gerlak, 2014). A key focus here is the poorly adapted collaborative leadership.

CG is even more challenging in LMICs as a result of weak social and political systems, hierarchical leadership and entrenched political patronage and corruption (Bennett et al., 2018, Emerson, 2018). In northern Ghana, there have been attempts for adaptive CG for climate change management, but these have been constrained by

> "*...interwoven governance challenges that include questions of trust, commitment, transparency, accountability and the representation of diverse interests...powerful state actors and NGOs set the agenda, frame problems, and implement rules and incentives that are contrary to the normative tenets of collaborative governance theory*" (Dapilah et al., 2021).

These challenges partly contribute to the lack of incentives to work across jurisdictional boundaries.

In summary, the aspirations of Nigeria's MLG to a collaborative MNCH policy process have not worked optimally because of the above challenges, which are a familiar scenario in other LMICs. The constitutional federal structure of Nigeria, as described, was already in place (since 1999), so intuitively, cross-level collaboration would be the aspiration, to bring about the mandates of the Strategy. Early stages of the Strategy development showcased significant collaboration across the government levels, but these were not adequately sustained with time. Within the vertical programme context, prior to the Strategy development, there had not been a prior history of cross-level stakeholder dialogues and deliberation, as was also identified as a constraint in Ethiopia's water management collaboration (Woldesenbet, 2020). Therefore, the level of collaboration initiated by the FMoH under the leadership of Prof. Lambo was new and needed iterations, which were not achieved.

In his discourse, focusing on CG in LMICs, Emerson (2018) suggests that,

> *"A reasonable reaction might be to turn back from the aspiration of collaborative governance and the higher bar of shared decision making and instead refocus on communication, coordination and cooperation – simpler, more straightforward approaches that keep the command and control systems in place, keep roles and responsibilities clear and reduce the messiness and risk of power sharing"* (Emerson, 2018).

These options and others will be explored in the next chapter, where this study is concluded and possible recommendations are made, for moving along the existing MLG design in Nigeria to a more collaborative and functional arrangement, or other measures in between, and areas for future research are also identified.

Reflections on the Integrated collaborative governance framework

The CG framework has proved a very useful tool in this study in understanding the nuances around the Nigerian governance structure and its impact on collaborative policy aspirations. Reflecting on the use of the CG framework for analysis in the Nigeria context and for that matter, other resource-limited settings or developing

countries, I would isolate fiscal capacity (funding sources, control) as a key driver, alongside leadership, rather than being subsumed under *incentives,* especially in countries with quasi-federal structures. In these contexts, also, transaction costs of collaboration may need to be prospectively determined at the early stages of policy making, especially where there is an explicit collaborative intent. A prior knowledge of transaction costs of collaboration will likely reduce uncertainties in a collaborative process. However, Emerson (2018), in recognition of health system weaknesses of developing countries also recommends mid-way approaches between top-down and collaborative approaches (Emerson, 2018) , as we see in the next chapter.

Strengths and Limitations of this study

A strength of this study was the qualitative nature which allowed for in-depth exploration and rich description of the process. Another was the scope of the study which allowed for a historical tracing of the case. Due to the long study period, a number of respondets had been in different roles and were in a position to discuss issues from different perspectives which provided a balance. Those respondents who had been in the same role for a larger part of the study period were able to give robust information as a result of their institutional memory and also provided a balance where there was recall bias.

Limitations and challenges of this study are as follows; some documents were incomplete or not freely available even after having obtained permission for access. Quality of data in some availble documents was also poor. However, this was mitigated by triangulating information from interviews iteratively. Interviews of respondents required travel to three different cities to meet respondents with some of them cancelling interviews and appointments were sometimes rescheduled multiple times. We also recognise that some key informants, especially those in government positions may want to provide only answers that portray the government positively. Respondents were continually assured that their information will be completely anonymised. These groups of respondents were also balanced with independent or retired respondents who no longer had this concern and were more reflective, hence reducing bias. The long time span of the study - a decade long and continuing reforms

in the overall health (and MNCH) policy environment made researching this phenomenom like "tracking a moving target"(Walt et al., 2008b). Capturing various actor elements (interests, position , level of power) and how they changed over the long duration of the study was also a challenge. Historical data collection and analysis of such a long span was a challenge due to recall bias, non-availability of earlier key actors, changing political actors. Hence there was the risk of taking a reductionist approach, however adequate saturation was reached in the interviews and reporting will additionally be done in series of papers in order to adequately report the study in-depth.

