



The District Health System in Enugu State, Nigeria: An analysis of policy development and implementation

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LIST OF ACRONYMS

CHEW	Community-based Health Extension Workers
DFID	Department for International Development
DHA	District Health Authority
DHB	District Health Board
DHS	District Health System
FGD	Focus Group Discussion
IDI	In-depth Interview
LGA	Local Government Area
LHA	Local Health Authority
MOH	Ministry of Health
PDPD	Policy Development and Planning Directorate
PHC	Primary Health Care
SHB	State Health Board
SMOH	State Ministry of Health
WHO	World Health Organization
UNICEF	United Nations Children's Fund

EXECUTIVE SUMMARY

The District Health System is a form of decentralization that was introduced in Enugu state, Nigeria, as a policy to reform the health sector through increasing its functionality, leading to improvements in the health status of the citizens. Past studies on such policies have had limited consideration for the underlying factors shaping policy design and implementation and their constraints to achievement. It is therefore important to investigate the policy development and implementation process of DHS so as to understand how and where these factors could impede or facilitate its successful implementation.

Two district health authorities were chosen as case studies, one politically marginalized and worse performing; the other, politically favoured and better performing. Information was collected through document review and in-depth interviews with state level policy makers and key actors including district/local level policy makers and implementers, and health workers. Focus Group Discussions were also held with community members.

The study revealed that the policy guidelines were developed by the state and technical team, and covered the re-organization of the district and state structures, donor investment in physical infrastructure improvement and training, and improved health worker availability. Cascaded supervision between the levels of state organization actors and additional supervision from donor technical team across levels was also evident; however, some key actors like the Local Government Areas were not involved in the policy development. Additionally, rhetorical political commitment was not translated into action as government did not pay its counterpart funding and did not employ enough staff to cope with the increased workload. Following the implementation of DHS, improved physical infrastructure, supervision and health worker availability was apparent although there were some differentials between district 1 and 2 and in favour of district 1, probably due to political influences.

The study concluded that the initiation of radical change within the health system in order to improve access to health care was enabled by a strong political and bureaucratic leadership, combined with considerable resource investment assisted by a donor agency. The study also demonstrated, however, that efforts should be made to engage important actors and political favouritism should be minimized in the design and implementation of new policies such as the DHS. Additionally, it was shown that without dedicated funding from government health system actors may be able to do little to support effective implementation.

1. INTRODUCTION

The District Health System (DHS) is a form of decentralization which was introduced in Enugu state, Nigeria, as a policy to reform the health sector through increasing its functionality, leading to an improvement in the poor health status of the citizens in the state. Health care reforms have been introduced globally with the objectives of improving the efficiency, equity and effectiveness of the health sector within a context of limited government resources and rapid demographic and technological changes (Berman and Bossert, 2000, Eriksson *et al*, 2001). Although health care reform is a global phenomenon, adopted reforms vary by country and region (Standing, 2002).

Decentralization was conceived as a strategy that could enable district development, community participation and inter-sectoral collaboration, and became closely associated with the Primary Health Care (PHC) approach (Green, 1992; Mills, 1990). Decentralisation has since become a major managerial reform in health services; however, in spite of the seemingly obvious advantages, progress towards decentralization is much slower in developing countries, such as Nigeria, than expected. The slow progress has two underlying causes: first, the ubiquitous reluctance of managers in centralised organisations to share or effectively delegate power to a lower level; second, the real or perceived incompetence of the district staff to take charge of hitherto centralized functions (Korte, 2004). Despite these problems, decentralization, as a policy strategy, has been implemented in many sub-Saharan countries in the last two decades as part of a wider process of political, economic and technical reforms (Owino and Korir, 1997).

Whilst decentralization programmes have received wide coverage and extensive theoretical support, decentralization does not automatically ensure welfare improvements. Moreover, it is possible that the decentralized health systems may have a more negative impact than centralized health systems. This is because decentralization may worsen vertical equity through reducing the redistributive powers of central governments and, therefore, the overall level of transfers from richer to poorer jurisdictions (World Bank, 2000; Dillinger, 1999). Several authors have argued that decentralized systems, particularly those without well-functioning democratic systems or mechanisms for community representation, could decrease welfare if they are associated with a higher degree of corruption or 'leakage' of resources than centralised systems (Akin *et al*, 2005).

Decentralization strategies, such as the DHS, aim to improve health system performance; however, there are various challenges to success. The implementation of DHS relies on the human capacity of the health systems and can therefore be affected by power struggles amongst the key actors, non-compliance of health staff with the new policy and system, or a sub-optimal number of skilled staff to face the emerging challenges in healthcare delivery. Similarly, some authors (Tanzi, 1996; Dillinger, 1999) have noted that even when local decision-makers are well meaning, they may lack the technical competence to make appropriate decisions, thereby reducing the supply and effectiveness of government health services. Further challenges can include the need for adequate finances and appropriate health system infrastructure (Hardee and Smith, 2000).

Past studies on such policies have given limited consideration to the underlying factors shaping policy design and implementation, and enabling or constraining their achievements. Several studies have highlighted some of the potentially negative influences over implementation, including: manipulation of the policy to favour more influential actors (Amaghionye and Osinubi, 2004); and stigmatization or dismissal of intended beneficiaries by health care workers who may react against the burdens placed on them by new policies (Walker and Gilson, 2004).

Through investigating the policy development and implementation process of DHS so as to understand the underlying factors that could impede or facilitate its successful implementation, this research aims to help progress previous studies, as well as providing a basis for new thinking around how policy and implementation managers might 'do things differently' and how the end users will perceive such policies.

2. RESEARCH QUESTIONS

The specific research objectives considered in this study are:

1. What factors amongst policy makers, public sector healthcare providers and community members, have influenced the development and implementation of the DHS, and its pro-poor orientation, including the level of co-ordination in policy making and implementation?
2. What are the perceptions and acceptability of the DHS by Program managers and health workers?
3. Who is doing what types of monitoring and supervision within the DHS?
4. Has resource use and allocation, and staff recruitment and posting been done according to how the policy was intended?
5. Do key actors perceive that health workers' performance has changed as a result of the DHS?
6. What are the differences in experiences of implementation of DHS in two sites judged by health managers as performing differently?
7. How can answers to questions 1 to 6 be used to improve the implementation of the DHS in Enugu state in a way that will preferentially benefit the poorest people?

3. OVERVIEW OF THE DISTRICT HEALTH SYSTEM IN ENUGU STATE

The Enugu DHS delivers healthcare services to a defined population within a geographical area (varying in size from 160,000 – 600,000) and through various categories of health facilities. The policy is delivered under a structured management system (the district health management team) which integrates the primary and secondary levels of healthcare. This structure was intended to eliminate the duplications/parallel service provisions and inefficiencies of the old stratified healthcare system through ensuring a functional referral system between the three levels of care, thereby increasing efficiency and equity in healthcare provision and utilization (SMOH, 2004) Enhanced community involvement in planning and implementation is a further key element of the DHS, leading to a level of community accountability in the implementation.

The DHS system includes exemptions from payment of user fees. Through introducing and upgrading district hospitals within specified geographic areas, the DHS is designed to decentralize high level health services, providing a well equipped secondary healthcare facility within each district. This means that consumers will not need to travel long distances to receive adequate and good quality healthcare, therefore improving equity of access. The policy also seeks to eliminate poor staff attendance to work and performance, and improve staff motivation, and the improved healthcare infrastructure aims to provide a conducive environment for health workers, helping to improve staff motivation and work performance.

