ATTAINING UNIVERSAL HEALTH COVERAGE THROUGH INNOVATIVE POLICIES: A REVIEW OF NIGERIA'S NATIONAL HEALTH ACT AND STRATEGIC HEALTH POLICIES

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A thesis submitted in partial fulfilment of the requirement for the degree of Master of Science in Public Health by Gideon Sorochi Okorie, Nigeria.

Declaration:

Where other people's work has been used (from either a printed or virtual source or any other source), this has been carefully acknowledged and referenced by academic requirements. The thesis "Attaining Universal Health Coverage through innovative policies: A review of Nigeria's National Health Act and Strategic Health Policies" is my work.

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To my ICHD/ MPH classmates who have contributed immensely to this learning experience, may God preserve us and move us to a greater height of impact in the society we live.

To God Almighty, who knows the end from the beginning, my mouth is full of praise, and I bow in adoration.

LIST OF ABBREVIATION

ANC	Antenatal Care
BHCPF	Basic Health Care Provision Fund
BMPHS	Basic Minimum Package of Health Services
CHE	Catastrophic Health Expenditure
EOCs	Emergency Operation Centres
FMOH	Federal Ministry of Health
GDP	Gross Domestic Product
GIS	Gabon Indigent Scheme
HIV	Human Immunodeficiency Virus
IHR	International Health Regulation
LGA	Local Government Area
MNTE	Maternal and Neonatal Tetanus Elimination
NCDC	Nigeria Centre for Disease Control
NCH	National Council on Health
NDHS	National Demographic Health Survey
NERMA	National Emergency Response Agency
NHA	National Health Act 2014
NHIS	National Health Insurance Scheme
NHP	National Health Plan
NPHCDA	National Primary Health Care Development Agency
NSHDP II	National Strategic Health Development Plan 2018 – 2022
NTHIS	National Tertiary Health Institution Standard Committee
OOP	Out-Of-Pocket Payment
PHC	Primary Health Care
PHCUOR	Primary Health care Under One Roof
PMNCH 2011	Priority Reproductive, Maternal Newborn and Child Health intervention
RMNCH	Reproductive, Maternal Newborn and Child Health
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
SHIS	State Health Insurance Scheme
SMoH	State Ministry of Health
SPHCB	State Primary Health Care Board
SPHCDA	State Primary Health Care Development Agency
TB	Tuberculosis
THE	Total Health Expenditure
UHC	Universal Health Coverage
VAT	Value Added Tax
WASH	Water, Sanitation and Hygiene
WCBA	Women of Child Bearing Age
WHO	World Health Organization

ABSTRACT

Background: To strengthen the coordination of the health sector based on identified weaknesses, the National Health Act 2014 was enacted. It provides the legal framework that guides activities in the health sector, including bedrock for policies to stir Nigeria into progressing towards attaining Universal Health Coverage (UHC) and achieving the Sustainable Development Goals. Six years after, indicators for monitoring progress towards UHC are worsening while some countries with comparable GDP to Nigeria are making progress.

Objective: To review strategic health policies instituted by Nigeria to guide progress toward attaining UHC, ascertain implementation status, and make recommendation of best practices that will fast-track progress towards UHC to stakeholders.

Methodology: Literature review of articles related to the attainment of UHC in the context of Nigeria was conducted. Analysis was done using the WHO's three dimensions framework of UHC. Semi-Structured interview of purposively selected stakeholders was conducted and used in triangulating the result of findings.

Findings: The Nigerian health policies are optimal to drive the attainment of UHC. However, due to poor commitment by the government and fragmentation of funding, the critical measure of progress, including population coverage and financial protection, is below expectation. Also, a significant disparity exists in population coverage, and a large proportion of Nigerians still fall into poverty because of catastrophic health expenditures. The share of government spending on health is low, and out-of-pocket payment is increasing. Access to health services is limited due to non-function primary health care, poor community-focused program, and a lack of a program for the poor and vulnerable.

Conclusion: The unsatisfactory progress to UHC is primarily due to the government's insufficient commitment to implementing existing health and financing policies.

Recommendations: An innovative financing policy devoid of fungibility is required to ensure regular and adequate funding of health programs. Making social health insurance mandatory will improve enrolment, service, coverage and financial protection.

Key words: Nigeria, Universal Health Coverage, Basic Health Care Provision Fund, National Health Act, Catastrophic Health Expenditure, Out-Of-Payment, Essential services coverage, Disparity, Health Service Access.

Word Count: 13,178

INTRODUCTION AND ORGANIZATION OF THE THESIS

My motivation to go into public health dates to an online course I did in 2011, "Health and Society." It was centered on how collective action in a society can reduce costs and offer public goods to the more significant population, including the impoverished and vulnerable. I saw this idea put into practice in my over seven years' experience in HIV programming. While the effective pooling of resources by partners and government enabled bulk procurement of commodities with assured availability at the facility level, I also witnessed that the sum of US$1 user fee for registration deprived patients of accessing already available services at a health facility. And sometimes, healthcare workers used their funds to pay for registration so a client can access care.

Having observed both facets, I developed a memo to the National Council on Health (highest health policy-making body in Nigeria) to remove user fees for at least all pregnant women seeking care at public health facilities. The memo was adopted, and all States were mandated to implement this policy in 2016. Five years later, only few facilities were able to operate this policy, which has reduced the number of pregnant women accessing services in Nigeria. On gaining admission to study master and having heard so much about the Nigerian National Health Act 2014 and the Basic Health Care Provision Fund. I decided to explore the legislation and the policy document to know how well it fits into other countries' policies and its implementation in Nigeria.

This thesis is organized into five chapters

- Chapter one presents background information about Nigeria
- Chapter two presents the problem statement, justification, and methodology
- Chapter three presents the findings from literature and analyses of Nigeria's progress towards attainment of UHC using the WHO's three dimensions framework
- Chapter four presents the findings
- Chapter five presents conclusions and recommendation

CHAPTER ONE: BACKGROUND INFORMATION ABOUT NIGERIA

1.1 Introduction

This chapter presents the background information about the Federal Republic of Nigeria. The geography, demography, and socio-economic status of Nigeria. Also explored are the health system organization, health profile, and an overview of Universal Health Coverage.

1.2 Geography

Nigeria, a country within the Western Coast of Africa, occupies 923,768 Km2 making it the 32nd largest country in the world (1-3). It is bordered southward by the Gulf of Guinea and part of the Atlantic Ocean, eastward by Cameroon and Chad, northwards by Niger, and westward by Benin (1) (3-4). It has 36 autonomous states and the administrative center know as Federal Capital Territory Abuja (FCT). (See figure 1) (5-6). Its latitude and longitude lie between 4 degrees to 14 degrees North and 2 degrees to 15 degrees East, respectively (1). Plain land lies north and south with hills and plateau at the center (1)(3). (Figure 1 represents the administrative map of Nigeria).

Figure 1 **:Administrative Map of Nigeria (6)**
Source: Net maps, 1997

1.3 Demography

In 2021, Nigeria's population is estimated at 211,472,788, with a growth rate of 2.60% (5). The growth rate has remained above 2.5% over the last decade due to early marriages, high birth rates, and inadequate family planning culminating in Nigeria being the most populous country in Africa and 7th in the world (5). It is estimated that Nigeria's population constitutes 2.71% of the world population translating to one in every 47 persons being a Nigerian (5). The median age of its population is 18.4 years, with even distribution between males and females, and the average life expectancy is 54.5 years (men: 53.7 years, women: 55.4 years) (5). Over 72 million persons are under 15 years, of which 31 million are under five years. Furthermore, over 40 million persons are women of childbearing age (WCBA) (15 -49 years), and the estimated number of births every year is 7 million (7). (See figure 2 for Nigeria's population pyramid). There are three major ethnic groups, the Hausa, Igbo, and Yoruba, comprising 30%, 15.2%, and 15.5% of the population, respectively(5).

