CASE STUDY

# NIGERIA

Nigeria's health sector is primarily funded by out-of-pocket spending, which accounts for 70% or more of total health expenditure. Development partner funding amounts to 7% and public funding to 16.5% of total health expenditure.[1] Public funding for health is limited at US$ 32 per capita annually.[2] Total public health spending is 5.3% of total government spending.[3] Nigeria's highly decentralized system of governance gives state and local governments considerable autonomy in setting their own health priorities and allocating resources to health and specific services. Most of the funding from development partners and the government is spent on salaries and tertiary care, or in vertical funds managed by different directorates at different levels of the health system. In addition, the limited funds that are available are not always well managed, resulting in stock-outs, ill equipped health workers and poor quality of care.

As a result of resource shortages, providers charge informal or formal user fees for even the most basic services, such as antenatal visits, which are meant to be free of charge in the public sector. A study in Cross River State found that informal user fees were as high as US$ 2.50 for an antenatal visit.[4] These fees discourage the poor and most in need from seeking care, or exacerbate poverty. One quarter of the population spends more than 10% of household income on health care, more than double the figure for the rest of the continent, and as a result many suffer financial hardship or are pushed below the poverty line by health care costs.

Nigeria has the second highest rates of maternal and newborn mortality globally, with 814 maternal deaths per 100,000 births.[5] Despite many recent efforts to improve maternal health and primary care coverage, key coverage statistics have remained relatively constant. The under-5 mortality rate is high at 100.2 per 1,000 live births. See Table 1 for key demographic and health indicators. With large variations between income quintiles, the poorest carry the heaviest burden.[6] Northern states and remote rural areas also lag far behind in terms of service coverage. To improve access and overall health outcomes, there is a critical need to strengthen health systems and remove user fees that prevent patients from seeking care.[7]

*Prioritizing the benefits package*: The package of services available is not clearly defined and varies across the country, depending partly on limited funding from development partners and government at the state and local levels and the goals of new

1 World Bank. Financing UHC in Nigeria: rationale, policies, and practices. Presentation. 2018.

2 Ibid.

3 World Bank, 2018. https://data.worldbank.org/indicator

4 Edu BC, Agan TU, Monjok E, Makowiecka K. Effect of free maternal health care program on health-seeking behaviour of women during pregnancy, intra-partum and postpartum periods in Cross River State of Nigeria: mixed method study. Open Access Maced J Med Sci. 2017; 5(3):370–382. doi: 10.3889/oamjms.2017.075

5 Numbers from WHO Global Health Observatory, most recent year available.

6 Ibid.

7 General Disclaimer. Indicator estimates in this case study may differ from those listed on the WHO Global Health Observatory or other UN estimates' websites.

initiatives and schemes. Each funding source (development partners, insurers, government agencies and Ministry of Health departments) may prioritize different services; there is limited coordination between them. Nigeria has recently developed the National Strategic Health Development Plan II (2019-2023) which defines increased utilization of an Essential Package of Health Care Services (EPHCS) as one of its five strategic pillars. This package includes SRHR services, as well as communicable and noncommunicable diseases, mental health and other key areas. Some key areas on SRHR, such as family planning, were included generically, with little detail about specific commodities or levels of service delivery. By contrast, more detail is included about products included in the Essential Medicines List. This package also omits reproductive cancers and services for gender-based violence. Safe abortion services are omitted: induced abortion in Nigeria is prohibited unless the life of the pregnant woman is threatened.

States have also developed State Strategic Development Plans to align with this national plan. However, it is not clear how the benefits they include

## Table 1. Nigeria: key demographic and health indicators

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|---|---|
| **Total population (2016)[1]** | 185,990,000 |
| **GNI per capita (PPP international US$, 2013)[1]** | 5,360 |
| **Life expectancy at birth M/F (years, 2016)[1]** | 55/56 |
| **Total expenditure on health as % of GDP (2015)[1]** | 3.7 |
| **Out-of-pocket expenditure as % of current health expenditure (2016)[2]** | 75 |
| **Voluntary health insurance as % of current health expenditure (2016)[2]** | 1 |
| **Nurses & midwives/10,000 pop.(2013)[3]** | 14.524 |
| **Physicians/10,000 pop. (2013)[3]** | 3.827 |
| **Percentage of births attended by skilled health personnel (2013-2017)[4]** | 43.0 |
| **Percentage of married or in-union women of reproductive age whose need for family planning was satisfied with modern methods (2017)[4]** | 26.3 |
| **Abortion at the woman's request (Y/N)[5]** | Law varies by jurisdiction |

[1] WHO Global Health Observatory https://www.who.int/gho/en/
[2] Global Health Expenditure Database http://apps.who.int/nha/database/Select/Indicators/en
[3] National Health Policy 2016 accessed via WHO Global Health Observatory https://www.who.int/gho/en/
[4] Multiple Indicator Cluster Survey 2016-2017 https://microdata.worldbank.org/index.php/catalog/3002/
[5] Global Abortion Policies Database https://abortion-policies.srhr.org/country/nigeria/

will be financed, and resource shortages often prevent services from being delivered, or being delivered without charge, to the population. In addition, the National Primary Health Care Development Agency has defined a Ward Minimum Package of standard services available at primary health care level, but its implementation has been severely limited, due largely to limitations in resource availability and other challenges.[8]

Given the challenges involved in financing and delivering this National Strategic Health and Development Plan package, the government undertook a new reform, pooling external and government resources to finance and deliver priority services especially for the rural poor. This resulted in the Basic Healthcare Provision Fund (BHCPF), formally launched in January 2019. Resources being limited, the government chose to prioritize key services, including SRHR, and specifically many of the services recommended in the Guttmacher-Lancet Commission on SRHR, for the most vulnerable populations (see Table 2). As in the Strategic Health and Development Plan, services such as safe abortion and management of reproductive cancers were not included.