The DHS comprises of the following categories of health care facilities under each District Health Authority (DHA): health post; health clinic; community health centres; cottage hospital; and district hospital with a tertiary hospital as an apex referral centre for the state. In the existing structure, the apex state tertiary health facility is the Enugu State University Teaching Hospital at Park Lane, Enugu with a reference model laboratory. The district hospital is linked to and controls all the primary healthcare centres and cottage hospitals within the district so as to ensure that each health facility is focused on health service appropriate to their resources, capacity and role. The district hospital also serves as the focus of its secondary care and as a referral centre. As a minimum standard, the district hospital should contain, six departments including: Medicine, Surgery, Obstetrics and Gynaecology, Paediatrics, Diagnostic Services (X-ray and laboratory) and Pharmacy.

For effective coordination, control and accountability, four layers of authority were created: the Policy Development and Planning Directorate (PDPD); the State Health Board (SHB), District Health Board (DHB) and the Local Health Authority (LHA). Their functions and membership are as shown in table 1 below.

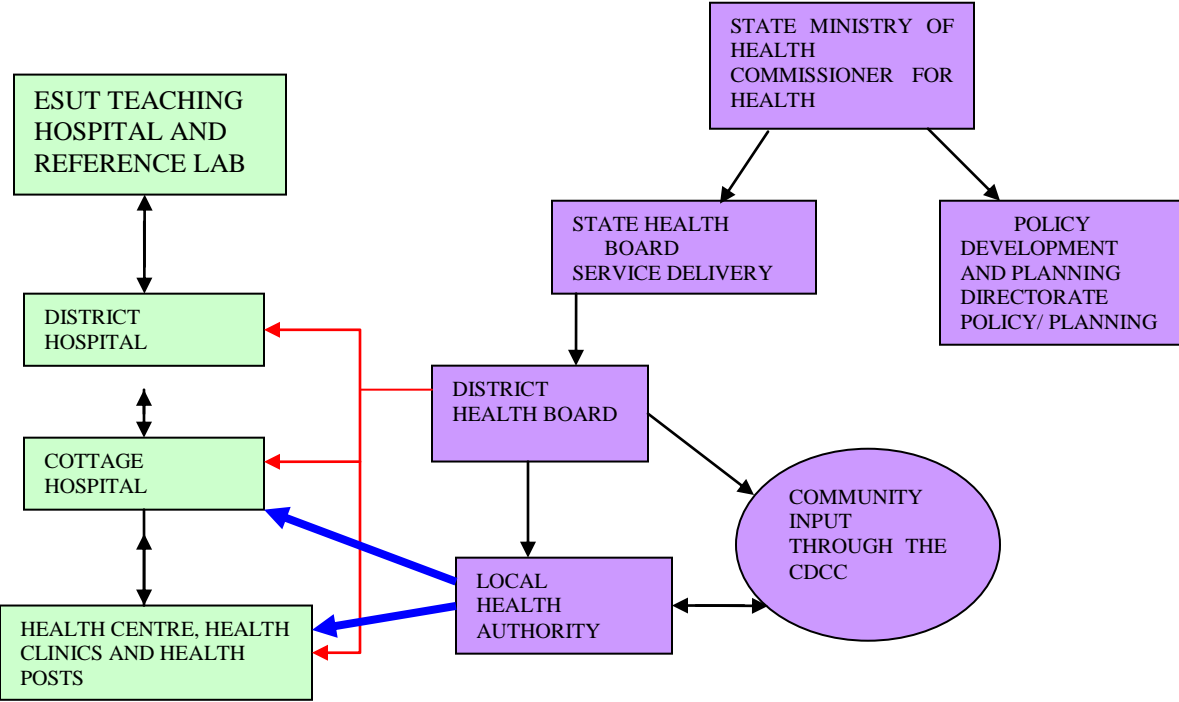
Table 1: Layers of authority in the District Health System

	Membership	Function
Policy Development and Planning Directorate	<ul style="list-style-type: none"> • The Permanent secretary • Directors of Medical Services Nursing, Finance, Planning, Research and Statistics, Public Health services, Administration and Supply and Pharmaceutical Services 	<ul style="list-style-type: none"> • Develop major strategic health policies and plans for the state • Develop major operational management policies relating to financial, Human Resources and Commodity management. Quality assurance
State Health Board	<ul style="list-style-type: none"> • The Chairman, • Health Administrator • Directors of Medical Services Public Health, nursing Services, Financial Services, health Management Information Services, Human Resources • A representative from the Local Government Services Commissioner • A representative from the Community Development Coordinating committee • Three other members appointed from the private Sector 	<ul style="list-style-type: none"> • Oversee the performance of each District Health Board • Review and assess any income generating mechanisms developed within the DHS • Review disciplinary measures taken by a DHB • Determine financial management and reporting requirements for each DHB • Ensure the delivery of health services through the DHS • Supervise the DHBs to keep Bank accounts by the implementing facilities • Oversee the implementation of the State health Plan • Improve professional capacity in monitoring and evaluation throughout the DHBs
District health board	<ul style="list-style-type: none"> • The Chairman, • Medical Officer, Nursing officer, Community mobilization officer, Financial officer, Human resources and Logistic officer Public health officer • Health supervisors - appointed by the commissioner from each LGA in the District 	<ul style="list-style-type: none"> • Manage / control and operate the health services • Ensure access to health services • Manage financial resources effectively and with probity; • Promote the efficiency of and advancement of health workers through in-service and continuing education • Determine charges for health services rendered by the district • Ensure regular supply as well as proper preservation and use of drugs and other equipment provided for health services in the district

Local Health Authority	<ul style="list-style-type: none"> • A medical doctor with at least 3 years work experience; , • Head of the Health Department of the LGA, • Medical doctor, nurse and pharmacist deployed from the DHB and working in the secondary health care facility in the LGA, • Local Immunization manager of LGA, • Traditional ruler within the LGA, • One person from any religious body within the LGA 	<ul style="list-style-type: none"> • Manage/ control and operate health services • Ensure access to health services; • Provide equitably distributed health facilities in the LGA; • Manage the assets and property of the local government • Determine charges for health services rendered by the LGA; • Ensure that effective community mobilization and appropriate communication and programmes are in place; • Perform any other function that is relevant , protection and restoration of health in the local government
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As noted above, the integration of primary, secondary and tertiary health care system creates a network of health facilities within the state. The functional links of the DHS management structure with public-sector health providers in the state is illustrated in figure 1. There is, however, still no direct link of private service providers to the DHS.

Figure 1: Schematic representation of the functional links of the component levels of the DHS and the referral mechanisms of the facilities within the DHS



Contributions from PATHS have supported the implementation of the DHS in Enugu State. PATHS management committed the sum of £800,000 (184,000,000 Naira) as initial seed money to directly support the Enugu health sector reform project. This amount is more than 10% of the Enugu state health budget; and is outside of the technical and other supports that have been/are provided directly by PATHS. The rehabilitated hospitals and health centres took delivery of drugs and equipment worth £600,000 (138,000,000 Naira) procured by PATHS in the first instalment.

The intervention of PATHS in the Enugu State DHS is said to have supported capacity building in the health sector, as well as enabling the renovation of hospitals and provision of drugs and equipment. All the district hospitals and the 21 early bird PHC centres have now been rehabilitated. These hospitals and health centres are said to have taken delivery of good quality drugs and equipment including emergency obstetric care kit that will address the problem of high maternal mortality rate in the state. The Park Lane Specialist Hospital has also undergone unprecedented transformation in line with the new direction of healthcare delivery.