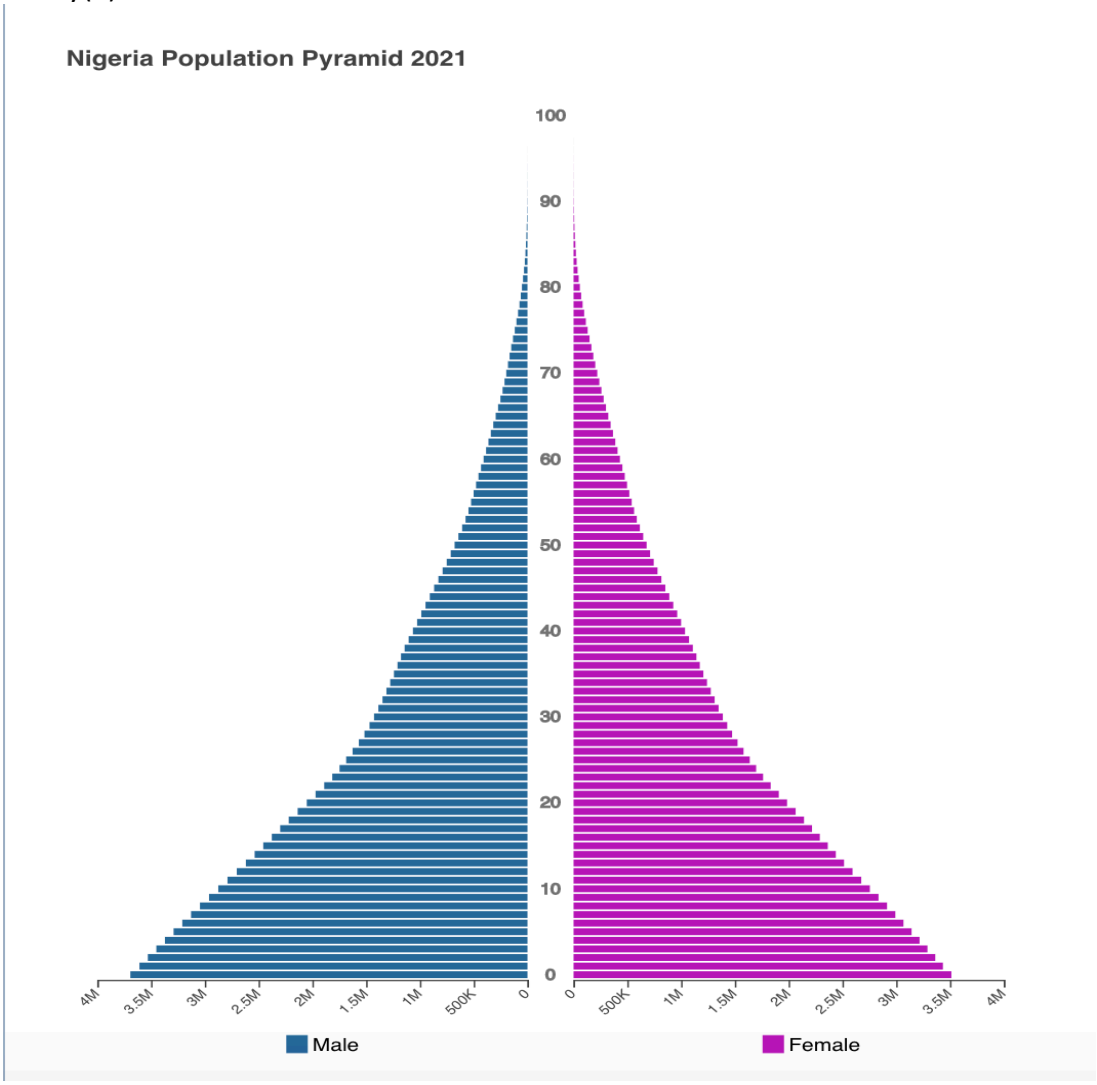


Figure 2 :Nigeria Population Pyramid (5)
Source: world population review., 2021.

1.4 Social Economic Status

In 2020, the Global COVID-19 pandemic worsened the economic status of Nigeria (9). Nigeria also went into recession the second time within four years (2016 and 2020): excess crude account has gone down (money gotten from the sale of crude oil more than budgeted amount), and external reserve depends on short term flow (8). Currently, 40% of the population lives below the poverty line (82.9 million people live on less than 137,430 Naira or $381.75 per year), and 25% (53 million) more may fall into poverty to the economic impact of COVID-19. Furthermore, Nigeria ranked 152 of 157 countries in the World Bank 2018 Human Capital Development Index (8). Crude Oil and gas is the primary source of revenue: generating about half of the total government income, 80% of export, and a third of banking sector credit in 2020 (8). Nigeria, a low middle-income country, had a Gross Domestic Product (GDP) of $432.29 billion in 2020 at a growth rate of -1.8% (9).

1.5 Health System Organization

Healthcare providers in Nigeria could be from public, private or traditional health institutions (10). The services provided by the public sector are concurrently governed by the three tiers of government operational systems. The Local Government (LG) and State governments are responsible for Primary and Secondary health care respectively. The tertiary health care and specific public health programs (HIV, tuberculosis, malaria) are led by the Federal Ministry of Health (FMOH) or its agency (see figure 3: Organization of Health system) (10 - 11). In line with the National Health Act, 2014 (NHA 2014) and the National Health Policy, the FMOH has prioritized delivery of Basic Minimum Package of Health Services (BMPHS) through PHC in every political ward (population of 10,000 – 20,000 persons) (10 - 11). The setting of minimum standard of training, health priority, and health policymaking is the Federal Government's traditional role while the states authorize practices of facilities in their locality (11). (see figure 3)

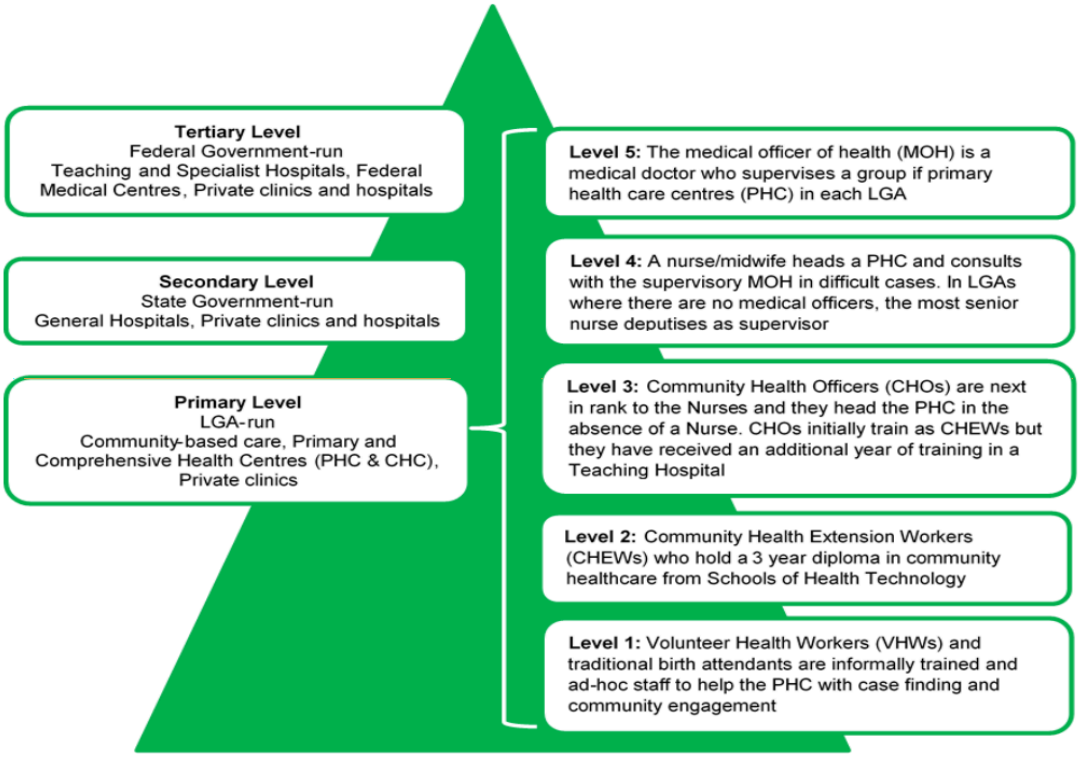


Figure 3: Organization of Health system and level of care (10)
Source: NSHDP II 2018-2022, FMOH

1.6 Health Profile and Disease Burden

In 2021, the life expectancy at birth increased by 0.6% from 2020 and stood at 55.1 years (12). There is an ongoing epidemiologic transition with Nigeria now facing the problem of the double burden of disease. However, infectious diseases remain the primary cause of death, with non-communicable diseases contributing about 29% (See figure 4 for top 10 causes of death) (13). over 40 million WCBA and children are affected by health issues disproportionally. Nigeria contributes about 10% of global maternal deaths at 576 per 100,000 live birth, ranking 4th in the world. The infant mortality rate is 69 per 1,000 live births, with estimated 262,000 babies dying at birth annually (2nd highest in the world). The under-five mortality is 128 per 1,000 live births, with 65% of these deaths attributed to malaria, pneumonia, and diarrhea (7). In 2015, 57 million Nigerians were without access to an improved water source, 130 million are without improved sanitation, and 25% practice open defecation (7). Even though primary education is free, over 33% of children are without access. One in every five out of school children anywhere in the world is expected to be a Nigerian (7

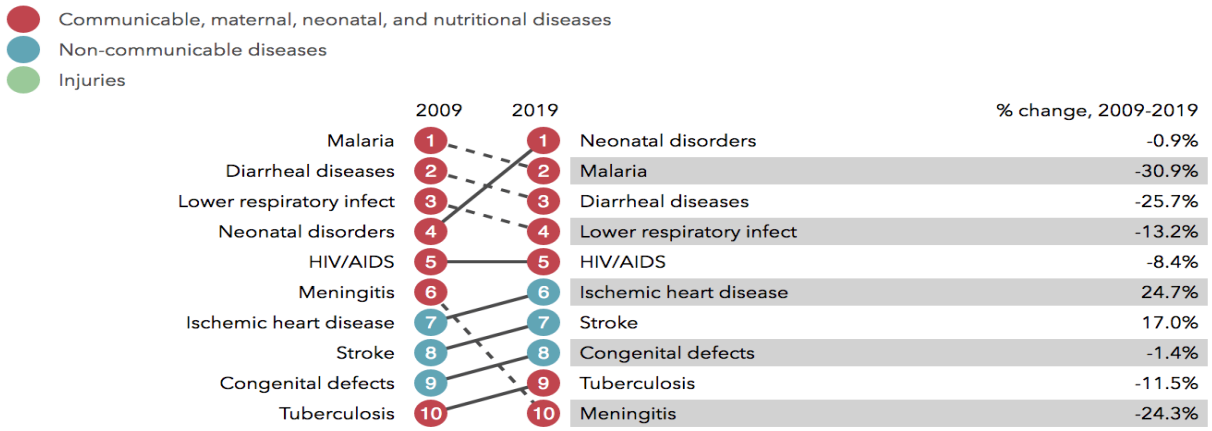


Figure 4: Top 10 causes death (13)
Source: WHO healthdata.org/Nigeria. 2019.

