

## **The District Health System in Enugu State, Nigeria: An Analysis of Policy Development and Implementation.**

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### **Abstract**

The District Health System (DHS) is a form of decentralised provision of health care where health facilities, health care workers, management and administrative structures are organised to serve a specific geographic region or population. The system was introduced in Enugu state following the election of a new government. However, experiences suggest that implementation of this policy is particularly complex and can be hindered by several factors. This study therefore investigated the development and implementation of the DHS in Enugu State in order to reveal the underlying factors that affected the implementation of the policy.

The study involved case studies of two communities from different district health authorities in Enugu state Nigeria that had varying levels of success in implementing DHS. In-depth interviews were conducted with 21 policymakers and 12 focus group discussions were conducted with health workers and community members at the 2 study sites. In addition, document reviews of relevant documents and observation of health facilities and infrastructure were carried out.

The implementation of DHS in Enugu State has led to significant improvements in health facilities and has stimulated demand for health services. However, challenges to successful implementation persist including a lack of government funding for health, a ban on the recruitment of health workers, lack of 24 hour services, uncertainty about the sustainability of the DHS, irregular monitoring and evaluation of staff, a lack of trust between State and local government officials and no accountability of local government health workers to the State government. Additional health workers should be employed to maintain provision of services, Mistrust between local and state government actors has led to resistance at the local level to policy implementation and, in some instances, the withdrawal of funds for DHS. When planning and implementing new policies, efforts should be made to consult with and engage all actors, especially those who are responsible for implementation at the local level. Without dedicated funding and support from the State government, local level actors will have limited ability to support effective policy implementation

**Keywords:** District Health System; Enugu State: Policy Analysis

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## Introduction

Introduction:

The District Health System (DHS) which is a form of decentralization process was introduced in Enugu state as a policy to reform the health sector to improve its functionality and improve the poor health status of the citizens in the state. Health care reforms have been introduced around the world with the objective to improve efficiency, equity and effectiveness of the health sector against the background of limited government resources and rapid demographic and technological changes.<sup>1,2</sup> Although health care reform is a global phenomenon, adopted reforms vary by country and region.<sup>3</sup>

A key vehicle to drive health sector reforms is decentralization in respect of health which emerged in the wake of the Primary Health Care (PHC) conference at Alma-Ata in 1978.<sup>4,5</sup> Decentralization, conceived as a strategy that could enable district development, community participation and inter-sectoral collaboration, became closely associated with the PHC approach.<sup>5</sup> Decentralization has since become a major managerial reform in health services, but progress towards this goal is much slower in developing countries such as Nigeria than expected in spite of the seemingly obvious advantages. The slow progress has two underlying causes: first, the ubiquitous reluctance of managers in centralized organizations 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.<sup>6</sup> In spite of these problems, decentralization as a policy strategy has in the last two decades, been implemented in many sub-Saharan countries as part of a wider process of political, economic and technical reforms.<sup>7</sup> In spite of the wide coverage of decentralization programmes and extensive theoretical support, decentralization does not automatically ensure welfare improvements and may have impacts worse than centralized health systems. Because it often reduces the redistributive powers of central governments and therefore the overall level of transfers from richer to poorer jurisdictions, decentralization may in fact worsen vertical equity.<sup>8,9</sup> Several authors such as Akin, et al,<sup>10</sup> 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 centralized systems.

The main challenges are that while decentralization strategies such as the District Health System (DHS) aim to improve health system performance, its implementation relies on the human capacity of the health systems, power tussles among the key actors, sub-optimal number of skilled staff to face the emerging challenges in healthcare delivery and non-compliance of health staff with the new policy and system. Others include, adequate finances and appropriate health system infrastructure.<sup>11</sup> Similarly, some authors, Tansi, 1996 and Dillinger<sup>12-13</sup> 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.

Past studies on such policies have had a limited consideration on the underlying factors responsible for the designing and implementation of the policies and their constraints to achievement. Some studies have highlighted with limitation some of these influences over implementation. These include: manipulation of the policy to favour more influential actors,<sup>14</sup> health care workers may react against the burdens placed on them by new policies by stigmatizing intended beneficiaries, or even turning them away<sup>15</sup> or may be involved in sharp practices<sup>16</sup> among others.

It is therefore important to investigate the policy development and implementation process of DHS so as to understand the underlying factors that could constitute impediments or facilitate its successful implementation. It is expected that the results of this research will help to take forward past work and provide a basis for new thinking about how policy and implementation managers might 'do things differently' and how the end users will perceive such policies.