4. METHODOLOGY

4.1. Study area

This study covers Enugu state, south east Nigeria, which has an estimated population of about 3,257,298 (NPC, 2006). There are seventeen LGAs in Enugu State which are officially recognized by the federal government, as well as development council areas created by the state. Five of the LGAs are largely urban. The state is divided into seven health districts for the purpose of healthcare delivery system; each health district is made up of between one to three LGAs. Within Enugu State, there are six district hospitals, 36 cottage hospitals and 366 primary health care centres, including comprehensive health centres, health centres, and health posts. There are also approximately 700 private health facilities comprising of non-profit and profit making facilities, and faith-based facilities.

4.2. Study design

The study involved an initial set of data collection activities at the state level, followed by data collection in two districts selected as local level case study sites.

State level data collection activities:

Initial state level activities included obtaining support for the study from Ministry of Health officials and the collation of data on DHS initiation and development.

Case study selection and data collection activities:

Two communities from two DHA were selected for inclusion in this study. One more (District 1) and one less (District 2) successful DHS site were chosen, with scheme success judged by State level DHS managers. These managers were asked to indicate the districts where the scheme has been more successful and those that have been less successful. Out of the 7 districts, 3 were judged to be successful and 4 not so successful. The managers reported that judgement was based on availability of personnel and equipment, the level of infrastructural renovation and community participation after DHS implementation. From the list of 3 successful and 4 not successful districts, one district each was chosen by simple random sampling.

The two study sites are of the same socio-economic level and about the same distance from the state capital. All the public health facilities within the DHS in each district were included in the study. While District 1 is made up of 2 LGAs with 3 development areas, District 2 has 2 LGAs with 4 development areas .

4.3. Data collection

Document review:

To understand the factors that have enabled or constrained the planning and implementation of the DHS by the policy makers, the following documents were reviewed: the DHS policy document; the legal framework for the DHS; the Enugu state health situation report; grey literatures on the DHS in Enugu State; and agreement documents (Memorandum of Understanding) between the drivers of DHS and Enugu State. These reviews provided a basis for assessing the interview materials and other data collected in order to establish whether the intentions of each element are being met in practice.

In-depth interview (IDIs):

In-depth interviews (IDIs) were conducted with 21 policy makers to identify the factors that have enabled or constrained the planning and implementation of the DHS by the policy makers.

In order to understand the perceptions and acceptability of the DHS by the Programme managers, health workers and community members, including the change in power and responsibility within the health system, the IDI guide was also used to collect information from 12 Programme managers, 9 health workers per site, and 2 health facility committee members per site.

FGD:

Focus Group Discussions (FGDs) were also held with members of 6 purposively selected catchment villages within each health district. Two villages were selected from the community where the district hospital is located; two villages located relatively near to the district hospital; and a final two villages from communities considered far from the district hospital. Two FGDs were conducted in each of the catchment villages; one for women of childbearing age and one for men. They were 9–10 members in each FGD, purposively selected with the help of the village heads. Each FGD lasted between 60 and 75 minutes, and a discussion guide was used to direct the dialogue which was moderated by a sociologist, assisted by a research assistant. In total, 12 FGDs were conducted per site.

The FGDs were used to assess consumers' perceptions of workforce performance before and after the introduction of the DHS. They were also used to examine the extent that the DHS is beneficial to the poorest groups.

Observations:

Using a check list prepared by the research team, the level of hospital infrastructural renovation was observed.

4.4. Data Analysis

The IDIs and FGDs were all transcribed verbatim, including the notes and background information on the transcripts. Thereafter, the transcripts were coded using codes reflecting the various study objectives.

State and case study data were analysed independently of each other as each set of data reflected different experiences. Data from each case study was also analysed separately and case study experiences were then compared and contrasted. Within each set of data, there was triangulation across interviews, and then between interview data, document reviews and household survey data, as relevant. This approach allowed identification of both similarities and differences in views and experiences, and supported investigation of explanations for key differences.

5. FINDINGS

5.1 The context of District Health System development

5.1.1 Political context and structure

Enugu State is located in the south eastern part of Nigeria and is one of the 36 states of the federation. At the head of the political structure is the governor who is usually elected by the people. The governor is the Chief Executive Officer and Chief Security Officer of the state, and forms the government by appointing executive members, usually political party loyalists or individuals recommended by other party stalwarts. In some cases this appointment could be based on geographical consideration, experience and competence. The governor also appoints special assistants and permanent secretaries of different ministries who work with him. The executive council meets once a week to discuss matters of the state and is made up of the commissioners in the different ministries, personal assistants and the secretary to the governor.

State Assembly members are the lawmakers of the state and have the power to approve budgets and important appointments in the state. The State Assembly members are also elected from different constituencies in the state.

The State is made up of three senatorial districts, 7 districts and 17 LGAs, as well as 56 Development Centres created from the existing legally recognized LGAs. Each LGA has a chairman who is usually elected at general elections and councillors from different wards who are the law makers of the LGA.

5.1.2 Health system overview

Health is on the concurrent list in Nigeria. This means that both the state, local government and the federal government have responsibility for the provision of different health care services to its citizenry. As such, Enugu's state government has the constitutional authority to initiate health policy, although this must be in accordance with the country's general health policy plan.

There are a wide range of health care providers in Nigeria including private, public, non-governmental, mission and traditional health care providers. The state government has three channels through which it provides health care services to the people: primary health care; secondary health care (district hospital); and tertiary health care (teaching hospital with specialist doctors where complicated cases can be referred). The state also has a school of health technology where semi-skilled health staff are trained Community Health Extension Workers (CHEW). The local governments are responsible for the provision of primary care.

Prior to the election of the new democratic government in 1999, the healthcare delivery system in Enugu State was ineffective, inefficient and inequitable, leading to poor health status of the people (SMOH, 2004). As in other parts of Nigeria, there was no joint planning between state and local governments and, therefore, service delivery was fragmented with weak or non-existent referral mechanisms between the health centres and the hospitals. There was also poor management of available resources and the system was centralized with minimal local or community level input into decision making processes.

In terms of resources, inefficient provision was caused by inadequate numbers of skilled staff, as well as uneven staff availability and distribution. An over-concentration of healthcare workers in the urban areas impacted negatively on the rural areas where more than 70% of the population resides, most of whom are very poor. Furthermore, the centralized healthcare system did not allow for the effective monitoring and supervision of healthcare workers, especially those located in the rural areas. As a result, most of the healthcare workers were hardly seen in their duty posts and, even when present at work, often left early to attend to their personal needs.

The health infrastructure, especially in the Primary Healthcare Centres, was in a state of neglect and dilapidation (SMOH, 2004). This led to inequity in access and generally low levels of health care utilisation: the cost of healthcare was increased as those in more remote locations, often the poor, had to travel great distances to access good quality healthcare services. Further difficulties were presented by an unavailability of most essential drugs at health facilities, partly due to the centralization of the drug distribution system.

Not surprisingly, therefore, the health indicators of Enugu State, as with those of the country at large, were generally poor. For instance, Nigeria was ranked 187th of the 191 UN members states in the year 2000 (WHO, 2002), and infant and maternal mortality remain one of the highest in Africa. Specifically, these characteristics manifested in the following poor health indicators for Enugu State (2004):

- Infant mortality rate 110 per 1000 live birth
- Under-five mortality rate 170 per 1000 children
- Maternal mortality rate 144 per 10, 000
- Crude death rate 18 per 1000 population
- Crude birth rate 45 per 1000 population
- Life Expectancy at birth 51 years
- Total fertility rate 5.6
- Rate of population growth 2.85%

5.2. Policy Development

Table 2 shows the timeline for the policy development of DHS from conceptualization stage to the time the case study was conducted. It details the important events that occurred in the process of DHS development.

