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RESEARCH ON THE COMPARATIVE ANALYSIS OF THE MINIMUM SERVICE PACKAGE IN PAS PROJECT STATE WITH THE PROVISION OF THE BASIC HEALTH CARE PROVISION FUND

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Background of the Study

The PACFaH@Scale project is a health advocacy project anchored by the Nigerian non-profit, the dRPC and implemented by 23 local NGOs and health professional associations and supported by The Gates Foundation. The focus of PAS is limited to evidence-based advocacy. The project's timeline is 2018 to 2022 and the issue areas of the project are: Routine Immunization, Family Planning, Amoxicillin as first line treatment for Pneumonia and ORS-Zinc as treatment for childhood diarrheal diseases and. Primary Health Care under One Roof (PHCUOR)

PAS is designed as an evidence-based advocacy intervention to catalyze government at national and state levels to deliver on pledges in the areas of: health financing; administrative/regulatory procedures and child and family health policy

Activities of the project revolve around a classical evidence-based advocacy model. It includes research to generate the evidence for advocacy; constituency mobilization for implementing CSOs to build strong coalitions issue focused coalitions; capacity building and training to equip the lead CSO and coalition members to use evidence and develop an advocacy message for face to face advocacy; identification of advocacy targets; conducting advocacy visits; follow up by back-up NGOs; and monitoring, documentation and learning.

The focal states of the project are Anambra, Enugu, Kaduna, Kano, Niger, Rivers, Taraba and Lagos States.

Introduction to the Minimum services package concept

The concept of a Minimum Services Package or basic health care package grew out of the 1993

World development report (WDR) a World Bank report that focused on health in developing countries. The overall conclusion from this and other studies was that public health expenditures in developing countries were often not directed towards the most cost-effective programmes. Substantial amount of the public funds was being spent on services which resulted in little gain for the population in terms of life expectancy or quality of life. The report argued that the most effective use of the public funds, in which the greatest amount of population health can be obtained per dollars spent, this is when the ministries of health ensures that their resources are allocated in a manner that ensures most cost-effective public health and clinical services accessible to all. No country in the world has the resources to meet all the health needs of it people and Nigeria is not an exception.

The Nigeria Government adopted the Minimum Services Package (MSP) concept to address the basic health needs of the majority of Nigeria. The concept Of the MSP is rooted in the National Health Act (section 11 & 13) to guarantee a basic package of public health and clinical intervention that are Cost effective, Socially and economically accessible especially to the poor and deal with priorities disease burden of the Nigeria population

Therefore, MSP is a guaranteed minimum priority set of health care intervention or services that is provided at the primary or secondary health facilities daily and always through government financing mechanism with the aim of concentrating scare government resources on intervention which will provide the best value for money grains. It is expected to improve efficiency, equity, political empowered and accountability. Three components of the MSP were adopted by the PAS state for their PHC namely Health infrastructure, services and Human resource for health. Implementation of the MSP are in two categories

1: The development of PHC intervention package: the PHC intervention package of the MSP require state to stated clearly the

° Facilities typology based on the services they provided

° Standardized list of health services to address common health problems for each type of facility

° Standardized treatment for each clinical intervention using standard treatment guideline

° Resources for standardization in number and skills mix of staff, infrastructure, equipment, Drugs, lab and medical supplies

2: The costing of the PHC intervention package: costing of the PHC intervention package require state to stated clearly the

° Catchment population

° Diseases prevalence in catchment population

° Total number of human resources for health needed

° Service utilization: average prescription, EMOC and family planning

Stakeholders implementing the Minimum services package at the state level

° State primary health care board (SPHCB) for responsible for developing and driving the implementation process

The strategic objective of the MSP is to ensure increase in coverage and quality of health services and to increase access to health services in all part of the state. The benefit of MSP as outline include Promoting access and equity to health services, Improving efficiency and effectiveness in services delivery, The MSP is used as a vehicle for rapid attainment of UHC as it addresses 90% of maternal mortality & morbidity and U5 mortality conditions and lastly Improving the standardization of facility typology in relation to clinical services it providing