Thus the objectives of this study were to determine the differences in experiences of implementation of DHS in two different sites (with one site doing well and the other not doing well); whether the resource use and allocation and staff recruitment and posting been done according to how the policy was intended; And what the perceptions and acceptability of the DHS by the Program managers and health workers and community members, including the change in power and responsibility within the health system are. In addition, the level of monitoring and supervision as well as the factors affecting this, as well as determining whether there are differences in monitoring and supervision between geographic areas?

## An Overview of the District Health System in Enugu State

The health sector was ineffective, inefficient and inequitable in Enugu state prior to the onset of the new democratic government in 1999, as was also the case in other parts of Nigeria. The Enugu state healthcare system was centralized with minimal local or community level input into decision making processes. The referral system was poor or non-existent in some cases, and the number of skilled staff was highly inadequate, resulting in inefficient service provision. Health infrastructure, especially in the Primary Healthcare centres, was in a state of neglect and dilapidation.<sup>17</sup> This meant that those in more remote locations, especially the poor, had to travel long distances to access good quality healthcare services, thus increasing costs of healthcare. Hence, there were both financial and geographical inaccessibility of healthcare to most citizens, especially the poor that reside in these remote areas.

In addition, the centralized healthcare system did not allow an effective monitoring and supervision of healthcare workers, especially those of them in the rural areas. As a result, most of the healthcare workers were hardly seen in their duty posts and even when they do go to work, they usually left early to attend to their personal needs. Staff availability and distribution was also inequitable and led to over-concentration of healthcare workers in the urban areas to the detriment of the rural areas, where more than 70% of the population reside, with predominant of them very poor. Furthermore, all the health facilities were most often "out-of-stock" of most essential drugs, partly due to over centralization of drug distribution system. All these made the Enugu state healthcare delivery system to be ineffective, inefficient and inequitable, leading to poor health status of the people.<sup>17</sup>

In order to reform the health sector so as to improve its functionality, the Enugu state government decided to use the District Health System (DHS) as the vehicle for improving the poor health status of the citizens in the state. The Enugu State Council on Health recommended the DHS as a framework for reforming the health sector and the DHS was adopted officially in January 2004 by the state government, as the central plank of its healthcare reform process. Since then, the system has undergone series of developmental stages and is now been implemented in the state. The necessary technical assistance, support and expertise for developing and implementing the DHS was/is provided by the British Department for International Development (DfID)-funded Partnership for

Transforming Health Systems (PATHS). This involved the framing of the required legislation to introduce the DHS; extensive capacity building for 776 members of the constituent bodies to orientate them to their revised role 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.<sup>18</sup>

The DHS was designed to equitably improve access to good quality healthcare services by improving primary healthcare (PHC) centres and secondary healthcare (SHC) facilities in rural communities including the resuscitation of the many non functional ones. This involved infrastructural development, health workforce capacity building and their redistribution. It also seeks to improve referral network in public facilities through the interface between the health centres, the cottage hospitals, district hospitals and apex teaching hospital, thereby providing a continuous and comprehensive healthcare services.<sup>19</sup> This was expected to potentially make it cost-effective and easy for the poor to access a wide range of services whenever the need arises.

## Methods

### Study Area

The study area was Enugu state, south east Nigeria. There are seventeen local government areas (LGAs) in the state officially recognized by the federal government besides development council areas created by the state. Five of these local government areas are largely urban. Enugu state has an estimated population of about 3,257,298 (NPC 2006). There are six district hospitals, 36 cottage hospitals and 366 primary health care centres, including comprehensive health centres, health centres, and health posts as well as about 700 private health facilities comprising private and non-profit, private for profit, including faith-based facilities. The state is divided into seven health districts. Each health district is made up of between one to three LGAs. The two study sites are both 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 local government areas (LGA) with 3 development areas, district 2 has 2 LGAs with 4

development areas.

## Study Design

The study involved case studies of two communities from different district health authorities in Enugu state Nigeria that had varying levels of success in implementing DHS. It involved an initial set of data collection activities at the state level, followed by data collection in the two local level case study sites.

## Sampling

*Case study selection and data collection activities:* Two communities from two DHA were purposively selected for inclusion in this study. One more successful (District 1) and one less successful (District 2) site was 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 adjudged to be successful and 4 less successful. When asked how they made their judgment, they said it was based on availability of personnel and equipment as well as the level of infrastructural renovation and community participation after DHS implementation. From the list of the 3 more successful and the 4 less successful districts, one district each was chosen by simple random sampling.

## Data collection

### *Document review:*

The following documents were reviewed:

- The DHS policy document,
- The legal framework for the DHS,
- Enugu state health situation report,
- Grey literatures on the DHS in Enugu state,
- Agreement documents (Memorandum of Understanding) between the drivers of DHS and Enugu State.