Table 2: Timeline narrative of policy development of DHS

Year	Event	Political context
June 2003	Conceptualization of the DHS by the Governor of the state.	Enugu State Governor elected into political office after the 1999 general election where he completed his four year term and was re-elected in 2003.
October, 2003	DHS became part of the Enugu State Health Policy.	This was based on the identified strategic directions contained in the State Economic Empowerment and Development Strategy(SEED) document
Late 2003	PATHS provided the necessary technical assistance and expertise for the development of the DHS approach to health care.	The development of the DHS framework took the particular context of the state into account.
July 2004	Development of the DHS legal framework.	
Early August 2004	Governor approved governance structure and the constituents bodies of the DHS (PDPD, SHB, 7 DHBs and 56 LHAs)	
Late August, 2004	Starting of the first Ministry of Health (MOH) business plan.	
September 21, 2004	The various bodies of the DHS inaugurated by the Governor.	

October 2004 – July 2005	DHS Bill submitted to the house of assembly and debated.	
July 2005	The State House of Assembly signed the bill into law.	
August 2005	The Governor signed the bill into law.	
	Infrastructural development and posting of two medical doctors in 2005, and one in 2007, then a theatre nurse posted in 2005 and two cleaners in 2006	
November 2006 to February 2007	Current study undertaken.	

A general election was held in Nigeria in 1999, ushering in democratic rule after a long history of military rule. A governor of Enugu State was elected that same year to take over the leadership of Enugu State for four years. In 2003, another general election was held and the then State Governor was also re-elected to handle the affairs of the state for a further four years.

In order to develop a new vision for the state health system, a range of policy and systems reviews and assessments were conducted across the State. The political commitment and active participation and support of the State Governor provided the overall drive for reform.

In October 2003, the state health council sat down in a meeting which was held over a 4- day period, and attended by private and public health service providers, as well as all other stakeholders, including donor agencies involved in health services in the state, such as UNICEF and WHO, and some allied institutions. The Enugu State Council on Health recommended the DHS as a framework for reforming the health sector through improving its functionality and providing a vehicle for addressing the poor health status of the citizens in the state. This policy was officially adopted as the central plank of its healthcare reform process by the state government in January 2004.

Following the State Council decision, the Partnership for Transforming Health Systems (PATHS), an initiative of the British Department for International Development (DfID), was requested to help the state develop its concept of DHS. Their work has included: the framing of the legislation required to introduce the DHS; extensive capacity building for 776 members of the constituent bodies to orientate them to their revised roles and responsibilities; design, development and implementation of the underpinning systems for financial management, human resource management, health management information and drug revolving funds; development of business plans and budgets for each of the constituent bodies and the working interfaces between them; strengthening the new management lines of accountability and a study tour to learn from the Ghana DHS (SMOH 2008). PATHS management also committed the sum of £800,000 (184,000,000 Naira) as initial seed money to directly support the Enugu health sector reform project. Although more than 10% of the Enugu state health budget, this money is additional to the technical and other supports that have are provided directly by PATHS.

Since 2003, the system has been through several stages of development and is now being implemented in the state. According to one of the policy makers interviewed,

“We had discussions amongst us here at the Ministry of Health with PATHS Consultants, and after that we had a workshop where we invited stakeholders, Private healthcare providers and then sought their inputs after which we looked at the entire thing and finally came up with a document. So I can say three or four stages these consultations took place because we felt whatever document or service we are giving we should seek the opinion of the stake holders let it not be a one sided affair. It is also important because they use the service and they know what and what input they should make that would help the policy become effective whenever it is out. So we think it is important to seek their opinion in order to

come out with a policy that can be implemented for the benefit of all" (Interview with a policy maker at the Ministry of Health, Enugu).

In July 2004, the legal frame work of DHS was developed, including the delineation of the roles and responsibilities of the range of new structures (see earlier section xx). In early August 2004, these structures were approved by the Governor and, in late August, the first ever Business Plan of the Ministry of Health was developed, providing the impetus for the launch of the DHS in Enugu State. The various bodies of the DHS (PDPD, SHB, DHB, and LHA) were inaugurated by the Governor in late September 2004. The Commissioner for Health, with the Governor's prior written approval, established a DHB for each of the health districts to provide health care services for its local population. Between July and December 2005, infrastructural development of the health facilities took place.

In July 2005 the State House of Assembly signed the Bill establishing the DHS into law. The bill was signed into law by the Governor of the State in August 2005, thus establishing the DHS Policy document as a legally binding working tool for health care delivery system in the State.

The implementation of the Enugu State DHS started in November 2005, and occurred in the seven designated health districts across the entire State, with initial implementation efforts focused on 21 PHC facilities within these. These 21 facilities, as the first to benefit from the infrastructural renovation, were designated "early bird clinics", with a further 35 facilities spread across the seven health districts identified for the next phase of renovation.

At the date of case study, all the district hospitals and the 21 early bird PHC centres had been rehabilitated. These hospitals and health centres are said to have taken delivery of good quality drugs and equipment, including an emergency obstetric care kit which will address the problem of high maternal mortality rate in the state. The Park Lane Specialist Hospital had also undergone unprecedented transformation in line with the new direction of healthcare delivery.

5.3. Implementation Experiences

Case studies (District 1 and 2):

Programme Managers' views of the DHS' influence over the health system

Interviews with the Programme Managers revealed the state of health care delivery in Enugu State prior to the DHS. Health care was said to be characterized by a number of problems, these being: the unavailability of health workers; inadequate monitoring and supervision of staff; dilapidated infrastructures; and minimal drug supplies and equipment, with Out – of –stock ("OS") a common term within government health facilities. The interviews also revealed that there was no exception to this standard across the government's primary health care and secondary health care facilities, and this resulted in patient patronage becoming low in government hospitals, and tending towards the private hospitals which offered better services.

Table 3 presents Programme Managers' perceptions of the health system situation over time. It also shows that respondents gave the impression that there had been perhaps less improvement in District 2, in comparison to District 1, in terms of monitoring and supervision, health worker availability, renovations and utilization levels.

Table 3: Key experiences in the old and new health systems

Features	Old System District 1 and 2	New System (DHS) District 1	New system (DHS) District 2
Supervision /monitoring	<ul style="list-style-type: none"> Supervision minimal and irregular 	<ul style="list-style-type: none"> Improved supervision which was more 	<ul style="list-style-type: none"> Improved supervision but less regular

		regular	
Building /Renovation	<ul style="list-style-type: none"> • Dilapidated buildings • No fence 	<ul style="list-style-type: none"> • Proper renovation and fencing of the hospital premises 	<ul style="list-style-type: none"> • Renovation of some buildings and fencing of hospital premises • A functional borehole
Health worker availability	<ul style="list-style-type: none"> • Unavailability of health workers • Poor attendance 	<ul style="list-style-type: none"> • Availability of health workers though not enough • Improved attendance to work 	<ul style="list-style-type: none"> • Unavailability of health workers • Poor attendance to work
Drug Supplies/ equipment	<ul style="list-style-type: none"> • Always out –of-stock syndrome • Less equipment 	<ul style="list-style-type: none"> • There is availability of drugs • More available equipment 	<ul style="list-style-type: none"> • There is drug supply • Equipment availability a little better
Patients patronage	<ul style="list-style-type: none"> • Very low 	<ul style="list-style-type: none"> • Patients patronage high 	<ul style="list-style-type: none"> • Patients patronage high

The perceived improvements are seen as having resulted from the restructuring of the health care delivery system, the capacity development of human resources, regular monitoring and supervision of health facilities, and the State Government's increased commitment to the health sector.