1.7 Overview of UHC and the Health System

Universal Health Coverage (UHC) implies that all people have access to promotive, preventive, curative, and rehabilitative health services they need, when and where they need them, without suffering financial hardship (14 - 16). Achieving UHC is a developmental agender and core in the Sustainable Development Goals (SDGs) given the multiple benefits accruable and its role in accelerating the attainment of other goals (17 – 19). (See figure 5). Key among benefits is increased life expectancy, quality health care at a lower cost for all, poverty reduction, gender equality, and inclusive economic growth (17 - 18). For nations to attend UHC and enjoy these benefits, they must invest in the expansion of health services coverage and access, increase health work force, improve infrastructure, ensure availability of essential medicines, and ultimately protect its population from financial hardship due to medical expenses through health system strengthening (18).

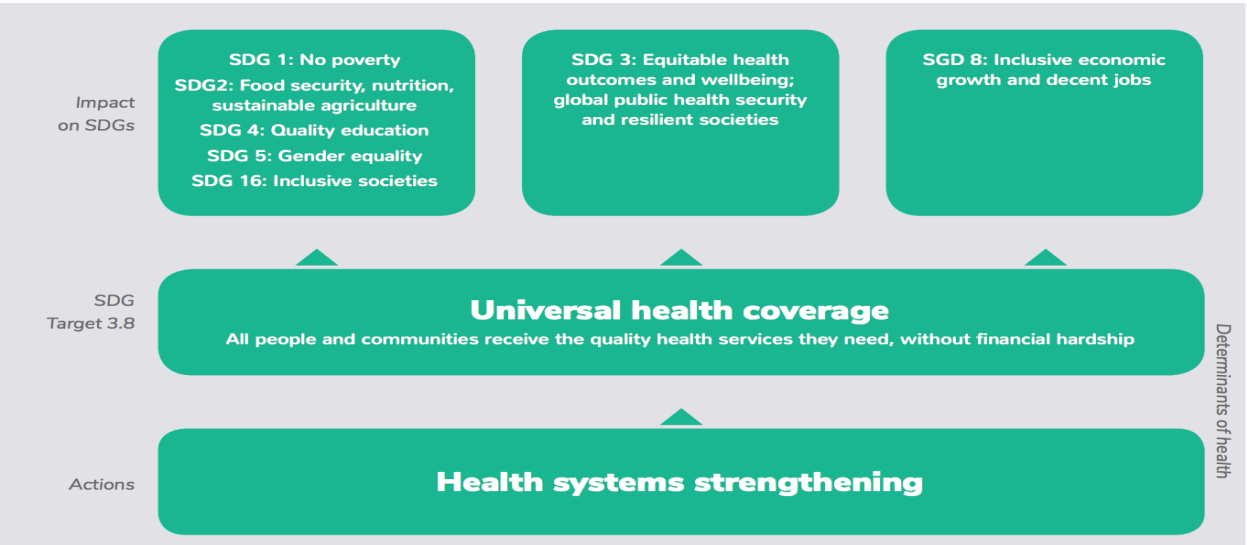


Figure 5: UHC contributes to the achievement of other SDGs (19)

Source: Health system for UHC- a joint vision for a healthy life. World Bank

In recognition of the importance of UHC as a tool for leaving no one behind, the United Nations General Assembly on December 12, 2012, adopted UHC as an essential international development principle and recommended achieving it through primary health care and social protection approach. Furthermore, on September 25th, 2015, the target for UHC was set for 2030, and it included "financial risk protection, increased population coverage and access to quality essential health services including access to safe, effective, quality and affordable essential medicines and vaccines for all" (20 - 21). December 12, each year, is dedicated as UHC day since 2017. The day provides an opportunity for advocates of UHC to celebrate achievements, identify gaps and make a call for a more substantial commitment by the government and the private sector toward attaining UHC by 2030 through building strong and resilient health systems (20).

Despite efforts at achieving UHC, in 2017, it was estimated that half of the world population have no access to essential health services: 800 million people spent over one-tenth of their income on health, and 100 million people are pushed into extreme poverty because of Out Of Pocket payment (OOP) on health (14) (18 - 19) (22 - 23). Progress has been made mainly on access to immunization, anti-retroviral for Human Immunodeficiency Virus (HIV), and family planning services, and fewer people are pushed into poverty. But the level of progress on access to health services is still unacceptable as inequity abounds within countries and between continents, with Sub-Saharan Africa and Southern Asia accounting for significant gaps (19)(22). Three key barriers to attaining UHC are the non-availability of resources, over-dependence on OOP and donor funds, and the inequity and inefficiency associated with the use of resources. Mitigating these barriers are the core principles for designing the path countries should follow to achieve UHC. These principles include "raise sufficient funds, reduce the reliance on direct payments to finance services and improve efficiency and equity." (24).

Some low- and middle-income countries (Rwanda, Ghana, Gabon, Brazil, Cambodia) have demonstrated that UHC is not an entitlement of High-Income Countries (21)(24). In a bid to strengthen the health system and push toward attaining UHC, Nigeria enacted "the National Health Act" in 2014. The NHA 2014 provides the "legal framework for regulation, development, and management of the health system." It further protects, promotes, and fulfills the rights of Nigeria's citizens to have access to health services (25). A prominent tool for UHC in the NHA is establishing the Basic Health Care Provision Fund (BHCPF). The BHCPF (which will be financed through federal government annual grant of not less than one percent consolidated revenue, donors fund, and any other sources) will be used to fund service delivery at primary and secondary health care levels and health emergencies (25)(26).

CHAPTER TWO: PROBLEM STATEMENT, JUSTIFICATION AND METHODOLOGY

2.1 Introduction

This chapter presents the problem Nigeria is facing in its effort to attain the UHC as stipulated in the SDGs and justification for this study. Also explained are the methodology and the conceptual framework for analysis.

2.2 Problem Statement

Achieving UHC (Sustainable Development Goals (SDGs) 3.8) is a backbone to attaining the 17 SDGs (23). The critical measurement indicators are the essential health services coverage, the population coverage, and the proportion of the population with financial protection (23)(27). The UHC service coverage index which is correlated with under-five mortality rate, life expectancy, and human development index, varied widely across continents, between and within countries. The variation between countries ranged from a minimum of 22 % and maximum of 86% essential services coverage, with Nigeria at less than 45% essential services coverage (see figure 6). Sub-Saharan Africa has the lowest index at 42%, and people at the lowest wealth quintile within countries are affected most: they fall into poverty in seeking care or cannot seek care (23)(28). The proportion of people who suffer financial hardship measured by catastrophic health expenditures (OOP beyond what household can pay) and impoverishing (spending on health leading to a budget reduction on essential non-medical items like food, shelter, and clothing) expenditure on health are two focal areas for UHC. In 2010, the proportion of the global population with catastrophic health expenditure at 10% and 25% of household consumption were 11.7% and 2.6%, while Nigeria was remarkably higher at 25% and 8.9%, respectively (23)(28)(29).

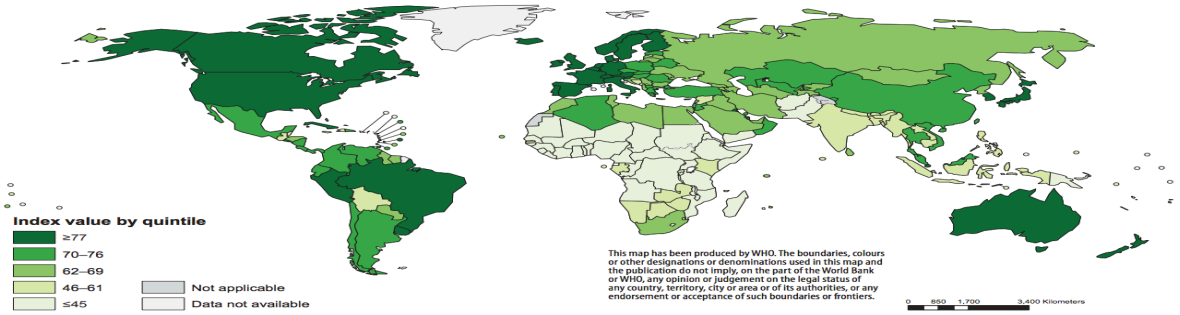


Figure 6: UHC essential health service coverage index, 2015 (23)
Source: Tracking UHC, 2017; World Bank

Furthermore, it is essential that both catastrophic and impoverishing spending on health and service coverage is evaluated together as low incidence of financial hardship could mean poor accessibility or non-affordability of needed health services by the people (poor households do

not seek care). A study of the WHO African region in 2017 on developing a framework for monitoring UHC scored Nigeria below average (low service coverage and high OOP) on service coverage indices with financial risk protection indicator (21). (See figure 7).