These reviews provided a basis for assessing from other interview materials and data collected whether the intentions on each element do appear to be met in practice.

### *In-depth interview (IDIs):*

To understand the perceptions and acceptability of the DHS by the program managers, health workers including the change in power and responsibility within the health system, IDI guide was used to collect information from 12 programme managers, 9 health workers ( junior, middle and senior) per site.

### *Focus Group Discussions (FGD):*

FGDs were also held with members of the 6 purposively selected catchment villages within each health district. Two villages were selected from the community where the district hospital is located; another two villages nearer to the community where the district hospital is located were equally selected, and the last two villages were from a community that was considered far from the district hospital. In each of the catchment villages, 2 FGDs were conducted (one each for women of childbearing age and men.). They were 9–10 members in each FGD and each lasted between 60 and 75 minutes. The participants were purposively selected with the help of the village heads. All in all, 12 FGDs were conducted per site. A discussion guide was used to direct the discussions during the FGDs, which was moderated by a sociologist and assisted by a research assistant.

The FGDs were used to assess the perceptions of community members about workforce performance before and after the introduction of the DHS. They were equally used to examine the acceptability of DHS by the community members.

### *Observations:*

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

## Data Analysis

All the IDIs and FGDs were transcribed verbatim including all the notes and background information on the transcripts. Thereafter, the transcripts were coded using codes and specific codes which reflect the various objectives.

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

## Results

### Policy Development

As shown in table 1, in the year 1999 general election in Nigeria, the Ex-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 Ex-Governor was also re-elected to handle the affairs of the state for another four years. The need to reform the health status of Enugu state given its large negative health indicators drove the governor to initiate a new form of health care delivery system called the DHS during his second tenure in office in June 2003.

The state health council in October, 2003 sat down in a meeting over a 4-day period composed of private, public health service providers, and all other stakeholders including donor agencies involved in health services in the state like UNICEF and WHO and some allied institutions. The Partnership for Transforming Health Systems (PATHS) which is a brain child of DFID was requested to come in following the State Council decision. It was a government initiative and that of the stake holders in health, that a specific request was sent to PATHS to source for expertise to help the state develop its concept of DHS. That was when PATHS came in. Before then, PATHS was not in existence in Enugu state.

Thereafter, in July 2004, the legal frame work of DHS was developed. The legal framework

established the different structures of the system with each level's responsibilities thus creating the Policy Development and Planning Directorate (PDPD), State Health Board (SHB), 7 District Health Boards (DHB), and Local Health Authority (LHA). This arrangement was non-existent in the old system. In early August 2004, these structures were approved by the Governor. In late August 2004, the first ever Business Plan of the Ministry of Health was developed which provided the impetus for the take-off of the DHS in Enugu State. The various bodies of the District Health System (PDPD, SHB, DHB, and LHA) were inaugurated by the governor in late September 2004. The Commissioner for health with prior written approval of the Governor established a District Health Board for each of the health districts to provide health care services for its local population. Between July and December 2005, there were infrastructural developments of the health facilities.

In July 2005 the State House of Assembly signed the Bill establishing the District Health System 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.

**Table 1: Timeline narrative of policy development of DHS**

Year	Event	Political context
June 2003	Conceptualization of the District Health System by the Ex-Governor of the state	He was 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 peculiarity 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 district Health system (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 was 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 The 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	Case study took place	

**Policy Implementation**

*Difference in implementations experience in both District 1 and 2*

*Features of the Old and New System:*

As shown in table 2, from observation and

interviews with program managers it was discovered that prior to the emergence of the District Health System, the old system (previous system of health care delivery prior to the beginning of the District Health System in Enugu state.) was characterized by unavailability of health workers, dilapidated infrastructures, drug supplies/ equipment were very minimal even non-existent in

some cases. Given the situation then, out-of-stock (“OS”) became a common phenomenon used in the government health facilities. There was no exception in all the government’s primary health care and secondary health care facilities in the state. Patient patronage became low in government hospitals as patronage tilted towards the private hospitals whose services were found to be far better than the government health facilities in the state. Furthermore, supervision and monitoring of health workers in the old system was perfunctory and was never accorded a priority.