Renovation of infrastructure: observation

The state of renovation in each site outlined in Table 3 was confirmed by observations made during the study.

A number of positive measures were observed, including the renovation and painting of all the buildings in District 1 Hospital and ongoing progress on the fencing of the premises at the time of visit. The hospital was well equipped by both UNICEF and PATHS; and, whilst the existing generator had broken down, a group carrying out research on drug trials and using the District Hospital as a sentinel study site had provided the one which was functioning at the time of the study. Similarly, another generator seen parked in the hospital premises was said to belong to the UNICEF, who wanted to use the hospital as a HIV test and counselling centre. A borehole was observed; however, this was not functioning.

The improvements were not as consistent in the District 2 Hospital although some positive changes were observed including a functioning borehole; commencement of fencing of the hospital; and the provision of twenty beds by PATHS and a further eight by UNICEF. Only four of about 7 buildings in the hospital, however, were properly renovated and painted at the time of the study; the other three buildings were dilapidated. Furthermore, the laboratory section of the hospital was being housed by one of the dilapidated buildings.

It is not clear why there was a better infrastructural renovation in District 1 than in District 2; however, it is of note that the Chief Executive of the State is from District 1 and this may have influenced the decision of the PDPD to accord the district top priority in the infrastructural renovation. District 2, on the other hand, is known to be politically marginalized, hence the low priority.

Monitoring and supervision roles: triangulating respondents views

Monitoring and supervision are crucial aspects of the new DHS, and seek to ensure that health workers and the various structures they represent in the DHS comply with the demands of the new system. A structured monitoring and evaluation framework for service delivery has been created as each of the structures is, in turn, accountable to the Commissioner for Health. This approach appears to have produced some positive outcomes: health workers are conscious of the regular supervision and are said to be more often at their duty posts (see Table 3).

Table 4 (derived from annex 1) shows both the formally allocated supervision and monitoring role of each new structure (in column 'policy assigned roles'), and the views of the different respondent groups about whether these roles are being performed in practice. The tick "✓" indicates that the specified respondent group judges the structure of focus to be fulfilling its policy mandate; the "X" indicates that the group judges the structure is not fulfilling its policy mandate (and the wording in the such a cell identifies the actual practice of the structure); and, a dash "–" means that the interviewees did not say anything about the supervisory and monitoring functions of that structure.

Table 4: Respondents' responses on supervision and monitoring roles of different structures of DHS and actual practice

Policy assigned roles of each structure		PDPD	SHB	DHB 1	DHB 2	LHA 1	LHA 2	HOSP 1	HOSP 2
PDPD	Develop major strategic health policies and plans for the state	X Monitoring	✓	---	X Supervision	---	---	---	---
SHB	Oversee the performance of each of the District Health Board	✓	✓	✓	✓	✓	---	✓	✓
	Supervise the District Health Board in keeping Bank accounts by the implementing facilities	✓	✓	✓	✓	✓	---	✓	✓
	Supervise the delivery of Health services of Local Government	---	✓	---	---	---	---	---	---
PATHS	No formal supervisory role assigned to it	---	X Supervision	---	---	---	---	---	X Supervision
DHB	Monitor the activities of the Local Government Health Board	✓	✓	✓	✓	✓	✓	---	---
LHA	Manage, control and operate health services for the proper health care delivery in the local government	✓	✓	✓	✓	✓	✓	---	---

Overall, the table suggests that the PDPD are carrying out some supervision, although not mandated by policy to assume this responsibility. This may be due to the PDPD's need to verify whether DHS implementation is proceeding in accordance with the policy itself; however, even among PDPD members there is some disagreement on their roles.

One of the PDPD interviewees held that,

"The Policy Development and Planning Directorate of which I am a member is in-charge of policy and planning but the service delivery, by that I mean monitoring and supervision, is specifically that of the other components of the District Health System namely: the SHB, District Health Boards, and Local Health Authority. So, for instance, to the best of my knowledge, the State Health Board has monitoring teams, and each of the team is in-charge of a specific District Health Board, and the District Health Board too has monitoring team within them. The Local Health Authorities monitor the primary healthcare centres and the cottage hospitals within their area of jurisdiction." (PDPD member, Ministry of Health, Enugu).

A contrary view was expressed by another PDPD member who was of the opinion that supervision and monitoring is the duty of the PDPD. Expressing his views on this, he opined that

"As implementer, they (SHB) cannot monitor. What are you monitoring when you are implementing? It is the person that sets the policy that set up monitoring team to monitor what they have set. If you are my staff, I will send you to go and monitor what? You are not monitoring what you are doing? It is somebody else that will go and monitor what you are doing to ensure that the programme is working. I can't see why they should be involved in monitoring." (PDPD member, Ministry of Health, Enugu).

The PDPD and its self assigned supervisory role has the potential for both positive and negative impacts on the overall implementation of the DHS. Disagreements may be raised if the PDPD's involvement is perceived as usurpation by the other components; or, the regularity of supervision and monitoring by the State Health Board (SHB) may be affected negatively. The knowledge of the policy assigned functions of the different components of DHS is therefore important as this could ensure focus and efficiency in the implementation of the DHS. Whilst misunderstanding of the role of a member of any of the structures may not affect the overall focus of such structure in monitoring and supervision, where the whole structure loses focus on the clear roles within the monitoring and supervision framework, a negative implementation experience may occur.

The SHB is mandated by the policy document to carry out supervision and monitoring of both the DHBs and the LHAs. *"Our work here is purely supervisory, monitoring and evaluation of the programs with DHBs and down lines to see that it tallies with the policy developed by PDPD."* (State Health Board member, Enugu).

Although not amongst the official structures, PATHS, as a major financial contributor to DHS in Enugu State, has its own monitoring team that is sent into the field to review progress. PATHS' financial contributions include paying the Policy's counterpart funding, as well as investing in drugs, training of human resources and even renovation of some health facilities for the DHS implementation. The organization has consequently raised its own monitoring team which, whilst independent from that of the official DHS structures, works in collaboration with DHS' teams to ensure efficient health care delivery services.

The Policy document provides a monitoring framework: the DHB is mandated to supervise both the District Hospital and the Local Health Authority within the district; and the Local Health Authority (LHA1 and LHA 2) are to supervise the primary health care facilities beneath them. Similarly, the top health workers in the District Hospital supervise the health workers in their respective departments (internal supervision). These roles must, however, be properly communicated within the Policy Document in order to ensure proper implementation as the extent of knowledge held by each of the levels of DHS in relation to the officially-assigned supervisory roles is important. The LHA level seems to know little about the PDPD and their roles; and, indeed, the general lack of good knowledge around the role of each of the structures of DHS may be an indication of poor communication at the conception phase

Health worker views and availability: District 1

In the previous system, the number of medical doctors in the District was small; however, the patients' patronage was also minimal. The availability of health workers is identified as a factor supporting the smooth operation of DHS, particularly when demand is stimulated.

Our findings show that, in District 1, it was perceived that there were too few health workers at the District Hospital. Workers complained of having too much work to do now that patient loads had increased and it was found that a ban on staff recruitment in the State had made it impossible to increase staffing levels. Virtually all departments in the hospital were said to need more health workers.

One of the interviewees in the District said,

"We know generally that we have shortage of staff right from the local government to the ministry of health. We believe that we are hoping from my own perspective that if we can move forward with the few personnel, we have, when they now recruit people may be things will be better. We the pioneers we have a lot of stress now. We are working more than our capacity now. But if the system can be sustained with the few personnel, and they recruit more people, things will be easier for us".