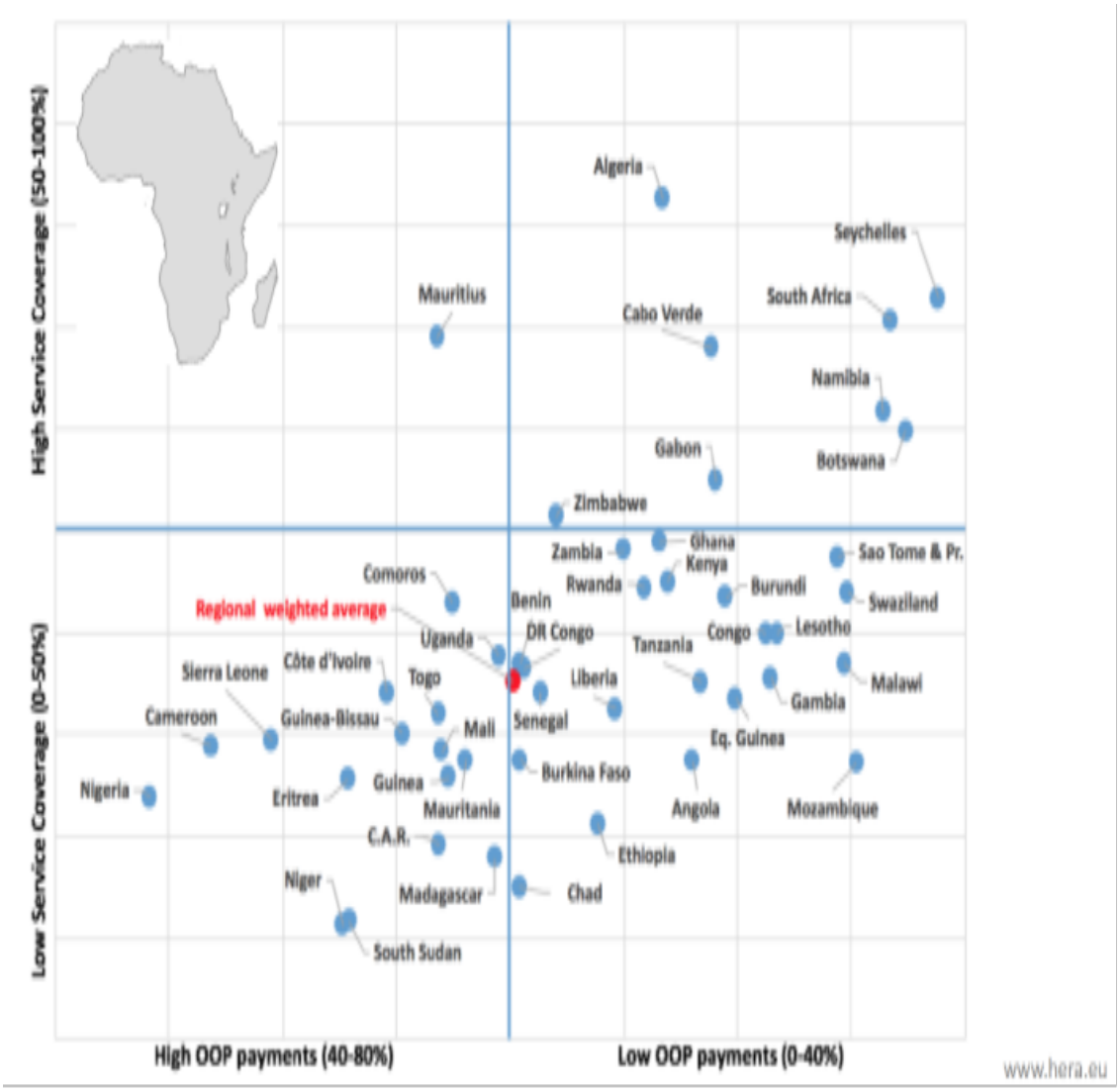
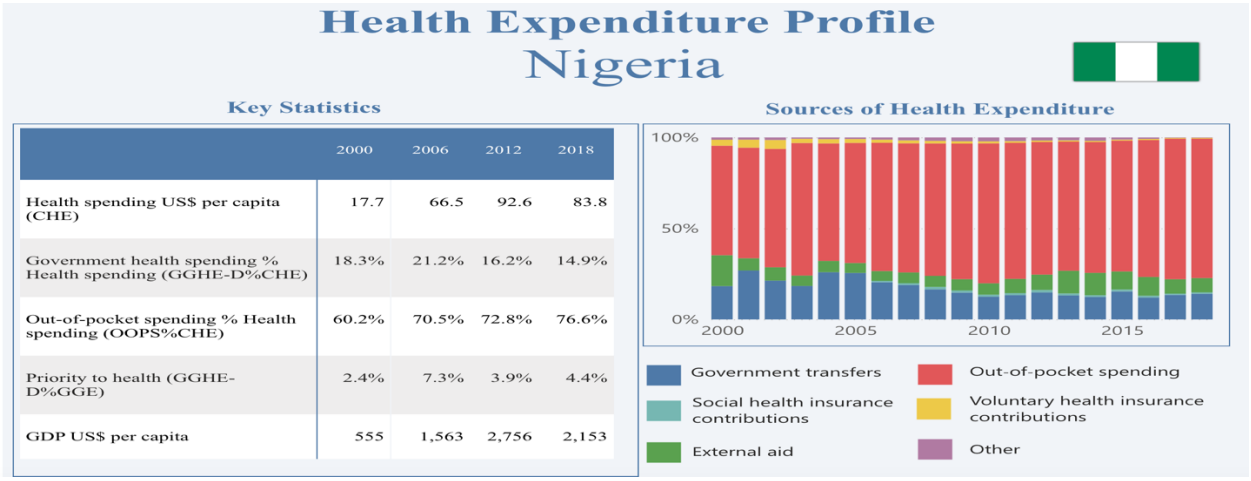


Figure 7 :Coverage V Financial risk protection for WHO Afro region 2017 (21)
Source: www.hera.eu › news › uhc-in-the-who-afro-region

While essential health service coverage, population coverage, and financial protection are strategic, they are only part of broader tools in monitoring progress towards UHC (23). Again, while UHC is not just about free health services or reduction in OOP, it is a framework for health financing (23). It is geared toward improving physical access to health services and financial protection to people when and where they are needed. Implying that countries must adopt the health system strengthening approach in moving toward achieving UHC (23). Nigeria, in recognition of the importance of health system strengthening (HSS), modeled the goal of its

"2016 health policy and strategy" toward strengthening the health system; particularly the primary health care (private and public), to deliver essential health services package to all Nigerians in an effective manner and sync with the NHA 2014 (30).

Despite these lofty ideals, the health system is faced with severe challenges. Poor gatekeeping, the flawed referral system, poor commodities and medical products distribution, poor human resource management and mal-distribution, high OOP, and minimal budgetary allocation for health characterize the Nigerian health system (31 - 32). Even with the introduction of the BHCPF, OOP still drives health spending at 76.6% while Social Health insurance at 1%, donors aid at 7.86%, and government contribution at 14.9 % in 2018 of Total Health Expenditure (32)(33) (see figure 8). Budget allocation has also remained at about one-third of the 15% Abuja Declaration two decades after (see figure 9) (34). Also, in 2016, less than 5% of Nigerians, mainly from the formal sector, participates in health insurance schemes (35). These statistics are below par and standards for a country pushing to attend UHC in the next nine-year.



	2000	2006	2012	2018
Health spending US$ per capita (CHE)	17.7	66.5	92.6	83.8
Government health spending % Health spending (GGHE-D%CHE)	18.3%	21.2%	16.2%	14.9%
Out-of-pocket spending % Health spending (OOPS%CHE)	60.2%	70.5%	72.8%	76.6%
Priority to health (GGHE-D%GGE)	2.4%	7.3%	3.9%	4.4%
GDP US$ per capita	555	1,563	2,756	2,153

Figure 8: Nigeria Health Expenditure Profile (33)
Source: https://apps.who.int/nha/database/country_profile/Index/en

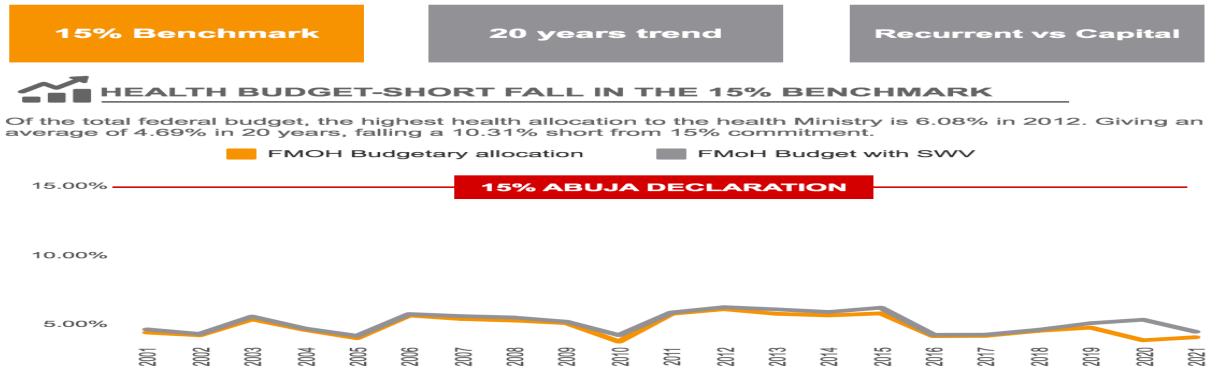


Figure 9: Nigeria budget against 15% Abuja declaration (34)
Source:www.devex.com/news/sponsored/2-decades-on-nigeria-falls-short-of-landmark-health-pledge-99555

2.3 Justification

In 2021, Nigeria has an estimated population of 211,988,844, of which over 40% live below the poverty line (82.9 million people live on less than 137,430 Naira or $381.75 per year) (36 - 37). Nigeria has 36 States and the Federal Capital and 774 Local Government Areas (38). Nigeria's governance and health system operate in three tiers structure with devolution of power between states and the federal government. This structure creates a challenge of delay (devolution of governance requires multiple stakeholder agreements to implement the program) and unique opportunity (services can reach masses faster because of the smaller unit of government) for progress towards UHC (38). Since 2005, when WHO member states committed to achieving UHC as a tool for health well-being and human capital development, Nigeria's health policies have evolved to accommodate developmental issues. Still, vast system inequalities have persisted, subjecting a lot of Nigerians to financial hardship from health spending (30)(39)(40).

