Humanitarian Development Nexus (HDN) in Nigeria

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General Overview

- Spectrum of differences in every emergency.
- Commonalities of methodology and approach.
- Example of differences in Nigerian findings:
  - A reduced offer of health services i.e lack of staff, destroyed facilities
  - HR availability seems not to be the main bottleneck because when we search for them we find them, but then other HR related issues.
  - Mobile teams appreciated by WB as a good element for recovery.
  - Coordination at all levels and with donors and at the most local LGA level.
Issues to explore with mobile teams

- Mobile teams appreciated not only by emergency
- Seen as an element of resilience but also as possible future long-term staff for rehabilitated units
- New mechanism opens the possibility to transfer them to the State with salaries and supplies financed maybe by the WB under PBF
The issue of finances with a few novelties

- The upcoming (tbc) new 1% of the state Budget dedicated to pay for PHC
- How can this fund in the north be used
- In NE Nigeria, the fund could be used for uprooted and difficult to reach population, via e.g. to pay for the NHIS, National Health Insurance, that today covers 4.5% of the population?
- The WB through one of their 5 lines, one of them on PBF, currently piloted with success in 2 LGA, expanding to 6 and then 12 safe areas
- How can the grey zone in between safe easy access zones and hard to reach zones be covered?
- How NGOs working in the grey zone could ensure the future of their staff and their own exit, by raising to the PBF standards?
Coordination at federal level Abuja:

- Ensure active engaging of ministries of Health and planning and finances
- With donors to provide coherence of funding to solve current fragmentation that makes local coordination more difficult.
- MoH to provide policy guidance in key aspects e.g limits and rules of incentives
- The coordinated work between donors and MoH for the agreements of Health Service Packages and standard MoUs
- Nigeria to register and accreditate partners, including MoU on standards, packages, incentives and other policies
At the level of LGA

- Reinforcing leadership and governance
  - To be better coordinated locally by the same health authorities already trained on surveillance and early alert.
  - This work should be facilitated by donor coherence and standard MoUs with implementing partners, based on FMoH policy guidance.

At the State level

- Subgroup inside the health cluster, being strongly animated by WHO, specifically working on HDN with regular feedback to the larger health cluster group.

Overall

- Build on the draft WHE/HSS support mission report to produce a government led roadmap.
  - Allows flexibility in implementation and indicator target, to match the context evolution.
Extra slides

THANKS FOR YOUR ATTENTION
BIG OLD

- Nok Statues 3000 years old.
- Middle age city states, kingdoms and empires, including Hausa kingdoms and Borno dynasty in north, Oyo and Benin kingdoms in south.

A SNAPSHOT OF NIGERIA

**POPULATION (2016)**
186 million
Global ranking: 7

**GDP PER CAPITA (2016)**
$2,178

**GDP GLOBAL RANKING (2016)**
$405 billion
Global ranking: 26

**MEDIAN AGE (2016)**
18 years

**HUMAN CAPITAL INDEX (2016)**
48.36
Global ranking: 127

**TARIFFS**

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<tr>
<td>Agriculture</td>
<td>Non-agriculture</td>
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<td>15.7%</td>
<td>11.5%</td>
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Copyright: Stratfor 2017

Weekly Brent and West Texas Intermediate crude oil spot prices, 2011-2017

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<th>Brent West Texas Intermediate</th>
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<td>Source: U.S. Energy Information Administration, based on Thomson Reuters</td>
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Geographies intersect

Bornu Empire
- Current Shehu (title of a ruler) is Abubakar Ibn Umar Garbai

Boko Haram

Lake Chad Basin long ongoing crisis
- Nigeria, Cameroon, Niger, Chad
- Population: 17 million. People in need: 10.9 million (7.7 in Borno/Yobe/Adamawa)

Kanuri Language

Poor health indicators
WHO Global Programme of Work

**Mission**

*Promote health - keep the world safe – serve the vulnerable*

**Strategic priorities**

- **Health coverage** – 1 billion more people with health coverage
- **Health emergencies** – 1 billion more people made safer
- **Health priorities** – 1 billion lives improved

**Strategic shifts**

- Step up global leadership – diplomacy and advocacy; gender, equity and rights; multisectoral action; finance