Similarly, another noted

"..... we have acute shortage of manpower. [There is] only one pharmacist working here for instance. [He is] the attendant, the dispenser, the youth corps member pharmacist etc. You can imagine that managing the whole district hospital. So acute manpower shortage is another factor that affects DHS service provision".

Overall, there was agreement that demand for health care services has been stimulated; and that patients now come to the health care facility because they have heard about the changes that have taken place as a result of the new system. These patients now expect prompt and quick attention, in contrast to the long waiting time caused by the unavailability of health workers which characterized the old system. The number of workers available to attend to the patients is therefore crucial for the implementation of the DHS and action needs to be taken to prevent it continuing as a problem.

In the Primary Health Care centres of the LHA most staff are Community based Health Extension Workers (CHEWs), supported by a few nurses. In some cases, the CHEWs are voluntary workers who are not on the pay roll of the local government. Although there is also supposed to be a medical doctor that visits the health centres at regular intervals, such supervision does not generally occur.

Human resource availability has strong potential to affect the implementation of the DHS. Though there is a general ban on recruitment of workforce in Enugu State, effort has to be made to consider staff needs in the health sector.

Health worker views and availability: District 2

The effect of human resource availability on the implementation of DHS was also noted in District 2 where respondents judged that the current number of health workers was inadequate. With the exception of a few medical doctors posted to the hospital, no health workers have either been recruited or posted to the hospital since the inception of the DHS in 2005. Furthermore, following the retirement of the only personnel officer, no staff were working in the Personnel Department of the hospital and only one elderly woman was employed in the Medical Records section, meaning that, should she arrive late, patients are unable to see a doctor. This situation, given the demands and expectation of the new system, may prevent successful implementation of the DHS.

According to a respondent in this site,

"The things I think should have been done or may be should have happened at the same time is the recruitment of relevant staff, so it has not been done and I think it should have been done. Many of the facilities are understaffed. If you go to the primary care centres, you may have just two people working there. They have to take delivery, they have to take the account, they have to go and lodge the money in

the bank. That is why they are not meeting up. So staff recruitment has not been done to take care of the anticipated increase in the clients that access the facilities. The other thing I think is that there has not been enough financial input to see to all the various aspects. They still need to put in some more money. The enough money is not yet there. Otherwise some of these facilities should have been secured, if nothing else, some perimeter fencing, and provision of ambulances to convey people from very remote areas to the secondary health facility where there are better cares. The referral system is not very well developed”.

Another respondent noted,

“Since the policy came out I don’t think there has been any recruitment. That is what I am telling you. We have written that there should be recruitment to meet up with the demands of the District Health System. But there has not been any recruitment and that is why we are saying that the District Health Board should be allowed to recruit at least the junior cadre since these people are the people that are going to work in the rural areas, You cannot recruit somebody from district 1 and post him to district 2, it will not make sense. So there has not been any recruitment since the District Health System has been in place. It is only the old personnel that are the ones implementing the District Health System for now”.

The reasons behind the differences in health worker availability between the Districts are not very clear; however, this situation may, again, be connected to political influence at the state level with the chief executive of the state coming from District 1.

Health workers level of satisfaction with the operations of the DHS

In both case study sites the health workers held some reservations about the DHS operation: although satisfaction about infrastructural renovation, drug supply and the general improvement of the hospital environment was expressed, so too was the lack of financial and other motivations for the health workers. The transformation of the old system of health care into a new system was thought to have brought general facelift to the district hospitals in the state. Different categories of health workers – the junior, middle and senior workers – from both study sites examined some of the features characteristic of the old system and how these have given way to an entirely new system. The views of the junior workers from District 1 seem to agree with those of both the middle and senior health workers in the same district, with the shared opinion that there has been a complete renovation of infrastructure, as well as increases in patients’ attendance in the hospital, the numbers of medical doctors posted to the hospital and drug supply, etc. The only exception to these positive views is the health workers’ expressions of dissatisfaction in relation to a lack of financial motivation.

As the respondents noted:

“Like when I came here in 2004, this place was like an abandoned place. Patients were not coming as now. And the whole building was dilapidated. But now the whole place is renovated, patients are coming in every shift. On Friday we had about 8 in-patients but before then we were not recording 3-in patients.” (Health worker, District 1).

“.....we have more doctors now. You find out since the inception of this DHS, there has been this increase in patients attendance to the hospital. But if you want me to go further on our benefits, nothing has changed salary- wise.” (Health worker, District 1).

“I am going to talk about my own self; there is no change financially.” (Health worker, District 1)

“No, we are not all that satisfied the same with my colleagues. As this new system is going on now, at least motivation should be included. But we have not seen anything like that. So we are not all that happy.” (Health worker, District 1).

Most health workers at DHB 2, on the other hand, did not see much change following the introduction of the DHS although the renovation of buildings, leading to changes in the hospital environment, was highly commended and an increase in patients’ hospital attendance was perceived. Other participants complained that the attitude of some health workers to work seemed worse than before with health

workers, including doctors, arriving at work late. Similarly to District 1, a lack of financial motivation for health workers was noted and, in an attempt to show how he feels about the situation, one of the respondents says,

“Before, you would not be able to sleep on duty because a lot of patients would be coming for treatment due to the fact that sometimes patients sometime might be more than 100 or 70 in number. In some cases, they may be eighty or fifty. The least you can get is thirty patients. You cannot see less than twenty patients. And that period you would see that the Doctors would be around till 3.30 pm from morning. If there is emergence such as accident, you would see doctors but now look around and see for yourself whether you would still see workers on morning duty. Why you are still seeing some is because we are in Out Patient Department (OPD). Most workers in other areas have gone since. If somebody goes out or wants to go as a junior staff would I tell the person not to go? The era of General hospital is better than now that it is district hospital”. (Health worker, District 2).

Table 5 gives a general view of the feelings of satisfaction / dissatisfaction of the different categories of the health workers in both case study sites. There are some suggestions here of better practical experiences in District 1 compared to District 2. For example, according to the health workers, patients’ attendance in District 1 has increased, as have the available drugs and doctors, and the infrastructural development is much better than before. There is also improved patients’ patronage in District 2; however, most of the health workers seem to lack proper orientation on the demands of the new system, for example, attendance to work by health workers is still sluggish, and some of the equipments and materials are not readily available.

Table 5. Health workers level of satisfaction with DHS

Categories of health workers	District 1	District 2
Junior Health workers	N = 3	N = 3
Q. Are you more satisfied with your working conditions now than before the introduction of DHS	<ul style="list-style-type: none"> • Now this hospital has picked up and patients attendance has increased sharply • We had one doctor before but now we have more • The hospital used to be bushy and dirty but now has been transformed by PATHS • The number of beds in the hospital has increased 	<ul style="list-style-type: none"> • We have witnessed the renovation carried out but no major difference • Doctors come late to work, sometimes patients wait for a longer period for doctors • Not getting a lot of patients is caused by the doctors • The only difference I can see is the renovation
Q. Have you been motivated in any way under this DHS, either in terms of financial motivation, or in any other form?	<ul style="list-style-type: none"> • No there is no motivation, the way our salary is now is the way it has been 	<ul style="list-style-type: none"> • Attitude to work is worst under this DHS than before the DHS
Middle Health Workers	N = 3	N = 3
Q. Are you more satisfied with your working conditions now than before the introduction of DHS?	<ul style="list-style-type: none"> • There has been several capacity development trainings and workshops in the new system • Ways and manner of work have changed and there are more patients than before • The hospital has attracted researchers who use the 	<ul style="list-style-type: none"> • The environment did not look like a hospital before the DHS • Before the DHS, we had 2-3 patients but now the number of patients have increased tremendously • The renovation of the hospital makes it look like a hospital now