It was also gathered that the old system was characterized by unavailability of health workers and poor attendance to work, dilapidated buildings, no perimeter fencing, drug out-of-stock syndrome, lack of equipment, very low patients’ patronage and minimal monitoring and supervision. According to one of the health workers interviewed,

*“In fact there is a lot of improvement since the DHS. Before we didn’t have patients like now. Before we used to have about 2-3 patients before PATHS came into this DHS. Since December, 2005, there has been a great difference. The difference is clear in short. And the doctors are even happier than before. Then doctors came to work and had nothing to do. The environment before the District Health System was very bushy. It did not look like a hospital.”* (Health worker, DHB 2 Hospital)

*“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 Hospital).

**Table 2: Features of old and new system**

Features	Old System District 1 and 2	New System District 1	New system District 2
Health worker availability	<ul style="list-style-type: none"> <li>• Insufficient numbers of health workers</li> <li>• Low levels of work attendance</li> <li>• Long waiting times</li> </ul>	<ul style="list-style-type: none"> <li>• Health workers are available but shortages persist</li> <li>• Improved levels of work attendance</li> </ul>	<ul style="list-style-type: none"> <li>• Insufficient numbers of health workers</li> <li>• Low levels of work attendance</li> </ul>
Monitoring and supervision of staff	<ul style="list-style-type: none"> <li>• Minimal and irregular</li> </ul>	<ul style="list-style-type: none"> <li>• Regular and improved levels of supervision</li> </ul>	Supervision improved but irregular
Building/renovation	<ul style="list-style-type: none"> <li>• Dilapidated buildings</li> <li>• No fence</li> </ul>	<ul style="list-style-type: none"> <li>• Proper renovation and fencing of the hospital premises</li> </ul>	<ul style="list-style-type: none"> <li>• Renovation of some buildings and fencing of hospital premises</li> <li>• A functional borehole</li> </ul>
Drug supplies and equipment	<ul style="list-style-type: none"> <li>• Frequent drug stock outs</li> <li>• Lack of equipment</li> </ul>	Drugs and equipment are available	<ul style="list-style-type: none"> <li>• Drugs are available</li> <li>• The availability of equipment has improved somewhat</li> </ul>
Use of facilities by patients	Low demand for services	• High demand for services	High demand for services

*Renovation of infrastructure:*

The two case study sites have certain things in common. There has been a turnaround infrastructural renovation at least compared with what the system looked like before the new system. However, observations made during the study showed that all the buildings in District 1 Hospital

were renovated and painted. Fencing of the premises was in progress at the time of visit to the hospital. There was a borehole but it was not functioning. The existing generator had broken down. A group that was carrying out a research on drug trial and uses as a sentinel study site the District Hospital provided the one which was functioning at the time of this study. Another generator that was seen parked in the hospital premises was said to belong to the UNICEF that wanted to use the hospital as a HIV test and counseling centre. In addition the hospital was well

equipped by both UNICEF and PATHS.

On the other hand in District 2 Hospital, out of about 7 buildings in the hospital, only four were properly renovated and painted at the time of this study while the other three buildings were dilapidated. The laboratory section of the hospital was being housed by one of the dilapidated buildings. Fencing of the hospital just commenced at the time of visit. The borehole was found to be working. PATHS also supplied twenty beds to the hospital whereas UNICEF supplied eight other beds.

***Is the resource use and allocation, staff recruitment and posting in accordance with the policy intent?***

*District 1*

Availability of health workers is said to be one of the ingredients that will help in the smooth operation of

DHS. No recruitment was said to have taken place since the inception of DHS in District 1. In the old system, the number of medical doctors in the district was small, though; the patients' patronage was said to be very minimal. Our findings show that there were no adequate health workers at the District Hospital. The result also showed that there was embargo on employment placed by the state government.

Workers complained of having so much work to do now that patients' load has increased. It was found that, presently, there is a ban on recruitment of staff in the state. This affected availability of health workers in the District Hospital. Virtually all the departments in the hospital need more health workers. It was equally gathered that the money that should be built into the allocation that goes to the district hospitals from the government for exemption is not usually included. In the light of this, one of the interviewees at the district hospital 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"* (Medical Officer, DHB1).

*"..... we have acute shortage of manpower. I am the only pharmacist working here for instance. I am 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"* (Pharmacist, DHB 1).

Similarly, the health workers in DHB 2 were found to be inadequate. Generally, this was found to be a common problem across the sites but the situation seems worse in Udi (DHB2). With the exception of a few medical doctors posted to the hospital; no other health worker has either been recruited or posted to the hospital since the inception of the District Health System in 2005. It was found that there was no staff in the personnel department of the hospital as the only personnel officer had retired. In the Medical records section, only one elderly woman works there, and if she comes late to work, all the patients that come for one problem or the other in the hospital will not be able to see a doctor until she comes. According to the Chief Medical Officer of DHB 2,

*"We don't have enough personnel, we don't, for*

*example, I am the Chief Medical Officer in-charge of the District Hospital which is a lot of responsibility, I am also in charge of the entire district and all the health facilities. So it is a lot of stress. Sometimes some functions are delegated to others. .... The personnel are not there, we are hoping that the government should recruit in fact at all categories. We don't have cleaners; we don't have low cadre people."* (Chief Medical Officer, DHB 2).