*Participation*: The development of the BHCPF, and its inclusion in the 2014 National Health Act, occurred through an iterative multisectoral and multistakeholder process. While the Federal Ministry of Health has the power to define the services to be provided and the population to be covered, development of the benefits package for the BHCPF was conducted through a participatory process involving many stakeholders at different levels, including federal and state government representatives, civil society organizations, development partners and the private sector.

*Challenges*: This reform is at a very early stage, but significant challenges have already arisen in determining the institutional arrangements for the reform, and for the package itself. While the benefits package has been defined in broad terms, there is insufficient data about service availability and steps

8 A ward is the lowest administrative unit in Nigeria, below that of local government.

necessary to upgrade delivery to provide these services (e.g. training health workers to deliver the services). Many question whether the resources available will be sufficient to deliver and sustain these services.

*Successes*: The development of the basic minimum package was informed by data on cost-effective interventions that meet the needs of the population, based on evidence of disease burden, poverty and inequality in the country, and available financing across all levels of the system. Considerable thought has been given to designing the BHCPF to tackle financing and supply challenges that hampered the delivery of past reforms. Development partners and the government have earmarked funds to deliver this package, and this has been communicated at all levels of government.

*Reforms, revisions and plans for the future:* The BHCPF earmarks federal and state level public funding for a defined set of essential health services. Additional funding will initially be received from the Global Financing Facility and the Bill & Melinda Gates Foundation. The government released 25% of the fund for the BHCPF in 2019 and is working with an additional 15 states and the Federal Capital Territory, all of which have indicated readiness to implement the BHCPF for a planned rollout in those states.

The reformed basic minimum package of health services includes nine interventions: four for maternal health (antenatal care, labour and delivery, emergency obstetric and neonatal care and caesarean sections), one for reproductive and adolescent health (family planning), two for under-5s (curative care and immunization), as well as treatment of malaria and screening for select noncommunicable diseases (including cardiovascular and urinalysis tests). Government and development partner funding will be aligned with this package.

The BHCPF was included in the 2014 National Health Act, appropriated in the 2018 budget and formally launched in January 2019. However, the financing systems for this reform still need to be set up to ensure that providers and state and local governments are accountable for and incentivized to provide quality services. In addition, strengthening public service delivery (and/or partnering with the private sector) will be essential to ensure that services can be financed and delivered.

As described above, the design of this reform has been the subject of a consultative process for several years. However, SRHR actors, including civil society, can play a role in increasing awareness of the reform and of the rights and entitlements set out in the National Health Act, and by holding federal and state governments accountable for delivering on this commitment. Evidence is also needed about the logistical requirements for delivery of these services, e.g. in terms of system strengthening. SRHR actors will also have opportunities to influence expansion of this package and broader reform in future.

## Table 2. Interventions recommended by the Guttmacher-Lancet Commission on SRHR and their inclusion in/omission from Nigeria's health benefits package

| Interventions recommended by Guttmacher-Lancet Commission | Nigeria's Basic Health Care Provision Fund+: interventions included/omitted |
|---|---|
| **Comprehensive sexuality education*** | • Not included in the benefits package (nor in previous plans) |
| **Counselling and services for a range of modern contraceptives, with a defined minimum number and types of methods** | • Pills<br>• Condoms<br>• Injectables<br>• Intrauterine devices<br>• Implants |
| **Antenatal, childbirth and postnatal care, including emergency obstetric and newborn care** | • Antenatal care<br>• Basic and comprehensive emergency obstetric and neonatal care |
| **Safe abortion services and treatment of complications of unsafe abortion** | • Not included in the benefits package (nor in previous plans) |
| **Prevention and treatment of HIV and other sexually transmitted infections** | • HIV screening<br>• Antiretroviral therapy for mothers and newborns<br>• Note: other sexually transmitted infections were included in previous plans for the public sector<br>• HIV counselling<br>• Safe infant feeding<br>• Counselling for mothers with HIV |
| **Prevention, detection, immediate services and referrals for cases of sexual and gender-based violence** | • Not included in the benefits package or previous plans for the public sector |
| **Prevention, detection, and management of reproductive cancers, especially cervical cancer** | • Not included in the benefits package or previous plans for the public sector |
| **Information, counselling and services for subfertility and infertility** | • Not included in the benefits package or previous plans for the public sector |
| **Information, counselling and services for sexual health and well-being** | • Not included in the benefits package or previous plans for the public sector |

+ The BHCPF has not yet been implemented: services were therefore compared with the previous NHSDP (for the period 2010-2015).
* Comprehensive sexuality education is in most countries the responsibility of the ministry of education, and is not normally included in a health benefits package, which concerns interventions in the health sector.

The Partnership for Maternal, Newborn & Child Health

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