	<p>hospital as a sentinel site for malaria research</p> <ul style="list-style-type: none"> • The pharmacy section is now stocked with drugs • The laboratory is now provided with reagents 	
<p>Q. Have you been motivated in any way under this DHS, either in terms of financial motivation, or in any other form?</p>	<ul style="list-style-type: none"> • I am going to talk about my own self. There is no change financially • We are just believing that it will be but we have not seen it • 	<ul style="list-style-type: none"> • No! no! no! they don't. they don't even pay us as at when due. They don't give us our promotion and annual leave allowance • I do not think that there is financial motivation
<p>Senior Health Workers</p>	<p>N = 3</p>	<p>N = 3</p>
<p>Q. Are you more satisfied with your working conditions now than before the introduction of DHS?</p>	<ul style="list-style-type: none"> • The renovation of the entire hospital as everything was damaged in the past • We have more doctors and health workers now • We have more drugs and equipment unlike before that we had out-of-stock syndrome 	<ul style="list-style-type: none"> • They keep promising us equipment and laboratory reagents • Personally I am satisfied, patients turn out has increase, and there is drug availability • For many of us, our capacity have been built in one way or the other
<p>Q. Have you been motivated in any way under this DHS, either in terms of financial motivation, or in any other form?</p>	<ul style="list-style-type: none"> • There is no motivation both financially and otherwise • We are not all that happy because there is no motivation in this new system • There has been increase in patients attendance to the hospital but nothing has changed salary-wise 	<ul style="list-style-type: none"> • There is no motivation yet

The workers' satisfaction with the extent of improvement with the DHS demonstrates their feelings about the transformation of the health system. On the one hand, their working environment now looks better; on the other hand, they felt dissatisfied that they had received no additional remuneration. There is a risk that it will be difficult to ensure efficient health care delivery if the health workers have ill-feelings towards the system as they are responsible for delivery and therefore influence the benefits of the policy to the beneficiaries (clients). As such, it is important that their wellbeing is adequately addressed; indeed, while investment is being made in the infrastructural development of the hospitals, including human resources and drug supplies, health workers' motivation is equally important to boost their moral for efficient service delivery.

Perceptions on Challenges of DHS Implementation

Finally, what challenges face DHS implementation? The views of the interviewees from across the different structures of the DHS on this issue are represented in Table 6.

PDPD respondents saw funding as a catalyst that will help the scheme to work, therefore expressing fear over what will happen to the scheme if a lack of funding arises or should PATHS, as the major financier, leave or stop its financial support. They noted that the state does not seem to have shown much commitment in allocating government funding for the running of the DHS. In addition, PDPD respondents perceived risks in the fusion of the previously separate primary health care and secondary health care.

The local government sees the presence of the state government in the local government domain through the DHS as a threat. Although both the local and state government are expected to make a contribution to the health fund to run the DHS, the local government does not seem comfortable with this arrangement and appears to be withholding its funding, fearing that the state is trying to divert their funds which have previously been strictly under the control of the local government.

In explaining the situation, different respondents from the PDPD noted that:

“Health service is extremely very difficult even now there are still very tough challenges because you know the local government have their own fund and when you want to have something like health fund, they would not find it funny that you are trying to take their fund and plunge into the DHS.”

“The negative factor is lack of finance, you know, lack of funding. That is the only thing I can say is negative in the operation of the DHS”.

“As far as the implementation of DHS is concerned – I recognize that there were some counterpart funding that may not have been settled, may be due to poor financial resources.”

In the light of these problems, the failure to include a local government representative on the PDPD, thus ensuring their involvement in policy development and implementation, seems to have been quite naive.

SHB respondents were of the opinion that, because the state counterpart funding had not been paid, the operation of the system might be affected. The counterpart funding is an agreement between the state government and the PATHS with each contributing to the operation of the DHS; and, whilst PATHS has fulfilled its own part, the State government is yet to fulfil its responsibility. This has led to the feeling that the DHS may crumble if the present state government does not pay strong attention to the system.

A lack of materials and equipment for supervision was also identified as a constraint to successful supervision and monitoring by SHB respondents with, for example, insufficient vehicles noted as a barrier which could obstruct the regularity of supervision and monitoring. As one respondent stated *“...so I will even say that logistics is even part of the problem for the monitoring and supervision because they do not have enough vehicles in the state health board and district health board.”* (SHB respondent).

Finally, the possible difficulties in disciplining local government health staff was noted as the local government's health staff are fully employed by, and therefore accountable to, the local government rather than the state government.

Another problem identified by DHB respondents is the dual role of District Managers, as both the person in-charge of the district hospital and the district manager in-charge of the entire district. This dual function brings a heavy workload, meaning that District Managers do not have enough time to be committed to either of the roles. Similarly, a shortage of health workers was, again, mentioned as a challenge to the system, with some of the staff already complaining that the pressure of work created by the new system is greater and that more staff are needed to handle the volume of work that is required to be done. As one respondent expressed,

“.... district manager is playing a dual role, as the district health manger of the entire district and the chief medical officer in- charge of the district hospital. The district hospital is a very busy place by the time you do the clinical consultation, you do the administrative process, visitors will come and wait for you. When will you have time to go there and do your supervision?” (Respondent, DHB 1)

It was found that there has not been any recruitment since the inception of the DHS and the problem of a lack of personnel was commonly mentioned in both sites by both the DHB and the LHA. Staff shortages were conceived as an impediment to the DHS and it was stated that improvements in infrastructure, the availability of drugs and regular supervision and monitoring, are insufficient without the necessary staff recruitment to ensure efficiency. Where a few staff are burdened with a lot of work, there could be negative coping strategies to handle the stress arising from the work which may negatively impact on the smooth running of the system.

Table 6. Perceptions of the challenges of DHS implementation

PDPD	SHB	DHB 1	DHB2	LHA 1	LHA 2
N = 4	N = 7	N = 3	N = 2	N = 3	N = 2
<ul style="list-style-type: none"> • Lack of funding • People at the health centre see those at the secondary level as usurping their function • Merger of local government and state government • Fear of what may happen to DHS when PATHS leaves • Lack of logistics for supervision and monitoring 	<ul style="list-style-type: none"> • Not enough funding • Some counterpart funding may not have been settled due to poor financial resources • Health was given the 5th position in the year budget • Lack of funding • No staff recruitment • fusion of the local and state government by the health law is not healthy • Logistics for monitoring and supervision 	<ul style="list-style-type: none"> • Logistic for supervision and monitoring is a problem • District manager is playing a dual role, as the district health manger of the entire district and the chief medical officer in-charge of the district hospital. • Inadequate staff to run a DHS • Doctors and nurses to provide 24 hours service are not there • X-ray dept. is not functioning and the lab is not appropriate. 	<ul style="list-style-type: none"> • Logistic for monitoring is a problem • Lack of funding • Not enough personnel • No recruitment of new staff • The community is not committed • Lack of security 	<ul style="list-style-type: none"> • Acute shortage of manpower • No power and water supply • Logistics , finance and lack of vehicles for supervision 	<ul style="list-style-type: none"> • A ban on recruitment of staff • Lack of staff • Transportati on is a problem so we can't reach every compound we are covering.