*"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 centers, 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. 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 sick people from very remote areas to the secondary health facility where there are better cares. The referral system is not very well developed"* (Chief Medical Officer, DHB2).

Another respondent also holds:

*"Since the policy came out I don't think there has not 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"* (Member, DHB 2).

***What is the perceptions and acceptability of the DHS by the Program managers, health workers and community members, including the change in power and responsibility within the health system?***

The health workers in both case study sites have some reservations about the DHS operation.

Though they expressed satisfaction about infrastructural renovation, drug supply and the general improvement of the hospital environment, but hold the view that DHS lacks 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 the health workers – the junior, middle and senior workers from both study sites examined some of the peculiarities characteristic of the old system and how they have given way to entirely new system. The views of the junior workers from (DHB1) seem to agree with both that of the middle and senior health workers in the same district. They are all of the opinion that there is complete renovation of infrastructure, increase in patients' attendance in the hospital, increase in number of medical doctors posted to the hospital, increase in drug supply, etc. The only exception to these views is the expressions of dissatisfaction by the health workers on the ground of lack of financial motivation.

According to one of the respondents, *".....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"* (Senior Health worker, DHB1).

Another respondent equally has this to say, *"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"* (Senior health worker, DHB1)

On the other hand, the health workers at DHB 2 did not see much change following the introduction of the DHS. Though, renovation of buildings has taken place with the hospital environment taking a new shape which they highly commended. There is also perceived increase in the hospital attendance by patients. However, it was found that the attitude of some health workers to work seem worst than the era of the old system. We found that health workers come late to work including doctors. Even the doctors have fixed days they visit the District Hospital. In the issue of financial motivation for the health workers, there was none.

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*

*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".* (Junior health worker, DHB 2)

On the other hand, the community sees DHS as a good innovation. They hold the opinion that it is beneficial to the community by contributing to the improvement of their health. It is also understood as a way the government wants to help the people get good health care. One of the community members bares his mind this way:

*"When it was general hospital, people stopped going there because you hardly saw doctors but about two years ago, the hospital was renovated and people started going there to receive treatment"* (FGD Female participant DHB1).

The views of other community members appear contrary. One of them strongly affirmed that:

*"We have said it all. The first is that the doctors are not usually around; they come around 1pm or 2pm; the patient might even die before the doctor comes. The other one is about drugs sometime you come and there are no drugs. The third one is price, when they have drugs the price is always too high. It is not that drugs should be very cheap but at least if you give someone drugs you try and assess what they can pay; because if you strip a man naked it will be terrible"* (Male FGD participant DHB2).

However, community members generally expressed concern over some factors that inhibit the working of DHS such as lack of equipment, do not always have the prescribed drugs, with cost of treatment still high at times.

The programme managers were of the view that he DHS was put in place to achieve integration that will involve all stakeholders, to make patience have access to health care and for an integrated health structure in Enugu state. However, they had some reservations about things that should have been put in place that were lacking from the inception of DHS such as .lack of funding lack of equipment, inadequate personnel, poor remuneration of staff, absence of hospital equipment, poor operation of



the Drug Revolving Fund and delay in salary payment.

One of the managers puts it this way:

*"Yes if staff are not well remunerated after putting on this effort. If no commensurate 'pat on your back', human beings being what they are, as time goes on people may start losing interest again."* (Manager Nursing).

It was further noted that the issue of power tussle evolved due to lack of involvement of the local Government authorities in the planning phase of the policy. Prior to the emergence of the District Health System, the local government was in control of health in their respective administrative areas. It was understood that the local government envisaged a control by the state government in the new system and foot-dragged their contribution of the counterpart funding. This was as a result of the fear of dominance by the state government over that sector which they have had control over. It was until this was realized by the state government that the local government was incorporated into the main stream of planning of the DHS leaving them with the health facilities under their domains in a new structure called the Local Health Authority which is one of the structures of District Health System thereby making the Local Government Authorities stakeholders in the new system. Monitoring and Supervision of Different Structures of DHS

The result of this study shows that supervision and monitoring is a crucial aspect of DHS. Each of the structures is meant to supervise and monitor the one below it. Each of the structures of the DHS plays different role on supervision and monitoring of the activities of the DHS. Thus the PDPD, SHB, DHBs, and the LHAs, each has certain roles assigned to it by the DHS Policy.