Introduction to the Basic Health Care Provision Fund

In October 2014, the National Health Act (NHACT 2014) was signed into law, The Act provided a legal framework for the provision of the basic health care services to all Nigeria. A key component of the NHACT 2014 is the establishment of the basic health care provision fund which aims to ensure improved accessibility, affordability and availability of basic healthcare services to

all Nigeria. 50% of the fund will be used to provide basic minimum healthcare package of services at Primary Health Centers through the National Health Insurance Scheme (NHIS) gateway. The National Primary Health Care Development Agency (NPHCDA) gateway will disburse 45% of the fund to state primary health care development board (SPHCDB) which will be used for procurement of essential drugs, maintaining PHC facilities, equipment, transportation and strengthening human resource capacity. 5% will be used by the Federal Ministry of Health (FMOH) to respond to health emergencies and epidemics. Its source of revenue as contain in the NHACT of 2014

° 1% of FG's share of the Consolidated Federal Revenue (CFR)

° Donors

° Innovative sources

° internally generated revenue e.g. taxes, rate and levies

Stakeholders involve in the implementation of the BHCPF at the Federal level

° National Primary Health Care Development Agency (NPHCDA), responsible for transfer of funds to the State Primary Health Care Boards, who are in charge of disbursing the funds to the Local Government Health Authority (LGHA)

° National Health Insurance Scheme (NHIS) responsible for the provision of funds for basic minimum services package (BMHSP) at the PHC facilities

° Nigeria Centre Disease Control (NCDC) response for epidemic response

The Budget Office of the Federation under the Federal ministry of finance (FMoF) calculates the 1% CRF from the total revenue accrued to the FG and oversees the disbursement of the funds to the 3 gateways

State level

° State ministry of finance as custodians of the funds at the state level

° State social Health Insurance Scheme (SSHIS) which pays for the basic health care package at the PHC facilities from funds paid through the NHIS gateway

° State primary health care board (SPHCB) responsible for transfer of funds to the local government health authority, and eventually to the PHC facilities

Local government level

° Local government health Authority (LGHA)

° Primary health centre (PHC)

Criteria for accessing the basic health care provision fund

° state and local government are expected to contribute 25% of counterpart funding amounting to 100million towards the PHC project

° Renovation of all PHC facilities to be used for the basic health care provision fund (commitment to upgrading PHCs)

° Establishment of a functional state social health insurance scheme

° state and local government must also operate Treasure single account (TSA)

° PHC baseline assessment conducted

Basic minimum package of health services to be provided free of charge as stipulated in the National Health Act of 2014

1: maternal Health intervention for pregnant women (ANC, Labour delivery, Emergency Obstetric and Neonatal Care and family planning
2: Intervention for under 5s (Curative and Immunization)
3: Malaria Treatment for the general population
4: Non-Communicable diseases screening (blood pressure and Diabetes)

Justification

The justification for conducting this research study is to strengthen the social accountability aspect of the PAS project which aim to hold government accountable on policy and funding commitment in child and family health. The study help strengthen the achievement of PAS IPO 2 & IPO 10 in the result framework. Also, the MSP and BHCPF remains the rapid vehicle for the attainment of universal health coverage (UHC)

Objective of the study

° Identify key finding from MSP in PAS project state with the provision of the Basic Health Care provision fund

° To determine the agency responsible for developing and implementing the minimum services package in PAS project state

° To determine the quality assurance for monitoring the MSP in PAS project state and BHCPF

° To determine whether there is parallel PHC implementing the MSP in PAS project state and BHCPF

° To compared the MSP services provided in the PAS project state with the basic minimum health services package (BMHSP) of the BHCPF

Methodology

In-depth Review of the minimum services package document In Four PAS project state of Kano, Niger, Kaduna and Lagos. For the purpose this research two weeks was used as the duration for the study

Evaluation of the MSP in PAS projects state

Kaduna state minimum services package (MSP) was develop on the 23rd October 2017, the MSP document proposed to achieve 80% coverage for PHC services

° A diagnostic of the state PHC system shows low coverage of basic health intervention and poor quality of care, towards this an MOU was signed with DFID and BMGF to transform the PHC system, this effort seek to address issues specifically related to the supply side by developing a more viable public primary health care services delivery model implementation by 2020 (3- 4 years) and adopted all components of services provided by the ward minimum healthcare package WMHCP)