**Drive impact in every country** – differentiated approach based on capacity and vulnerability

- Policy dialogue – to develop systems of the future
- Strategic support – to build high performing systems
- Technical assistance – to build national institutions
- Service delivery – to fill critical gaps in emergencies

**Focus global public goods on impact** – normative guidance and agreements, data, innovation
Historic of WHO scale up and evolution of support and interventions

08/16 to 12/16
Control of a very high mortality, EWARS, service provision

1/17 to 6/17
Surveillance, preparedness, mobile teams, expansion

7/17 to 12/17
Cholera, malaria, new displacements, emergency response with a protracted future

1/18 and the future
Recovery with recurrent needs for response in a volatile and risky environment
**Actors:**

- LGA
- A State MoH
- A Federal MoH with sub institutions
- NCDC
- Health professionals
- The Government and State authorities
- The Shehu and traditional authorities
- The military
- Boko Haram
- UN agencies
- NGOs (few for the needs)
- Faith based organizations
- Donors: Countries, Banks, CERF, pooled fund
- Financing mechanisms
- IDP
- Receptor populations
- The private sector
Health System 3 interrelated Levels + private sector
Humanitarian Development Nexus NWOW

- Greater **connections between humanitarian and development** programming and effective coordination mechanisms are now being sought, using the SDG target for UHC as a collective outcome (Joint assessment & planning, coordinated implementation, joint M&E).

- Depends on the context, government’s stewardship and its willingness and capacity to respond to the needs of its population.

- Humanitarian partners need to seek opportunities for integration of their interventions with flexibility in implementation and risk management.

- **Even in unstable contexts** it should be possible to provide emergency lifesaving health services while using some aspects of health systems pillars, increasing robustness and resilience in the health system, putting it in better position to recover.
Summary of Key bottlenecks with service delivery

• Absence of a defined package of essential health care package adapted to the reality of the fragile environment and the delivery platforms available (hospitals, PHC facilities, mobile teams, community, referral system)
• Absence of organized programmes for many of the NCD
• Abundance of policies and plans, but limited implementation, not always adapted
• Low and inequitable coverage with interventions because of gaps in service delivery
• Poor service integration
• Limited scaling up of some services, especially EMS to primary and community levels
• Gaps in quality of care => reduced health services safety and effectiveness
• Absence of emergency medical services
• Dysfunctional referral services
• Gaps in availability of data for programming and tracking progress, especially for NCDs
• Weak surveillance system and risk reduction management

From NSHDP II, in bold ones can be improved with better definition of a package adapted to different security and operational contexts, including defining referral pathways
General findings and recommendations

• MOH and most partners and donors met have strong interest in Humanitarian Development Nexus (HDN), early recovery and health systems strengthening. They seek clarity on how to operationalize HDN work and are demanding support to take it forward

• **Donors to act in a better defined and coordinated way (geographical or sectoral) in order to facilitate coordination of the elements of the nexus**

• General principles:
  • Do not undermine the national systems
  • Where possible, seek alignment to health system policies, guidelines and standards
  • In protracted crisis develop policies, SOPs, strategies, tools and guidance adapted to the crisis environment and needs.
  • Work with national health authorities and partners where and when possible
  • Create a welcoming and collaborative environment for development actors
Governance, Leadership and Coordination

• At Federal level
  • Donors to act in a better defined and coordinated way (geographical or sectoral) in order to facilitate field coordination of the elements of the nexus.
  • Review health partners – FMoH MoU standards defining roles, responsibilities and adherence to aid-effectiveness principles; review approval process assuring role for SMoH and LGA

• At State level
  • Creation of a subgroup on HDN inside the frame of the current emergency coordination mechanisms (temporary, may evolve and grow)
  • Map donor and partners support and align them to ensure some LGAs don’t have too many partners while others very few or non and also that Partners align to the state annual operational plans
  • Apply JANS planning and review processes at state level linking humanitarian assistance