However, it was found from the study that PDPD are not empowered by the policy to involve itself in monitoring and supervision of other structures but they are doing so. The State Health Board is mandated by the policy document to carry out supervision and monitoring in both the District Health Boards and the Local Health Authorities. Partnership for Transforming Health System (PATHS) is not also among the approved structures of the DHS as found in the DHS policy document but it is involved in supervision and monitoring as well. The DHB is also mandated by the Policy document to supervise both the district hospital and the local Health Authority within the district. The Local Health Authority (LHA1 and LHA 2) on the other hand are to supervise the primary health care

facilities under them. The top health workers in the district hospital, on the other hand, supervise the health workers in their respective departments (internal supervision).

However, the interviewees who did not say anything about the supervisory and monitoring functions of some of these DHS structures shows that there is lack of knowledge of the roles of the different structures by the interviewees. One of the PDPD members holds that supervision and monitoring is the duty of the DHS policy setters (i.e. 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).

A member of the DHB on the other hand, maintains that:

*"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).

On the other hand, the result did show that PATHS, though, not among the structures but by the virtue of its position as a major financial contributor to DHS in Enugu state, has its own monitoring team that they send to field to see how things are going. Monitoring and supervision is said to have enhanced the implementation of DHS. It is focused on types of services provided to patients, presence of health workers on duty post and coming to work on time, attendance Register checked for number of patients attended to and amount realized from sale of drugs.

Specific factors were found to affect the supervision and monitoring of DHS these are availability of vehicles for logistics, availability of allowances for personnel, seasonal problems such as rainfall, and inaccessibility of difficult terrains due to bad roads. We equally gathered that when members of the supervision and monitoring team used their vehicle for supervision, they are not usually reimbursed for the cost of fuel. So this makes members of the team unwilling to donate their vehicle when the board did not provide one.

Some of the respondents had it 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... but PATHS do help by hiring vehicles at times” (Representative of Political and Local Government Matters at the State Health Board, Ministry of Health).

“During the rainy season the terrain in some places is flooded...Most of the time you may not even have enough money to fuel or maintain your car, because there is no money given to you specifically for that ... when the money is not there, you have to go to the sites closer to you and not the hard – to- reach areas...”(HOD health Udi local government area / LHA 1 executive secretary).

Monitoring occurs in both sites but it was said to be stronger in Agbani (DHB1) where the monitors make a weekly visitation and they pay unannounced visits. As noted by one of the health workers.

“The supervision is on weekly basis or twice in a month. They can just come at any time/ at random. They have been coming every now and then to supervise us.” (Health worker Agbani)

Again, the increased frequency was attributable to the chief actor of DHS coming from this district. The district was also said to have been a sentinel site for a malaria research in children as well as testing and counseling centre for HIV/AIDS by an international organization. These activities were not found going on in the DHB2.

## Discussion

This study provides evidence on the policy development and implementation process of the District health system in Enugu state southeast, Nigeria. The results from our interviews with the policy makers showed that the DHS policy among other things were expected to integrate the primary health care, secondary health care and the tertiary health care systems. This kind of decentralization policy strategy has been implemented in many sub-Saharan African countries as part of a wider process of political, economic and technical reforms.<sup>20</sup>

This is expected to ensure an improved health care delivery system in the state by improving access to quality health care, make the cost of health care affordable to the poor; and provide access to health care for both urban and rural residents. As found in

this study, decentralization may not guarantee welfare improvement and may worsen vertical equity.<sup>8-9</sup> This is a shift from the old tradition of health care delivery system where there was a parallel three tier levels of health care system in the state characterized by inefficiency and poor quality health care with its obvious wide inequity between the rich and the poor.

Difference in Implementations Experience in both District 1 and 2

The experience in the two case study sites clearly shows a gap in the policy intent and Policy implementation. Following the emergence of the DHS, most of the characteristics of the old system have disappeared. While there has been marked improvement in district 1 in some items such as health worker availability and patients' patronage, this is not so in district 2 (although better than the old system). Given more attention to one case study than the other suggests that there may be a different implementation experience. Poor infrastructural development of DHB2 can limit patients' access, workers performance and poor DHS policy implementation. Thus, poor infrastructure could be a de-motivator among health workers.<sup>21</sup> The implementation experience of any health policy such as DHS may as well depend on the impact of the influential actors (those who make significant difference at one or more stages of the policy process).<sup>22</sup> Those influential actors such as the Chief Executive of the State and the State Health Commissioner including the decision of the PDPD accorded the DHB1 top priority in the infrastructural renovation. Also, district 2 is known to be politically marginalized, hence the low priority it was given.