° The PHC services delivery plan fall between the current baseline system and the state minimum services package (MSP) aspiration. the state baseline system is estimated to cost 6.3billon with one thousand one hundred (1100) facilities, 248 PHC, 641 health clinics and 107 health post. 5400 employee 1595 (30%) CHEWs, 661 (12%) JCHEW, 468 (9%) Nurses and 0% Doctors

° Operational cost varies from facilities classified according to the SPHCB categorisation, PHC N50000, health post N25000 and health clinics N5000

° The minimum services package would cost 63 billion which is ten times the 2016 fiscal space of 6.5 billion and 35% of state annual total budget requiring an additional 4000 facilities and over 54 HRH

° Fiscal space projection is expected to reached 8billon – 9billion in 2020

° The state shortlisted three model options optimize facility mix based on population density establishing 1-2 PHC/ward and up to 11 clinics per ward, 33 wards require at least 2 PHC due to high population density resulting in 288 PHC in total and 648 clinics. Service will be standardised across all facilities to drive equitable provision care

A phrase approach of implementation over five years is proposed, starting immediately with a preparation phase followed by 3 stages of transformation to achieve the SDP 1

° Pre implementation phase assess current system and develop workplan for facility prioritization, HRH recruitment and out of facility delivery

° Phase 1 prioritise development of 255 PHC (January 2018- December 2018: establish and staffed 255 PHC priorities, providing standard set of priority services, pilot integrated outreach model and begin revitalising Ward development committee (WDC)

° Phase two expand transformation (January 2019 – December 2019): establish and staffed 33 remaining centers' and 255clinic, while deproristising 69 health post, Redistribute HRH in post across PHC and clinics, expand integrated outreach model, pilot Village health workers (VHW) driven community-based services and complete WDCs revitalization

° Phase three realise transformation and achieve SDP 1 (January 2020- December 2020): establish and staff remaining 393 clinic, complete roll out of VHW community-based services

• Service delivery plan (SDP) one will be achieved 69% access at the cost N22.1billion (10.5billion if state funded drugs and commodities remain at 7%, and facilities staffed to meet population in need. SDP two will achieve 76% access at a cost of 25. 7billion, 14.1billion if state funded drugs and commodities remain at 7%, PHC staffed to MSP guidelines and clinics staffed at 50%, SDP three will achieve 77% access at a cost 29.2billion, 17.7 billion if state funded drugs and commodities remain at 7% and PHC staffed at MSP level

Successful delivery of the implementation plan will be enabled by finance, governance, data and performance, stakeholder's communication, supply chain and HRH training

Kano state MSP document was developed in December 2019, as part of measures to achieve universal health coverage, kano state adapted and coated it Minimum services package for PHC and has developed an investment plan to guide and strengthen the implementation, the MSP is most directly related to PHC service delivery.

The state aspire to guarantee 100% of it population to access PHC services in a phase approach of 8 years by providing all the services In the ward minimum healthcare package (WMHCP) across its 484 facilities ward, defined services for each of the three health facilities types and health workers, The state required 487 functional PHC one per ward as a starting point, two per ward with population greater than eight thousand 80,000, additional 421 clinic across wards with more than twenty thousand population

The state currently has 1,377 facilities existing, 508 PHC and 868 health clinics with 918 given priorities, 543 of them required upgrade to meet the MSP guideline for health facilities, 175 of the facilities do not exist and need to be constructed. All PHC and clinics are to operate 24hours daily

The state required 21,654 minimum frontline and support HRH staff to delivered Effective PHC services to it population. The state MSP prioritize resources to revamp selected facilities to meet the MSP guideline, currently only 132 of PHC, 68 health clinics meet the MSP standard, 348 of the PHC and 263 of the health clinics do not meet the MSP standard for PHC and health clinics.