CHAPTER 9

CONCLUSION AND RECOMMENDATIONS

9.1 INTRODUCTION

The IMNCH Strategy was a positive paradigm shift, from fragmented vertical programmes, to a holistic and integrated approach towards delivering of evidence-based cost-effective interventions to improve MNCH. It was supposed to be an overarching strategy to strengthen and streamline existing MNCH interventions towards achieveing the maternal and child MDGs (4 and 5). These were not achieved at the end of the MDGs (2015), and hence have implications for the current SDGs in Nigeria. In this study, it is proposed that a better understanding of how the existing governance arrangements, where policies are made at the national level and transfered to sub-national level for implementation, will shed more light on possible reasons for the observed outcomes. It became clear that short of a federal constitutional amendment which addresses sub-national governance structure, ownership of health policies and adequate fiscal decentralisation, the other option was intergovernmental collaboration to bring about the mandates of concurrent policy responsibilities, and this was the aspiration of the IMNCH strategy, illustrated below(Figure9.1).

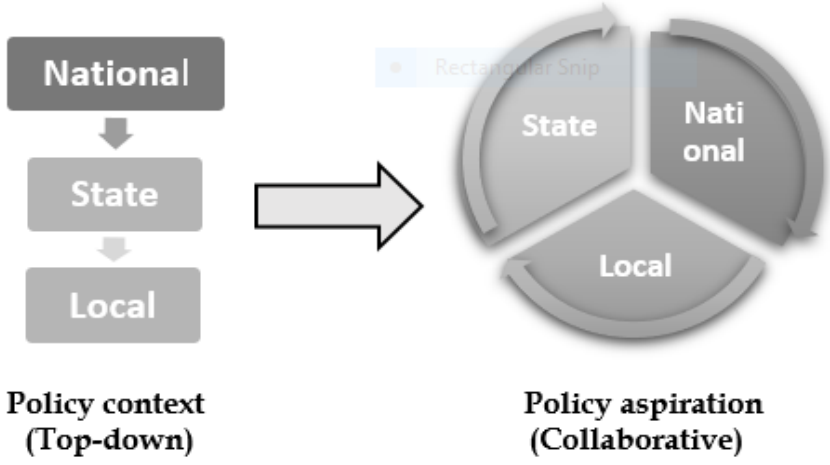


Figure 9.1: Policy context and policy aspirations of the IMNCH policies

New insights from the study have shown that the aspirational collaborative intent of the national level across jurisdictional boundaries was constrained by the governance arrangements and power imbalances across the three government tiers; partly due to a lack of the will to collaborate, and partly due to the high transaction costs of collaboration across government levels and between multiple actors. The two study cases (states) illustrated the complex contextual, political and path-dependent processes over the study period. Post-MDGs, despite a number of adaptations, these malalignments continue to plague MNCH policy implementation in particular, and health care delivery as a concurrent responsiblity of the government tiers, in general. The findings have shown that events that occured over the decade of MNCH policy formulation and implementation impacted on the implementation fidelity and consequently the outcomes. These included contextual changes in the political economy of the country and also changes within the programme contexts and content, at all government levels. Post-MDGs, MNCH has remained a priority on the national health agenda through advocacy efforts (Uzochukwu et al., 2020, Okeke et al., 2021), but the fundamental governance constraints remain, manifesting through various political and contextual factors, outlined in the discussion. Given that maternal and child health policy issues, even as as a national priority, do not guarantee implementation, there should be an initial refocus on the governance structure, as a recurring constraint.

Bianchi et al. (2021) envisage broad areas for future research and practice that can strengthen collaborative governance structures, some of which are relevant to the study and are outlined below:

- Dialogue and policy alignment between government levels,
- Reducing ambiguity, managing conflict, fostering trust, and legitimacy,
- Distribution of power and leadership roles, including local leadership which is paramount in collaborative governance involving local governments,

- Building up and deploying shared strategic resources, such as incentive systems, data, and knowledge to affect intermediate outcomes, and
- Turning collaborative governance evaluation from a discrete event to a continuous process, so to foster a learning-oriented approach in performance governance.