Despite progress in formulating policies that reflect government will move towards UHC, the gap in attaining optimal population coverage, essential health services coverage, and financial protection remains large (39). While countries on the road to UHC have maximized resources and improved their indices for UHC measures, Nigeria is on the decline, as shown by increasing OOP, donor funding, and reduction in government health expenditure (33). With the introduction of the NHA 2014, health policy and strategy 2016, and the operationalization of the BHCPF since 2018 (25)(26)(30), it is crucial to take a methodical approach to analyze the impact of these recent policies on the financing mechanisms and adequate health service coverage as Nigeria progresses towards UHC and compared with proven best practices in countries with similar demographic and economic characteristics.

Most studies on Nigeria's progress toward UHC focused on the health financing mechanisms or the social health insurance pathway (38). This study will add to existing knowledge on the critical progress made in strengthening the health system and moving toward UHC, reflecting on policies driving the attainment of UHC within this period and how these policies support each other and UHC. The findings will be used to make recommendations that will strengthen and fast-track the plausibility of achieving UHC in Nigeria by 2030.

2.4 General Objective

To review strategic health policies instituted by Nigeria to guide progress toward attaining UHC, ascertain implementation status, and recommend best practices that will fast-track progress towards UHC to stakeholders.

2.4.1 Specific Objectives

1. To critically analyze Nigeria's Health Policies and Strategies driving progress toward UHC

2. To analyze other health system factors influencing the attainment of UHC
3. To examine policies and strategies of other LMIC that have made remarkable progress toward attaining UHC
4. To make recommendations to relevant stakeholders to inform innovation and strengthening of strategies towards achieving UHC in Nigeria.

2.5 Methodology

2.5.1 Study method:

This study is mainly a literature review combined with semi-structured interviews to validate findings. The literature review focused on Nigeria while individual peer-reviewed articles vital to the topic were explored while snowballing technique was also used to review the list of valuable references. Reports and grey literature on specific publications were also utilized using Boolean operators.

2.5.2 Inclusion and Exclusion Criteria

Articles written in English and relevant to the study were explored and used for the study based on the study's specific objectives. Key informants who gave their informed consent to participate in the research were interviewed, and responses were utilized in the study.

2.5.3 Data collection method

Various databases, including but not limited to Pub Med, Google Scholar, VU e-library, were searched. Essential policy documents ranging from the National Health Policy, NHA 2014, National Health Development Plan, and BHCPF were reviewed to outline the changes effected to align with making progress towards UHC. The library searched for literature were Pub Med, Google Scholar, Cochrane, and Vu e-library. Snowballing and manual screening of referenced or reviewed articles were done to identify relevant studies. Relevant websites, e.g., World Health Organization, World Bank, Nigeria Federal Ministry of Health, National Health Insurance Scheme, National Primary Health Care Development Agency, National Agency for the Control of AIDS. Only studies conducted in the English language were selected for review.

Keywords: The following keywords were used in the initial broad search: Universal Health Coverage, Out-of-pocket expenditure, Nigeria, Essential Health Services Coverage, Cost coverage, Population coverage, and health systems strengthening. After which, further search was done based on the specific objectives. (See table 1 for keywords and their combination used to search the literature for specific objectives.

Table 1

Literature search table

No	**Sources**	**Objective 1**	**Objective 2:**	**Objective 3**
1.	PubMed, Google Scholar, Cochrane and VU e-library	National Health Act, Family Planning coverage, DPT3 coverage, coverage, Diabetic Coverage, Health system Strengthening, Sustainable Development Goal	Health care quality, Health facilities health policy Utilization, healthcare, inequity, horizontal inequity, access, socio-economic status.	Health care financing mechanism, National health insurance policy, Pooling of fund, Household Catastrophic Health Expenditure: Abuja Declaration
2.	National and International websites	National Health Policy, WHO's, World Bank, framework, UHC framework, NPHCDA, National Health Policy	Sub-Saharan Africa, Determinant, Incidence	NHIS, NPHCDA, World Bank, Gabon, Ghana, Kenya
3.	Grey Literature	UHC framework, BHCPF,		Health policy, NHI, SHI

2.5.4 Semi-structured Interview:

Semi-structured interviews were conducted that enabled triangulation of findings extracted from existing literature. The male and five participants were drawn purposively from strategic civil society organizations and government agencies involved in UHC policies and programs. The agencies are the National Primary Health Care Development Agency, National Health Insurance Scheme, Nigeria Youth for UHC coalition, Federal Ministry of Health, and Health Committee of National Assembly. All the selected participants agreed and participated in the study. They were not given any monetary benefit. The semi-structured interviews were administered remotely from The Netherlands using Zoom platforms. The interviews were recorded after the consent of the interviewees has been obtained. The topic guide focused on getting participants' opinions on the influence of various health policies, strategies, and health systems on Nigeria's progress toward UHC (see annex 2 for topic guide).

2.5.5 Data Analysis

The semi-structured interview was focused on using the WHO's three-dimensional framework to explore study-specific objectives. The researcher transcribed the zoom recording of the interview and notes taken during the interview verbatim on the same day. The transcription was compared again with the audio and notes for accuracy while ensuring protection with codes. The researcher did thematic coding and analysis for each transcript from the various participants. The coding reflected the interview guide: the inductive method was used to group generated data. The first and second coding was done to refine data into results and break them into smaller frames. Manual analysis was done and involved assigning codes to relevant parts of the transcript. Finally, the coded data were refined, merged, and put into use.

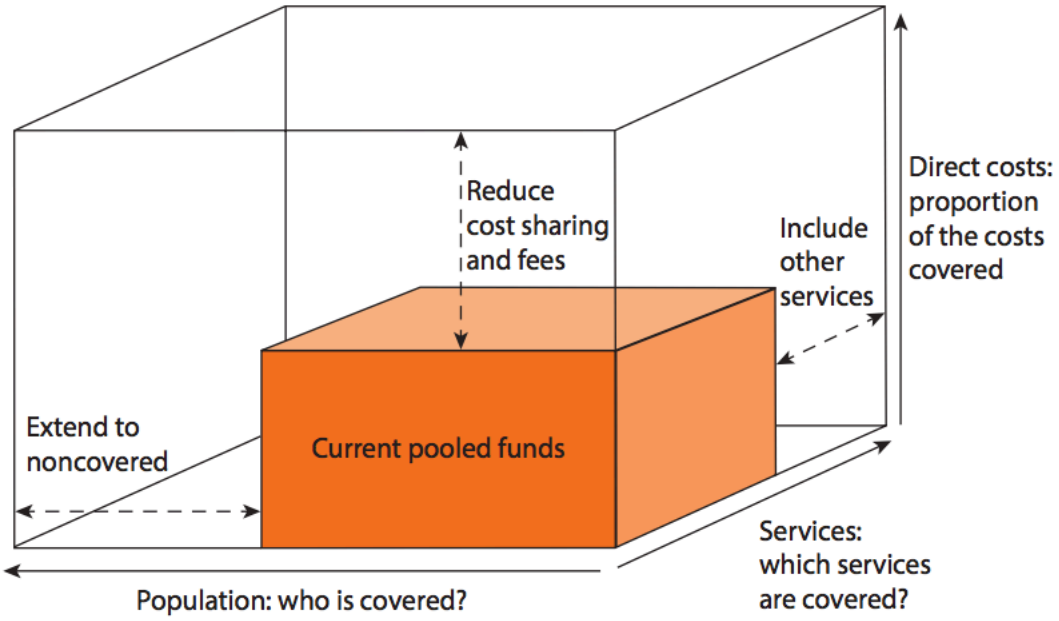
2.6 Conceptual Framework

The researcher examined two critical tools for UHC monitoring; the WHO's Health Systems Strengthening and the UHC three-dimensional conceptual frameworks for analyzing the findings from literature for this study. Both frameworks have their outcomes as financial protection and effective coverage for a defined basic health services package (41 - 42). The former, however, is focused on the timely generation of reliable data, accountability, tracking of progress and performance, and evaluation of the impact of resources in ensuring delivery of services equitably and efficiently for overall improvement in the health status of a country (41). The latter is more relevant to this study as it indicates the type of service included in the basic health services package that all people should have access to at the time of need and the cost (43). It also represents the country's policy and benefit design based on health objectives. The benefits package design requires technical know-how, political advocacy, and an excellent health financing mechanism to realize it (43).

Furthermore, the UHC conceptual framework shows a graphical representation of the three dimensions (see figure 10) of the UHC framework: essential health service coverage, population coverage, and financial protection. With the context of the provision of quality service been uniformly agreed, countries are to set the target for the three components of the UHC dimensions based on health priority and availability of resources (43). This study will analyze Nigeria's policies, strategies, and progress toward UHC using the three dimensions, which are:

1. Service coverage or essential benefits package dimension represents the basic services available at no cost or minimal cost to the population at the time of need for everyone in a country. The government usually decides the health services based on prevailing health situations using technical tools like cost-effectiveness of interventions and political settlement (27)(43).
2. The population coverage or beneficiary dimension describes the population segment that is provided with an essential benefit package and financial protection. Covering the private sector and the vulnerable population is tricky and often requires the country's financial policies to be driven by the equity principle (27)(43).
3. The cost or financial protection dimension represents the proportion of the population covered for their health need not to suffer impoverishing or undergo catastrophic

expenditure for health needs. The percentage of OOP in the total health expenditure (THE) is a measure of financial protection and reflects how well a country is progressing toward UHC (27)(43).



Source: WHO website, http://www.who.int/health_financing/strategy/dimensions/en.

Figure 10 :UHC dimensions (27)

2.7 Ethical Consideration

This study was conducted remotely from the Netherlands in Nigeria, and the ethical waiver was obtained from the KIT Ethical Board. Informed consent was obtained from respondents for the semi-structured interviews before the interview commenced. Afterward, they were given a certificate of consent for participating in the research (see annex?) Maximum confidentiality was ensured as every data was anonymously stored and processed after the interview was conducted.