### ***Have resource use and allocation, staff recruitment and posting been done according to how the policy was intended?***

Experience suggests that decentralization will fail in the absence of skilled staff, adequate finances and appropriate health system infrastructure.<sup>23</sup> The successful implementation of the DHS is dependent on adequate health work force availability. There was no disagreement on this among the health workers interviewed. They were all in agreement that there was inadequate health work force. This was as a result of the embargo placed on employment by the State government. By the creation of DHS, demand for health care services has been stimulated; patients now come to the health care facility because they have heard about changes that have taken place as a result of the new system. It is expected that prompt and quick

attention would be given to them. Therefore, the number of workers available to attend to the patients matters a lot for the implementation of the DHS. Long waiting time due to unavailability of health workers which was characteristic of the old system has equally become part of the new system. In the LHA where we have the primary health care centers, most of the health workers there are the community based health extension workers (CHEWs) with a few nurses. In some cases the CHEWs are just voluntary workers who are not in the pay roll of the local government. The availability of manpower in all the district hospitals has not been achieved. The district hospitals are still grasping with the problem of inadequate health workers. The managers of DHS may consider the need for health worker capacity, motivation and performance.<sup>24</sup>

With all the renovation of infrastructure coupled with the restructuring of the health system in the state without a corresponding employment of adequate health workforce, the implementation of the policy may not be successful. An incremental capacity building approach is thus recommended.<sup>25</sup> Staff motivation and remuneration are crucial for increased performance of the programme. Attitude of workers were found to be influenced by factors such as limited staff strength resulting from heavy work load which make them unhappy, and remuneration is inadequate and irregular leading to lack of commitment and involvement of workers in pursuit of private practice or involvement in other private businesses.

Similarly, resource use and allocation was said to be inadequate as well. This includes financial, equipment and medical supplies that are necessary for health workers to perform their job. The monthly allocation to the district hospitals is not enough and at the same time irregular. It created difficulties in running the district hospitals as they are short of fund. Both case study districts had almost the same problems. The monthly allocation stipulated by the policy was said to be far below what the district hospitals receive from the government. This has led to non-functioning of the exemption mechanism as conceived in the DHS policy thus resulting to demotivational effect among health workers.<sup>21,26</sup> It can also create unintended negative consequences as access to health care may be out of reach of the poor and indigent patients.

***What are the perceptions and acceptability of the DHS by the Program managers and health workers and community members, including the change in power and responsibility within the health system?***

The health workers satisfaction with the extent of improvement with DHS demonstrates their feelings about the transformation of the health system. Their working environment now looks nice; nevertheless they felt dissatisfied for not including them in the overall scheme in terms of remuneration. It is important to look at the entire feelings of health workers in the overall DHS framework. If the health workers have ill-feelings towards the system, it will be difficult to ensure efficient health care delivery. Since the health workers are the people to deliver the benefit of the policy to the supposed beneficiaries (clients), they cannot be neglected in the new system without some difficulty in the implementation. They have the potential to mar or enhance the implementation of any policy.<sup>15</sup> It is, therefore, important that their wellbeing is adequately taken care of. Even as these frontline health workers have no outlet to lodge their complaints, they may adopt coping strategies as a way of reacting to their financial neglect. The intended beneficiaries of the policy therefore will be the people to bear the brunt thereby making the policy to fail.

Actors such as local health managers and front-line health workers themselves directly influence the form that any policy takes within the routine practices of health care delivery systems through their words and actions. Their views are, in turn, influenced by the culture of the organization and society in which they work.<sup>15</sup> In public sector bureaucracies in particular, policies are also filtered through the ways in which these street level bureaucrats respond to and cope with the enormous pressures under which they work – such as high levels of demand, resource scarcity and uncertain job security.<sup>27</sup> Attempts to control the actions of street level bureaucrats only serve to encourage resistance to these actions, and act to increase their tendency to stereotype and disregard the needs of clients.<sup>28</sup> The nurses are not happy for not including them in the overall policy scheme. With the increase in their work load, they have been denied the opportunity of augmenting their salary using some additional part-time job as was obtained in the old system. Renovation of health facility buildings has been achieved, with the health facility environment wearing a new look yet the policy denied them of both moral and financial incentives but added more workloads on them. Not even a good number of them understand the policy. There is bound to be a problem of communicating this policy by way of implementation to the beneficiaries.