Some of these are explored below as recommendations and suggestions for future health policy and systems research and practice. Besides the above broad recommendations for effective collaboration, more specifically and based on findings from this study, we make the following recommendations.

9.2 RECOMMENDATIONS FOR FUTURE RESERACH, POLICY AND PRACTICE

9.2.1 Constitutional amendment considerations

A national constitution conference held in 2014 recommended that the local government areas (LGAs) be stripped of their status as the third tier of public administration and be constitutionally placed under full discretion of the states, however did not make any specific recommendation to delete LGAs from the sharing formula of the funds accruing to the Federation Account (FGoN, 2014a). Seven years on, these recommendations have not been given consideration for implementation. Even if and when implemented, it is unlikely to adequately mitigate the governance constraints highlighted in this study, the key being the sub-national executive powers in relation to policy processes. Another constitutional recommendation would be that health care be taken out of the concurrent list of responsibilities and fully devolved to the states, with the legitimacy to implement health policies residing at the state MoH, and incorporating adequate cross-level accountability and collaborative mechanisms backed by legal frameworks. This will also mean a more direct health care responsibility on the state governors. Barring these, we propose some interim recommendations below.

9.2.2 Economic and political reforms

Economic reforms: Given the high level of dependency of states on federal fiscal transfers, accountabilty levers like annual or bi-annual expenditure reporting requirements of the states by the national level could be instituted, through advocacy to the national legislature. A *political reform* to ensure that state governors conduct two yearly LG elections as stipulated instead of perpetually appointing caretaker chairmen as in Anambra state, could also be tied to the fiscal transfers. Diverse political representation in the state legislature would whittle down the executive powers of the governor.

9.2.3 Explicit mandates and distributed leadership for health care responsibility

Authors have noted that health care and other "wicked" problems of society cannot be restricted within one jurisdictional level or within one organisation, because "*they possess dynamic and complex characteristics, involving multi-level, multi-actor, and multi-sectoral challenges*"(Bianchi et al., 2021 p. 1), proposing that solutions to "wicked" and complex problems must be both collaborative and adaptive (Bianchi et al., 2021). However, where there are fuzzy boundaries of responsibilities, it is necessary to give clear mandates to the bodies involved. In Nigeria, it is proposed that this can happen in two ways.

First is, *further de-concentration* of health care responsibilities by the FMoH to the states, with the national level (FMoH) providing independent external evaluation and guidance only, using available collaboration dynamics, to be agreed between the two levels. Both options will bring the policy space down from the top into the policy adoption/commitment to act space (Figure 9.2), and will invariably impact on commitment to policy implementation decisions. This allows states to make context specific MNCH policies and appropriate financing policies to facilitate implementation.

To drive collaboration, leadership for MNCH services needs to be distributed both vertically and horizontally across LGs, and LG leaders empowered with resources and knowledge. At the state level, the commissioner for health should be given the explicit mandate of driving state level health policy making, and supervising the LG health