2.8 Limitations

There was bias of selection, only male participated in the Semi-structured interview. This bias was because of selection and interview been done remotely from the Netherlands and the

researcher was not able to reach any female. More of grey literature was used for this studies because it has to do with analyses of the country's policies. Data for some components of essential services were not available and therefore effort was majored on maternal child health programs.

CHAPTER THREE: STUDY RESULTS/FINDINGS

3.1 Introduction

This chapter will introduce the relevant areas from the National Health Act 2014, the National Health Policy 2016, and the National Strategic Health Development Plan 2018 – 2022 related to the attainment of Universal Health Coverage. It will also present Nigeria's scorecard on progress towards UHC attainment using the WHO's UHC three dimensions framework.

3.2 Health Policies in Nigeria

3.2.1 The National Health Act 2014

The National Health Act, which was first proposed in 2004, was enacted ten years after (31st October 2014) following series of stakeholder consultations, legislative and executive reviews (44)(45). It provides the legal framework for "regulation, development, and management of a National Health System and set the standard for rendering health services and for related matters" in Nigeria (25)(44)(45). It also represents a foundation for health policies in Nigeria (46). The NHA was formulated in seven parts including: "Responsibility for health and eligibility for health services and establishment of National Health System, Health Establishments and Technologies, Rights and Obligations of Users and Health Care Personnel, National Health Research and Information System, Human Resources for Health, Control of Use of Blood, Blood Products, Tissue and Gametes in Humans, and Regulations and Miscellaneous Provisions." (25)(44). These parts of the NHA are designed to ensure accountability and consistency of processes in the health sector, regulate the health services (private and public), bring all stakeholders together and establish regularity in the funding of the health sector (25)(44)(47)(48)(49).

Key issues addressed by the NHA, among others, include establishing the rights and obligations of health care providers, health establishments, and users (47). The provision of health care recognizes the formal and informal settings, including traditional and alternative therapy providers. It has an explicit condition for protecting, promoting, and fulfilling users' rights; every Nigerian and individual resident in Nigeria should have access to health services when needed (47). It also clarifies the roles and responsibilities of the Federal Ministry of Health and State Ministry of Health, especially technical assistance and state policies (47).

Important Committees Established by NHA 2014

The National Council on Health: This will serve as the highest health policy decision-making organ, in charge of administration and implementation of National Health Policy. The council will

inform and advise the federal government on technical issues regarding the organization, delivery, and distribution of health services to ensure that basic health services get to all Nigerians (25)(47).

The National Tertiary Health Institution Standard Committee (NTHIS): The committee is saddled with the responsibility of advising the government on establishing a tertiary hospital across the country based on need (25)(47).

The Emergency medical services: This stipulates that any Nigerian involved in an accident should receive emergency health services without making payment first. An emergency fund is set aside to refund all emergency treatment offered to Nigerian under the BHCPF. The aim is to reduce the number of deaths attributed to emergencies where individuals are refused treatment because of their inability to deposit money. It also requires that treatment is commenced for people with questionable injuries like a gunshot before requiring them to obtain a report from the police. Contraveners of this law are liable to 6 months imprisonment or a fine of (NGN100,000) or both (25)(47).

3.2.2 The National Health Policy 2016

This policy is centered on strengthening primary health care to provide health services to all Nigerians, especially the poor and vulnerable (30). The primary aim is to strengthen the health system's performance and provide financial risk protection to all Nigerians (30). key issues addressed by the policy include establishing PHC Under One Roof (PHCUOR) through which services will be offered free to all Nigerians on payment of premium to National Health Insurance Scheme or State Health Insurance Scheme combating challenges of insurgency to Health system (30).

3.2.3 The National Strategic Health Development Plan 2018 – 2022

The (NSHDP II) outlines the government (national and sub-national) health sector priorities. It also emphasized the importance of collaborating with other sectors to address social determinants of health in the SDGs (10). Key focus areas recommended include the essential package of health care services, acceleration of action towards UHC through consolidation of ward health care system in the PHC, and strengthening the health systems (10). It harmonized input from the health plans of the 36 States and the Federal Capital Territory

3.3 Coverage of Essential Health Services

3.3.1 Introduction

Essential Health services for a given country will keep shifting due to demography changes, citizens' expectations, epidemiological and technological trends (23). Also, national resource constraint means that all health services cannot be provided; countries should consider prevailing health situations and resources available in constituting essential health services packages for its citizen. In considering these expected changes, progress toward UHC has been dubbed a "continues process." (50).

3.3.2 Operationalization of Essential Health Services Package

Nigeria's essential services package is the "Basic Minimum Package of Health Services" (BMPHS). It represents services the government is providing or willing to provide through the public and private sector (using public resources and linked to the population's health needs) equitably to its citizens (26). The services included in BMPHS (see annex 1) are provided through social health programs like the NHIS to improve efficiency, equity, empowerment, and accountability (51). The FMOH and the National Primary Health Care Development Agency (NPHCDA), in operationalizing the NHA 2014, outlined the BMPHS for primary and secondary health care levels as detailed in section 4.14 of the Guideline for the Administration, Disbursement, and Monitoring of the BHCPF (see Annex 1). Also, section 2.2 of the NSHDP II is called the essential package of health care services (26)(10). For facilities to participate in the discharge of these services, they must be assessed by State Primary Health Care Development Agency (SPHCDA) or State Primary Health Care Board (SPHCB). And be accredited by State Health Insurance Agency (SHIA) or State Health Insurance Scheme (SHIS) in collaboration with the National Health Insurance Scheme (26). The basic annual premium for the services is N12,000 ($27) (26).

Rwanda has varied health benefits packages recognized by the Government (51): minimum package of activity for the social health insurance members and complementary package of activity for the Military forces and finally, the Rwanda Health Insurance Fund for public and majority of the private sector (51). There is also different service package for facilities at varying levels of Service Delivery (51). Ghana also has various defined packages of health services delivered through multiple national programs. The most prominent among them, the NHIS, is found financially unsustainable because of its broadness in services inclusion and non-actuarial-based payment (51).

Ghana's government's most recently introduced package is defined in the Community-based Health Program and Service operational Policy. It specified that the "basic package of services" is to be delivered at patients' doorstep by community providers (51). The Gabon Indigent Scheme (GIS) also exists for all individuals from 16 years (younger people are beneficiaries of insured parents) with income less than US$130 per month. The GIS members make a co-payment of 20% for services. They are entitled to the same essential health services package as those who paid a premium, usually covering 80% of common illnesses, 90% of NCD, and 100% of Maternal and Child health costs (52).

3.3.3 Nigeria's Essential Health Services Package

The Essential Package of Health Care Services for Nigeria is broadly specified in section 2.2 of NSHDP II into six categories, namely, RMNCH+N services, major infectious diseases, non-communicable diseases, emergency medical services, health promotion, and public health emergencies (10).

3.3.3.1. Maternal, Newborn and Child Health Interventions

The USAID's Health Finance and Technical (HFT) project that supports countries navigating economic transitions needed to achieve UHC assessed how priority reproductive, maternal, newborn and child health are represented in the country's EPHS. They found that services included by Nigeria from the priority reproductive, maternal, newborn, and child health (RMNCH) intervention (PMNCH 2011) is 39 compared to Rwanda's 49 and Ghana's 36 (51). Even though RMNCH interventions are free by the policy in Nigeria, user fees were introduced by States to alleviate budget constrain from the government (53). In a cohort of rural women aged 15 – 49 years who gave birth one year before a study, even though 49% of them has no means of income, they spent between N1,350 – N14, 859 (US$ 9 – 99) to access the total package of maternal health services of which 73.3% of the amount paid was OOP (53). About 50% of the cohort studied delivered at home and therefore did not receive skilled assistance. The major challenge faced by these women with access to health services was finance for accessing ANC, assistance in delivery at the facility, and postnatal care (53). Other challenges include the distance of health facilities from their residence, lack of drugs in a health facility, and opportunity cost (53). Another study showed that 90% of women who used ANC services in Nigeria were satisfied by staff empathy, provider assurance, and providers' non-discriminatory attitude except for the OOP for care (54).

Every Nigerian at risk of vaccine-preventable diseases is entitled by law to get a vaccine for free (56). Funding for immunization is a collective responsibility of the three tiers of government, and funds are usually allocated through the usual budgetary allocation (56). Donors (GAVI, European Union, World Health Organization, and United Nations Children Fund) also contributed about 24% of immunization funds in 2013. Availability of vaccines at point of service delivery is frequently affected by the government's inadequate and late release of funds (56). Even though immunization is free in public health facilities, indirect costs like travel time to health facilities or the cost of transportation limits access. Furthermore, fees charged by private facilities when immunization service is available also limit access (56).

Nigeria's growth rate has been above 2.6 in the last decade, and the fertility rate is 5.2 children per woman (from 6.52 in 1971 to 5.25 in 20218)(36). Nigeria could not meet the 2018 Contraceptive use target set at 36% (36) (57 - 60). The barrier to not reaching the 2018 target was attributed to hidden OOP expenses, which is a fee ranging from US$ 1.41 – US$ 5.52 per visit per woman, depending on the method of contraception required (61). The fee covers consumables (surgical blades, disinfectant, gloves, cotton balls) and is determined and charged

by the health facility (61). Stock-out of commodities is also a frequently occurring phenomenon despite central stores and regional stores mandated to store products that will serve for a minimum of nine months and a maximum of 18 months(57).