• At LGA level
  • Improve governance, leadership and coordination capacities of LGA authorities. Avoid fragmentation by a coherence of authorities, donors and actors to translate in less actors and higher coverage with emphasis on all delivering and agreed package of services and functions of alert, surveillance, supervision and performance aligned to national/state level standards.
  • Community engagement though Ward Development Committees or Village health committees, though CHW and link with health facilities and though HESPER
  • Support operational planning and review processes at LGA level linking humanitarian assistance
Health Workforce

• Seek standardization of incentives and motivation package for health workers employed by partners, and in hard to reach areas
• Establish State level health workforce information system
• Explore the approach to ‘bonding’ as in Yobe in other States
• Explore added value of introducing the staff performance monitoring and improvement, as used in the PBF
• Also assure staff accommodation where indicated
• State to show the political will in ensuring that all staff on payroll work in the LGAs of deployment and any arrangement with partner have to be with the full knowledge and permission of the government
• Upgrade the two nursing schools in Borno towards accreditation (WHO DG committed support to State MOH commissioner),
Service Delivery

- Define EPHS for the different service delivery platforms (hospitals, PHC facilities, mobile teams, community, etc.) adapted to different operational and security contexts.
- For IDP and crises affected areas, combine permanent, non-permanent and mobile services.
- Define and support referral pathways, well-functioning hospital for a cluster of LGAs.
- Develop performance and quality of services monitoring tools and processes specific for each delivery platforms as basis for improving quality and facility performance.
- Seek alignment with PBF performance standards and other relevant national quality of care standards.
- Consolidate the multiple CHW initiatives to standard CHW packages.
1. LGAs that are stable and accessible

- Mainly development support, current PBF, BHCPF, shift toward purchasing through NHIS
- Services to resident communities with large inflows of IDPs will be provided by a combination of interventions on existing permanent structures—upgrading them according to the FMoH standards—and non-permanent structures
- Selected humanitarian support for specific increased needs, such as SAM with medical complication, treatment of Lassa patients, etc
- Discourage short-term, small scale, small range or partial EPHS health services delivery projects.
2. LGAs that are insecure with large areas not accessible, or hard to reach or informal camps

• Mostly humanitarian support by partners operating mobile health teams to provide primary care services, working from the nearest permanent, sizeable facility.

• Higher emphasis on community based and outreach to bring services to the affected population.

• Selective package of services will be opportunistically delivered by mobile teams.

• Free services primary care.

• Define most appropriate location in LGA or nearest LGA by clustering several LGAs for referral care: reimbursing costs or seek contract of the hospital through PBF?
3. LGAs that are in between, where security is improved but not yet stable, and formal camps

• Seek integrated or complementary support between humanitarian partners for the unstable areas, and development investments in more stable parts, including a relative stable location for referral capacity within the LGA or the nearest stable LGA (clustering LGA for hospital referral purposes)

• Where services are interrupted and facilities dysfunctional/damaged: served by non-permanent structures, to be replaced in the future for permanent ones.

• Services to resident communities with large inflows of IDPs can be provided by upgrading existing permanent structures to FMOH standards, complemented by non-permanent structures.
Other pillars

• Health financing
  • Use an apply the evolving mechanisms of financing
  • Develop policy for reimbursement of prioritized services for referral to hospital
  • Consider the establishment of state level pooled funds.

• Health information
  • Revamp and generate digitally the IDSR and its articulation with DHIS 2, so that alerts and response can be generated in time at LGA level.
  • Use HeRAMs
  • Partners to use national HMIS systems

• Health structures
  • Couple physical construction and rehabilitation initiatives with revitalization of human resource, health services, supplies and other health systems initiatives, using national standards
  • Assure IPC and facility-WASH infrastructure
Development of the detailed joint HDN roadmap with the government and partners with focus on:

• Improved partner coordination (humanitarian-development-donors) at different levels;
• Adapted package of health services defined by service delivery platform with focus on both access and quality;
• Addressing different health workforce issues;
• HDN adapted planning and review processes and HMIS;
• Capacity building with strong focus on LGA health management teams;
• A NE Nigeria state WS focusing on HDN allowing sharing of experiences.
• Preparing “HDN in the health sector” as topic national conversations, Health Partner Coordination venues and pledging conferences.
• WHO to continue essential emergency response work serving affected population, embedded in HDN principles.