6. CONCLUSION

In conclusion, a reform, such as the Enugu State DHS, which has strong political and bureaucratic leadership, along with considerable resource investment, allows the initiation of radical managerial and structural changes within the health system, including physical infrastructural renovation and improved health worker availability, which can increase access to healthcare. However, implementation of such reforms can be impeded by errors in policy development, such as not involving a key stakeholder like local government in policy decision-making, and implementation issues, such as state and local governments not paying their counterpart funding levels or not employing more health workers to cope with the increased work load, or the lack of health worker incentives..

In planning and implementing new policies such as DHS, efforts should be made to engage important actors, dedicated funding should be committed by government and attention should always be paid to health worker morale and commitment. It is expected that the results of this study will be used to improve the implementation of the DHS in Enugu State in a way that will preferentially benefit the poorest people.

7. REFERENCES

Akin J, Hutchinson P, Strumpf K, 2005. *Decentralization and Government Provision of Public Goods: The Public Health Sector in Uganda*. Journal of Development Studies, Vol.41, No.8, November 2005, pp.1417–1443

Berman P, Bossert T. 2000. *A Decade of Health Sector Reform in Developing Countries: What have we learned?* UNAID, Washington

Dillinger WR. 1999. *Decentralization: Politics in Command', Chapter 1 in Beyond the Center: Decentralizing the State*, Burki SJ, Perry GE, Dillinger WR. (eds.), Washington, DC: World Bank Latin American and Caribbean Studies

Eriksson P et al. *Hospitals in reform – current trends*. In: Eriksson P, Diwan V, Karlberg I, eds. *Health sector reforms: What about hospitals?* Göteborg: Nordic School of Public Health, 2001.

Green A. 1992. *An Introduction to Health Planning in Developing Countries*. Oxford University Press, New York

Tanzi V. 1996. *Fiscal Federalism and Efficiency: A Review of Some Efficiency and Macroeconomic Aspects* Brunoand M, Pleskovic B. (eds.), Annual World Bank Conference on Development Economics 1995, Washington, DC: World Bank.

Mills A, Bennett S & Russell S. 2001. *Reforming Health Sector Reform* in Mills A, Bennett S and Russell S. *The Challenge of Health Sector Reform. What must governments do?* Palgrave: Basingstoke: 200-223.

Owino W, and Korir J. 1997. *Public Health Sector Efficiency: Estimation and Policy Implications*. IPAR Discussion Paper No. 07/1997. Nairobi: Institute of Policy Analysis and Research.

Standing H. *Framework for Understanding Health Sector Reform*. In Sen G, Gorege A, Osthin P. eds. *Engendering International Health: the Challenge of Equity*. Cambridge M.A. MIT press, 2002: 347-371

World Health Organization. 2002. *World Health Organization Country Cooperation Strategy: Federal Republic of Nigeria, 2002–2007*. World Health Organization, Regional Office for Africa, Brazzaville

World Bank. 2000. *World Development Report 1999/2000: Entering the 21st Century*. Washington,

State Ministry of Health Enugu, 2004. *Health Sector Reform: Implementing the District Health System*.

State Ministry of Health, Enugu, 2005. *Enugu State Health Law*.

State Ministry of Health Enugu, 2008. *Togetherness in Health the Enugu Experience in Health Sector Reform 2002-2008*. PATHS Final Programme Report.

8. Annex: Respondents views on monitoring and supervision of the DHS

Role of Respondents in supervision and monitoring	RESPONDENTS VIEWS								
	Official Policy Document	PDPD	SHB	DHB 1	DHB 2	LHA 1	LHA 2	HOSP 1	HOSP 2
PDPD	Develop major strategic health policies and plans for the state	<ul style="list-style-type: none"> - PDPD has its monitoring team - The various departments combine to form a monitoring team that monitors the facilities regularly 	<ul style="list-style-type: none"> - Supervision and monitoring is the responsibility of the Directors in the MOH - PDPD developed the Policy 	<ul style="list-style-type: none"> - Everybody is accountable to the Hon. Comm. Of Health 	<ul style="list-style-type: none"> - PDPD supervises 	<ul style="list-style-type: none"> - No comment about PDPD 	<ul style="list-style-type: none"> - No comment about PDPD 	<ul style="list-style-type: none"> - The MOH, Enugu use to come. -The commissioner for instance use to come to this place and also PATHS 	<ul style="list-style-type: none"> - No comment about PDPD
SHB	<ul style="list-style-type: none"> - Oversee the performance of each DHB - Supervise the DHB in their undertaking in the keeping the of Bank Accounts by the implementing facilities -Supervise the delivery of health services of Local Govt. 	<ul style="list-style-type: none"> - SHB is the core implementers of DHS - They implement polices developed by the PDPD. - SHB has monitoring teams and each team is in-charge of each district 	<ul style="list-style-type: none"> - Monitoring / Supervision lies mainly with the SHB -SHB supervises the DHBs - SHB team monitors the DHBs - Our work here, is purely supervisory; monitoring and evaluation of the programs - With the help of PATHS and SHB internal arrangement 	<ul style="list-style-type: none"> - SHB is responsible for supervising the DHBs - SHB supervises and monitors the DHB 	<ul style="list-style-type: none"> - SHB supervises all the DHBs - SHB sees to the drug revolving fund 	<ul style="list-style-type: none"> - The design is that the SHB monitors the district health board - Supervision is from the higher level to the lower level 	<ul style="list-style-type: none"> - No comment about SHB 	<ul style="list-style-type: none"> - People usually come from SHB, Enugu to supervise the hospital - A team of auditors from SHB, Enugu usually come 	<ul style="list-style-type: none"> - SHB, Enugu and PATHS come for supervision - We are being supervised by a committee from the MOH. They come from Enugu.

			there are 3-4 groups that monitor the DHB and the LHA on regular basis.						
DHB	<ul style="list-style-type: none"> - Monitor the activities of the Local Government Health Board. - Provide equitable distribution of health facilities in the local government - Perform any other function that is relevant to the promotion, protection and restoration of health in the district 	<ul style="list-style-type: none"> - DHB is responsible for implementation - DHB is involved in monitoring and supervision of LHA - DHB which is involved in monitoring the facilities in their districts 	<ul style="list-style-type: none"> - DHB supervises the LHA - Nothing prevents the DHB from supervising the facilities under them if need arises - DHBs also supervises down the line 	<ul style="list-style-type: none"> - DHB supervises the LHA - DHB monitors and supervise the LHA, - DHB supervises the LHAs and others below them 	<ul style="list-style-type: none"> - DHB supervises the LHA - DHB also supervises the District Hospital under them 	<ul style="list-style-type: none"> - DHB Monitors the LHAs 	<ul style="list-style-type: none"> - No comment about the DHB 	<ul style="list-style-type: none"> - No comment about the DHB 	
LHA	<ul style="list-style-type: none"> - Manage, control and operate health services as may appear necessary for the proper 	<ul style="list-style-type: none"> - LHA monitors primary health care centres and cottage hospitals -LHA as the 	<ul style="list-style-type: none"> - LHA supervises the facilities under them 	<ul style="list-style-type: none"> - LHA supervises the health facilities under them 	<ul style="list-style-type: none"> - LHA supervises the facilities under them 	<ul style="list-style-type: none"> - LHA supervises the health facilities 	<ul style="list-style-type: none"> - LHA supervises the health facilities in the local government -Both LHA and PATHS 		

	health care delivery in the local government	nearest organ to the facilities monitors the implementation of the policy					come to the health facilities for supervision		
HOSP (Health Workers)		- No comment about the PDPD			- We are also expected to monitor health workers			- Our superiors here in the hospital and people from PATHS use to supervise us	-The head, the director, and the departmental heads.