The state aspire Minimum service package require 56billion to implement it plan and additional 60billion naira for infra structural upgrade and maintenance across health facilities in the MSP, the state followed a three-step process to develop it investment plan to resource the MSP

° Step one determines state current and projected fiscal space: e.g the currently available funding for running the PHC program

° Step two define suite of options across the core MSP costing components (HRH, services delivery and channel, infrastructure)

° Step three make investment decision and trade offs, review implications- Best course of actions for maximizing available resources across the core MSP components

The state adopted a phased approach to achieve full Minimum Service package implementation. The timelines for the phases are largely driven by the state fiscal projection

° Phase one 1-4 years implementation plan (1PHC/ward focus)

° Phase two 5-6 years (1PHC/ward plus 50% health clinics

° Phase three 7-8years (1PHC/ ward plus 100% health clinics)

The identified five source of funding to finance it phase 1 investment plan, state and LGA, federal government, KHETFUND, BHCPF and KSCHAMA

Evaluation finding from the MSP document

° Health facilities in kano and Kaduna state classified inline with NPHCDA guidelines

° State minimum service package developed inline with NPHCDA guidelines

° Health service delivery performance outcome in both state regularly reviewed to track progress and to inform policy

° State investment plan developed inline with the MTEF

° State MSP resource gaps regularly evaluated

Key finding (similarities and differences) from the comparative evaluation of MSP in PAS project state, kano, Kaduna, Niger and Lagos with the provision of Basic Health Provision fund

Difference between MSP and BHCPF

Minimum service packages	Basic health care provision funds
1: The operational cost for PHC services in the MSP documents is disburse through the SMOF to the PHC	Operational cost is disburse through the NPHCDA gateway to SPHCB for onward disbursement to PHC
2: The MSP in PAS project state is financed through the state annual budget and MoU on PH {Kaduna and Niger state}	Financed from the 1% CRF of the federal government, partners and donor's contribution
3: The implementation of the MSP is been monitor through the instrumentality of ISS and annual performance review conducted by the SPHCB	The implementation of the BHCPF is monitor by the NPHCDA gateway, NHIS gateway, SPHCB gateway, SSHIS gateway and independent verification agency (IVA)
4: The ward minimum health care package (WMHCP) services provided for by the MSP documents is costed and paid for (this means it services is not free it is paid for by the citizens)	The Basic Minimum Health services package (BMHSP) as stipulated in the 2014 NHACT for the BHCPF is free of charge
5: the MSP is backed by the NHACT and Signed by the governor	The BHCPF is back by the NHACT of 2014 and signed by the president
6: The MSP documents address the health needs of the state population in order to attain universal health coverage	The BHCPF strengthen the implementation of PHCUOR policy reform at sub-national and sub-state levels to achieved and sustain universal health coverage
7: funds disburse through state commercial account	Funds disburse through TSA
8: The MSP document lay the foundation upon which the BHCPF thrive on	The BHCPF is used by state to finance their MSP documents
8: The MSP document specifies the amount disbursed to each PHC, health post and health clinic for operational cost	The BHCPF only specific percentage of funds to be disburse to PHC by the NPHCDA gateway through the SPHCB gateway
9	State and LGA contribute 25% (100 million) as counterpart funds before assessing the BHCPF

Similarities between

Minimum services package MSP	Basic Health Care Provision Fund
1: back by the NHACT section 11 & 13	Backed by section 11 of the NHACT 2014
2: adopted the ward minimum healthcare packages (WMHCP) service as its components of its MSP documents	Adopted the ward minimum healthcare packages (WMHCP) as the basic minimum health services package (BMHSP)

3: disburse funds to PHC, health post and health clinic for operational cost	Disburse funds through the NPHCDA gateway to SPHCB gateway for onward disbursement to PHC for operational cost
4: The MSP document Strengthen the implementation of PHCUOR policy reform	strengthen the implementation of PHCUOR policy reform
5: The MSP document addresses the health needs of the state population	address the health needs of the vulnerable group
6: The MSP document addresses 90% of the maternal mortality, morbidity and Under 5 mortality condition	if properly implemented will address 90% of maternal mortality, morbidity and Under 5 maternal conditions

Reference:

° 2017 Kaduna state MSP document

° 2019 kano state MSP document

° 2007-2012 Ward Minimum Healthcare Package (WMHCP)

° 2018 BHCPF operational Manual

° 2014 National Health Act (NHACT)