3.3.3.2 Major communicable Disease

According to NSHDP II section 2.2.2, malaria, HIV, TB, Viral hepatitis, and neglected tropical diseases were diseases included in the Nigerian essential package of health care. Malaria, which caused about 438,000 deaths globally in 2015, is endemic in Nigeria (62). Malaria is responsible for about 60% of all hospital attendance in Nigeria and was responsible for 30% of childhood mortality and 25% of infant mortality in 2016. Furthermore, pregnant women are not spared as about 4.500 of them die annually from malaria (62). Based on policy, pregnant women and children under five years should have free malaria treatment. However, not all the States in Nigeria are implementing this policy, and when they do, there is regular stock-out due to inadequate funding, leading to OOP for treatment (63). Due to the high cost of treatment for malaria, most clients present late after patronizing unqualified personnel and therefore spent more due to possible hospitalization (62). In general, the average cost for treatment of malaria for those that present at the clinic is N3,941 (US$ 11). The N3,941 comprises 10.3% consultation, 27.7% laboratory investigation, and 62% antimalaria drug cost (62).

3.3.3.3 Other Services Included in Essential Health Services Package

The non-communicable disease, emergency medical services (emergency medical services system is poorly developed in Nigeria, with estimated 1,000 ambulances meeting just 20% of the National need), health promotion and public health emergency and risk.

3.3.3.4 Essential Services Coverage in other LMICs

Gabon's maternal and child essential health service is operated under compulsory SHI called National Fund for Health Insurance and Social guarantee (NFHISG) (65)(66). The NFHISG was established in 2008 as a means of pooling resources to cover essential health services packages and equity in services the poor, the vulnerable, and the indigent. Through this scheme, Gabonese can access services at both private and public facilities, including primary, secondary, and tertiary, without payment of any fee (66). One of the identified challenges with Gabon's system is the favoritism in providing services to the wealthy who pay OOP, which increases waiting time for SHI members. Also, there could be stockout of drugs, disinfectants, and lack of clean water caused by inadequate capacity in manufacturing processes, marketing practices, poor procurement, and supply chain processes (65)(66).

World Bank study in Gabon noted that even though contraception is low and abortion is a significant contributor to Maternal mortality, the FP commodities and services are accessible and

affordable (67). Ghana's NHI was introduced in 2005. The policy to offer free comprehensive MCH services to all women was introduced in 2008; however, there is evidence that individuals in hospitals (68) usually collect illegal fees. Another study in Ghana found that all MCH services are not covered; An average of US$ 8.6 OOP was used to access MCH service. Most women used their savings (65%), others sold their assets 22%, while the poor and vulnerable did not access them because of inability to pay (69). The FP services are not included in Ghana's NHIS; clients pay between US$1.76 – US$3.03, which is about 81% of the daily minimum wage to access FP services as a direct cost (69). The price of FP is higher in private and tertiary facilities compared with primary health facilities (69).

3.4 Population Coverage

3.4.1 Introduction

The proportion of a country's population that has access to quality health care services when they need it without suffering financial hardship is a critical measure of progress towards UHC (27). To achieve this, country's financial policies and programs must be driven by equity (27). To attain UHC, health policy measures must see access to health services as an interest of all populations and component of human capital development and, therefore, aim to reduce inequity in health services utilization (70).

3.4.2 Situation of population coverage in other LMIC countries

The objective of UHC and, by extension, the health-related SDGs is to achieve 80% population coverage for basic essential health services by 2030 (71). There has been improvement in population coverage of certain essential health services in Africa, e.g., insecticide-treated bed nets by children and pregnant women, gaps still exist within and across countries (71). Other critical services that have experienced slow coverage include access to HIV, TB, Malaria, and water and sanitation (71). To mitigate inequality, government programs (e.g., in Ghana, Kenya, and Gabon) included some selected populations in the delivery of essential health service package. The specific population comprises women, adolescents, indigent, and rural populations (51).

There is somewhat of a fair coverage in Ghana, Gabon, and Kenya (51). Except for births attended by a health professional that strongly followed wealth, level of education, and urban versus rural population, other services are equitably covered in Ghana (51). In Kenya, full immunization was higher in rural at 70% compared to urban centers at 63%, representing a reversal of where the urban population usually has better access (51). In India, coverage of population for services follows wealth, level of education, and urban versus rural, e.g., women who skilled birth attendants attended to was 20% among the poor. In comparison, 90% for the wealthiest, full immunization among one year old was 39% rural and 58% urban (51). Kenya, Ghana, and Gabon community programs are designed to reach the rural, hard to reach, specific sub-population and

indigent population (51)(71). (See figure 11: below for a comparison of selected indicators for Ghana, Gabon, and Nigeria).

Variation in rural versus urban population coverage in Gabon					
S/N	Indicator	Year	National Value %	Urban %	Rural %
1	Modern contraceptive rate (mCPR) among married women aged 15 – 49 years	2012 DHS	19.4	20.7	11.3
2	Met need for family planning	2012 DHS	19.4	20.7	11.3
3	Population who slept under insecticide treated mosquito net (ITN) last night	2012 DHS	31.1	32.7	21.1
4	SP/fansida 3+ doses at least one during ANC visits	2012 DHS	6.3	6.4	5.5
5	Pregnant women who slept under insecticide-treated mosquito net (ITN) last night of those living in a household with at least one ITN	2012 DHS	63.7	61.9	75
Variation in rural versus urban population coverage in Ghana					
S/N	Indicator	Year	National Value %	Urban %	Rural %
1	Modern contraceptive rate (mCPR) among married women aged 15 – 49 years	2014 DHS	22.2	19.8	24.6
2	Met need for family planning	2014 DHS	29.9	28.7	31.1
3	Population who slept under insecticide treated mosquito net (ITN) last night	2019 MIS	43.2	27.6	56.6
4	SP/fansida 3+ doses at least one during ANC visits	2019 MIS	60.9	59.3	62.1
5	Pregnant women who slept under insecticide-treated mosquito net (ITN) last night of those living in a household with at least one ITN	2019 MIS	58.4	44.2	66.2
Variation in rural versus urban population coverage in Nigeria					
S/N	Indicator	Year	National Value %	Urban %	Rural %
1	Modern contraceptive rate (mCPR) among married women aged 15 – 49 years	2018 DHS	12	18.2	7.8
2	Met need for family planning	2018 DHS	16.6	26.4	10
3	Population who slept under insecticide treated mosquito net (ITN) last night	2018 DHS	43.2	35.6	49.1
4	SP/fansida 3+ doses at least one during ANC visits	2018 DHS	14.6	19.1	11.7
5	Pregnant women who slept under insecticide-treated mosquito net (ITN) last night of those living in a household with at least one ITN	2018 DHS	81.7	72.8	85.6

Figure 11 Comparison of Urban and Rural Population Coverage in Gabon, Ghana, and Nigeria (74).

Adapted from the Demographic Health Survey (DHS) Program

3.4.3 Situation of population coverage in Nigeria

There is growing inequality in the utilization of health services in Nigeria, and it is generally skewed against the poor (70). The utilization of health services is closely associated with the level of wealth, education, and rural versus urban residence; other factors include the proximity of health facilities to the rural populace (51)(70). In 2016, over 75% of health facilities in Nigeria were in the urban area that houses 52% of Nigerians. This distribution of facilities offers urban than rural dwellers greater opportunities to utilize health services (70)(72). Regarding types of health facilities in the country: primary health facilities constitute 88%, Secondary 12%, and Tertiary 0.25%. Of all the health facilities in Nigeria, 67% are owned by the government. However, 76% of secondary facilities are owned by private entities (38)(10). Most public sector facilities

offer services at minimal cost as they are not for profit, but clients perceive services as low quality, especially at the primary care level, and therefore seek health services at private or secondary facilities (38).

In 2018, according to NDHS, the modern contraceptive prevalence rate (MCPR) was 12% among currently married women aged 15-49; an additional 5% of them used the traditional method (73). There was a marginal increase to 13.4% in 2020 (58). Also, 57% of women aged 15 – 49 who gave birth in the preceding five years had at least four ANC visits and received care from a skilled provider (doctors, nurses/midwives, and auxiliary nurses/midwives) (73). However, only 43% were attended to by skilled providers during delivery, while 39% were delivered in a health facility (73). Pregnant women aged 15 – 49 receiving ANC from skilled providers has increased from 2008 (39%) to 2018 (43%). Furthermore, 22% of deliveries were attended to by relatives of the pregnant women, 20% by the traditional birth attendants, while 11% of pregnancies receive no assistant during delivery (73).

Also, clear disparity occurred in the utilization of essential packages at health services across various parameters, e.g., Modern contraceptive MCPR use among married women aged 15 – 49 in urban to rural was 26%: 10%, Highest wealth quintile to lowest wealth quintile was 22%: 4% and more than secondary education to no education was 23%: 4% in 2018 (73). ANC attendance and the use of skilled providers among pregnant women aged 15 – 49 years also witnessed disparity across the same parameters Urban to rural 84%: 56%, highest wealth quintile to lowest wealth quintile 93%: 41%, more than secondary education to no education 97%: 45% (73).

3.4.4 Health System Challenges Causing Inequity in Service Delivery in Nigeria

The Health System in Nigeria faces many challenges specific to a tier of health facility or the entire system, and these challenges fuel inequity (38)(76). The PHC, which is located in rural areas, is usually understaffed because the HCWs prefer to stay in urban areas with basic amenities and are more secure regarding kidnapping and other insecurities (38). Also, the government has no incentive package to motivate HCWs to stay and provide services in a rural location (38)(76). The secondary and tertiary health facilities in Nigeria that receive more attention from government (usually have direct budgetary allocation) are also located in the urban areas and have a larger workforce and greater budgetary allocation. Furthermore, the government does little or nothing to determine where health facilities will be in Nigeria; most times, facilities are in loosely populated areas solely for political reasons (38)(76). There is also poor coordination, inequity, and rampant brain drain (38)(76). Worsening the outlined health system challenges is the non-existent social security for the vulnerable(38)(76).