Community participation in health sector reform such as DHS cannot be overstressed. This gives

them a sense of belonging thus, seeing health as the peoples own, in which they should have stake in by involving them to take decision on their own health. In each of the Local Health Authorities, the extent of rapport existing between the community members and the health facilities under them remains an issue of concern. Any approach to health sector reform that fails to put into consideration the need to involve the community members to take decision on their own health may achieve some implementation failures. Therefore, participation should be seen as empowerment tool through which local communities take responsibilities for diagnosing and working to solve their own health.<sup>29</sup> DHS planners may take up the responsibility to create functional Health Facility Committees that will bridge the gap between the health facilities and community members.

Given the fact that the two levels (local and state government) before the new system ran parallel structures, disciplining a local government health staff found wanting by those at the state level under the new system may not be effective as such discipline could be thwarted. Reason for this is that the health staffs of the local government, likewise other staff under the local government are full employees of the Local Government which they are fully accountable to, instead of the state government. This may have the potential to generate power tension between these two levels. Except the string holding these two levels in the new system is well tightened, cooperation and coordination between the two as well as the services they render may not survive in the new system. It is a matter of concern that there is no LGA member in the PDPD which is the highest policy making body in the state. It is not clear why the LGA was not fully involved in the policy development process since their structure was to be integrated with that of the state. In our opinion, it was very naïve to have ignored the LGA. This might have led to their resistance.

***What is the level of monitoring and supervision as well as the factors affecting this, as well as determining whether there are differences in monitoring and supervision between geographic areas?***

Monitoring and supervision has been built into the DHS policy as a mechanism to ensure how DHS policy matches implementation. It is made part and parcel of the new system to see that health workers and the various structures they represent in the DHS comply with the demands of the new system. Since the old system lacks this ingredient, it is expected that the survival of the new system will

among other things depend on regular supervision and monitoring which compels people to work within the ambit of the policy establishing the new system. The different structures that make up the system therefore, are saddled with responsibilities with regard to supervision and monitoring. As a regulatory mechanism, monitoring and supervision can influence the quality of care and address assess problem by the beneficiaries (clients).<sup>30</sup>

This approach in actuality may have produced some positive outcome. Health workers are conscious of the regular supervision and are always at their duty posts. Each of the structures in turn is accountable to the Commissioner for Health. The system, therefore, has given rise to a structured monitoring and evaluation framework for service delivery. However, the important question is -who monitors who? The PDPD is not mandated by the policy to be involved in the overall monitoring and supervision likewise PATHS, yet they are all in the business of monitoring and supervision. The PDPD and its self - assigned supervisory role could have a potential for a positive impact as well as negative impact on the overall implementation. If their involvement is perceived as usurpation by the other component this may lead to disagreement, or affect negatively the regularity of supervision and monitoring by the SHB, or even add to the cost of running DHS as members of the supervision team have to collect per diem and other allowances. The knowledge of the policy assigned functions of the different components of DHS is important as this has the potential for focus and efficiency in the implementation of the District Health System. 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 but where the whole structure loses focus on its overall roles in the overall monitoring and supervision framework, it may bring about negative implementation experience.

However, it might seem to be usurpation of function as some of the structures, though, not mandated by the policy still carry out supervision of other structures. It is understood that such usurpation could produce both negative and positive outcomes. Nevertheless, this was not investigated in the study but has the potential to spark off contention between the two levels involved. Furthermore, if there is no proper coordination between both levels, it could be difficult to harness the potentiality of the supervision and monitoring strategy. The extent of the knowledge of each of the levels of DHS on the officially – assigned supervisory roles is important because poor knowledge of each level's role may be an indication of poor communication at the

inception stage. There is, therefore, need for proper communication of the roles of each of the structures which has been spelt out in the policy document if the policy will be properly implemented.

## Conclusion

The implementation of DHS in Enugu State has led to significant improvements in health facilities and has stimulated demand for health services. Additional health workers should be employed to maintain provision of services, ease the burden on current staff and ensure emergency health services are provided 24 hours a day. Without this, it is possible that health worker morale and commitment will suffer resulting in further staff shortages and poor quality of care. Mistrust between local and state government actors has led to resistance at the local level to policy implementation and, in some instances, the withdrawal of funds for DHS. One reason for this is that local government actors were not fully involved in the DHS policy development process. When planning and implementing new policies, efforts should be made to consult with and engage all actors, especially those who are responsible for implementation at the local level. The sustainability of the DHS is dependent on external funding sources and the State government has yet to fulfil its funding responsibilities. This raises serious concerns about how the DHS will be funded if donor funding stops and stifles long-term planning. Without dedicated funding and support from the State government, local level actors will have limited ability to support effective policy implementation

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