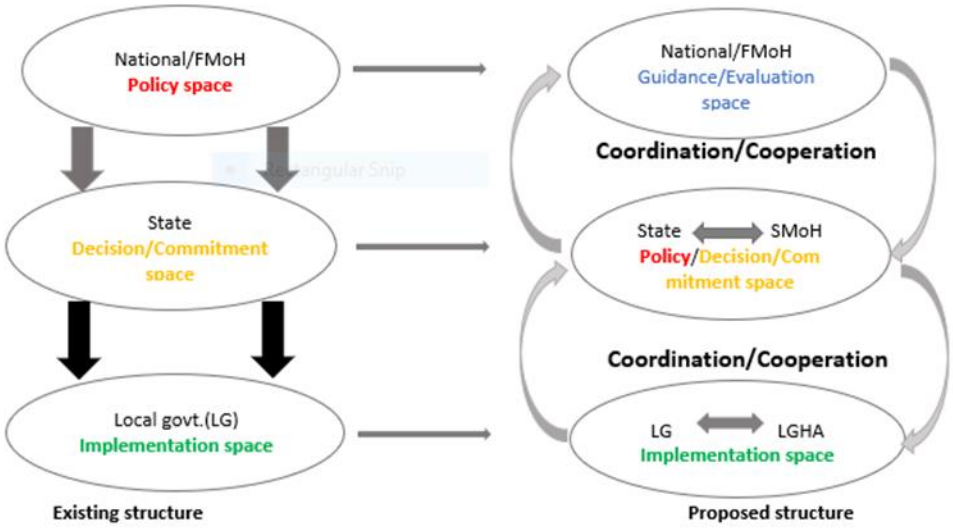


Figure 9.2: Proposed structure to enhance sub-national policy implementation

director who should be given the mandate for driving implementation. With the existing power structure , this requires *sustained advocacy* to the state governors, and in turn the LG chairmen. This will move the top-down hierachy to bi-directional vertical coordination and cooperation between the three governance levels, with similar horizontal relationships between the state executives and SMoH. This is hoped to, in turn, impact on the relationship between the LG executive and the local government health authority (LGHA).

Besides advocacy, other innovative ways of achieving a distributed leadership model where there is willingness on the part of the FMoH to cede this mandate (with matching resources) to the SMoH and the willingness of the state executive to expand the decision making authority of SMoH (amongst other sectors), require further evidence . Stakeholders need to be made aware of what other drivers are available to them for collaboration and what needs to be built within the system context.

This model will also need to take a critical look at the HRH. While there is now some form of sub-national re-centralisation of HRH at the states' Primary Health Care Development Agencies (SPHCDA) under the Primary Health Care Under One Roof Policy, the cross-level remuneration gaps also need to be addressed.

Domestication of the National Health Act (2014) by states, also requires strong and sustained advocacy to the state governors, since the Act provides for collaboration across the three levels of government, as earlier outlined in chapter 1.

These policy implications and recommendations are geared towards strengthening the key health system functions of interest in this study as outlined in Chapter 2– governance/leadership, health financing, and HRH.

Some authors see Coordination and Cooperation (Fig. 9.2), as perhaps serving as developmental precursors to later collaboration, whilst other authors (Keast, Brown and Mandell, 2007) see collaboration as actions performed together, and cooperation and coordination as information-sharing and planning together, but performing actions separately (Gray, 1989, Keast et al., 2007, Scott and Merton, 2021).

9.3 ALTERNATIVE OPTIONS TO COLLABORATION IN RESOURCE-CONSTRAINED SETTINGS

Having outlined the constraints of collaboration in LMICs and weak health systems, Emerson (2018), however, concludes that collaboration is a worthwhile experiment in LMICs, if the long-term benefits are deemed critical. He suggests that collaboration experiments can either be self-initiated, third party convened or externally mandated, and either take a longer view systems approach, a design approach or a leadership approach (Emerson, 2018).

This study has outlined the systems context and its impact on collaboration. It has also shown that leadership is critical for collaboration to successfully happen. It did not, however, explore avenues for instutionliasing collaboration, nor ways of mitigating existing collaboration barriers like transaction costs. With these in mind, a suggested area for further research is to include generating evidence for collaboration using either a design or leadership approach. Evidence also needs to be generated on the appropriate mechanisms of mediations that can adequately mobilise state executive powers.

To finally conclude this work, I reflect on its contribution to the academic literature in Nigeria, adding to previous discourses on Nigeria's federal decentralisation

misalignments in general (Banwo, 2012, Babalola, 2015, Babalola, 2017). As one of Africa's largest federations (Erk, 2014), transferable principles may provide additional lenses to the federalism issue in LMICs. In Nigeria's health sector specifically, this work contributes to previous studies (Abimbola et al., 2015, Eboreime et al., 2017, Eboreime et al., 2019), where shortcomings and less than expected health outcomes, programmes were observed to be linked to the existing governance arrangements. Internationally, it contributes to discussions and recommendations on adopting a collaborative governance structure for public health globally (Fierlbeck, 2010), especially in LMICs (Emerson, 2018). Further evidence will be useful to identify and understand health sector specific collaboration dynamics that are required to generate collaborative actions and outcomes.

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