3.4.5 Nigeria's policy and strategy to increasing Population Coverage

Nigeria, through the NPHCDA, adopted Primary Health Care Under One Roof (PHCUOR) as a policy to pursue the attainment of UHC and SDG 3 (26). The National Council on Health approved this policy in 2011. Its goal is to mitigate the fragmentation of Primary Health Services delivery,

increase health services utilization, and improve health outcomes for all Nigerians (30). The PHCUOR mechanism aims at ensuring effective coordination of integrated service provision, management of resources, allocation of responsibility, and establishing an effective referral system (30). The “three ones” (one management, one plan, and one M&E) were also elaborated in the operational manual. With the establishment of the BHCPF as mandated by the NHA, the states are required to establish their state health insurance agency and primary health care development agency to access funds from BHCPF for the operationalization of PHCUOR (30).

3.5 Financial Protection

3.5.1 Introduction

For a country to achieve UHC, and by extension, the SDG target 3.8.2 by 2030, everyone should have access to the quality health service they need without suffering financial hardship (23)(77). Financial hardship occurs when OOP is significant compared to the capacity to pay for health services (78). It affects every wealth quintile; small OOP can cause financial hardship for the poor, while significant OOP or long-term treatment can do the same for the rich (79). However, since essential services are not always free, the lowest quintile suffers most, and some even avoid seeking care because of the inability to pay (79). Two sets of indicators are used globally to monitor financial hardship; “the percentage of households experiencing catastrophic health expenditure (when OOP health expenditure is beyond 10% or 25% of household income net of subsistence needs or 40% or more of non-food consumption expenditure) and the number of households falling below the poverty line or being pushed deeper into poverty due to out-of-pocket spending on health care” (78)(79)(80)(81).

3.5.2 Global Perspective on Health Spending

Global spending on health has increased even faster than the global GDP (82). Significant variation exists in health spending per capita: the global average was US$ 1,099, high-income countries average was US$ 3,313, upper-middle-income countries average was US$ 466, low middle-income countries average was US$ 115 while low-income countries average was US$40 in 2018 (82).In all income groups, while OOP payment has been increasing in absolute terms since 2000, the average share for all country groups has decreased even though slowly (82). The OOP for various groups is in lower middle countries (42%), upper-middle countries OOP was 35%, in high-income countries, OOP was 20%, while OOP in low-income countries was 41% (82). External aid increased from 2000 to 2014 when up to US$ 19.3 billion was realized. However, it has been decreasing slowly, and in 2018, external aid was US$ 16.2 billion (82).

The per capita for external assistance is similar for low income and low middle income at US$ 11 while for upper middle income, it was US$ 3.50 on the average (only four countries that received

aid at US$10 per capita: Botswana, Jordan, Namibia, and South Africa was used to calculate the average). Of the US$ 16.2 billion available as aid in 2018, 43% was absorbed by nine (9) countries, of which four are in the lower-middle-income group (Nigeria, Zambia, India, and Kenya), while the low-income group received 42% (82). However, the share of international aid was 10% of total health spending in low-middle-income countries compared to 30% in low-income countries (82).

As a share of total expenditures, government health spending reflects the priority placed on improving health indices and attaining UHC (82). On average, government spending on health from domestic sources has grown from 2000 to 2018 compared to total government spending (82). In 2018, the share of health spending was 5.6% for low-income countries, 7.3% for low-middle-income countries, 11.6% for upper-middle-income countries, and 14.3% for high-income countries (82). When the share of government spending is broken down to various income groups, there has been a constant decrease in the low-income countries, a mild decrease in the low middle-income countries, and an increase in the upper-middle- and high-income countries (82).

3.5.3 Health Spending for African Countries

Due to the high poverty rate and macro-economic instability, the critical population of low and low-middle-income countries is vulnerable and prone to CHE (82). An estimated 11 million Africans fall into poverty every year because of high OOP payments (71). In 2018, the average OOP for low-middle-income countries was 42%, despite a meager contribution to the total global spending on health (82). The global average per capita spending on health was US$ 2,551, and the ratio of government expenditure as a share of GDP was 28% (82). The ratio of government expenditure as a share of GDP is low because of Africa's highly non-organized informal sector, making it difficult for the government to raise funds through tax collection (82). However, some countries have made progress in reducing OOP and providing financial protection to their citizens. A study by WHO of African region countries categorized countries into three strata (high service coverage and low OOP payment, low service coverage and low OOP payment, low service coverage and high OOP payment). See figure 12: below for the 2018 expenditure profile of selected countries in various categories (21) (33).

2018 Health Expenditure Profile of Selected African Countries								
Countries	Out Of Pocket spending of THE (%)	GDP per capita (US$)	Share of Government GDP on health (%)	External aid to THE (%)	Government health spending (%)	SHI Contribution to THE (%)	Government transfer to THE (%)	Health Spending Per Capita (US$)
High Services Coverage (50 - 100%) and Low Out Of Pocket Payment (0 - 40%)								
Algeria	32.6	4115	10.7		65.8	26.3	39.5	255.9
Botswana	3.3	8258	14.3	6.4	77.5		77.5	483
Gabon	25.5	7955	9.7		62.7	14.9	47.8	210.6
Namibia	8.4	5930	10.7	4.61	46.1		46.1	471.5
Zimbabwe	24.4	2964	7.6	20	28		28	140
Low Services Coverage (0 - 50%) and Low Out Of Pocket Payment (0 - 40%)								
Rwanda	10.5	773	8.9	30.68	31.5	9.4	22.1	58.3
Kenya	23.61	1710	8.5	15.51	31.5	9.42	32.72	88.4
Ghana	37.7	2202	6.4	12.44	38.9	3.13	35.76	77.9
Losetho	16	1344	11.6	25.9	58.1		58.06	124.8
Low Services Coverage (0 - 50%) and High Out Of Pocket Payment (0 - 40%)								
Nigeria	76.6	2153	4.4	7.86	14.9	0.76	14.1	83.8
Sierra lone	44.8	534	7.2	25.88	9.7		9.7	85.8
Cote d' Ivoire	39.4	1716	5.1	12.32	28.8		28.45	71.9
Comoros	74.5	1421	2.6	14.47	9.3	2.9	6.36	65.2
Mali	33.9	900	5.4	35.97	28.2	6.14	22.08	35

Figure 12: 2018 Health Expenditure Profile of Selected African Countries

Adapted from WHO Health Expenditure Database and Hera Right to Health and Development (21)(33).

When Gabon, Nigeria, Rwanda, Ghana, and Kenya were compared on their 2018 expenditure profile, Nigerians are paying far more than any other from their income (OOP at 76.6%). The high OOP reflects poor priority the government placed on health with a 4.4% share of GDP spending and less than the other countries. The Nigeria SHI contribution to the THE is also the least among the compared countries (figure 13).

Comparison of the 2018 Health Expenditure Profile of Gabon, Rwanda, Kenya, Ghana and Nigeria								
Countries	Out Of Pocket spending of THE (%)	GDP per capita (US$)	Share of Government GDP on health (%)	External aid to THE (%)	Government health spending (%)	SHI Contribution to THE (%)	Government transfer to THE (%)	Health Spending Per Capita (US$)
Gabon	25.5	7,955.0	9.7		62.7	14.9	47.8	210.6
Rwanda	10.5	773.0	8.9	30.7	31.5	9.4	22.1	58.3
Kenya	23.6	1,710.0	8.5	15.5	31.5	9.4	32.7	88.4
Ghana	37.7	2,202.0	6.4	12.4	38.9	3.1	35.8	77.9
Nigeria	76.6	2,153.0	4.4	7.9	14.9	0.8	14.1	83.8

Figure 13: Comparison of the 2018 Health Expenditure Profile of Gabon, Rwanda, Kenya, Ghana and Nigeria

Adapted from WHO Health Expenditure Database and Hera Right to Health and Development (21)(33).

The reduction in Ghana's OOP is attributed to the introduction of a health insurance scheme in 2005. OOP contributed to about 9.4% of Ghanaians living in poverty and 31% being pushed more into poverty (83). Specifically, the reduction in OOP was attributed to 62% and 63% reduction in the cost of medication and services provision (mostly obstetric care) with an increase in an insurance claim by 34% and 37% respectively between 2010 and 2014 (83). Ghana's National Health Insurance is a mandatory contributory scheme; however, benefits are extended to children under 18 years, pregnant women, pensioners, the elderly (above 65 years), and indigents (83). It is financed by premium payment (2.5% deduction from workers and 2.5% VAT on selected goods (83). Other funding is realized from budget allocation, external aid, donations, and investment returns from the national health insurance council (83). The NHIS essential benefit package covered over 95% of common disease conditions in Ghana including inpatient accommodation (83).

The government of Gabon rapidly increased its share of total health expenditure from 40% in 2001 to 65% in 2016 from revenue generated from 10% levy on mobile phone usage on telecom companies and in 2007, made participation in the National Health Insurance and Social Coverage Fund and the National Health Insurance Program compulsory (84)(85). This rapidly improved enrollment increased coverage to almost 99% of all indigent citizens and reduced OOP payment (84) (85). The Gabon Indigent Scheme (GIS) also exists for all individuals from 16 years (younger people are beneficiaries of insured parents) with income less than US$130 per month. The GIS members make a co-payment of 20% for services. They are entitled to the same essential health services package as those who paid a premium, usually covering 80% of common illnesses, 90% of NCD, and 100% of Maternal and Child costs (52).

3.5.4 Incidence and Determinant of CHE in Nigeria

The public and private sectors provide health services in Nigeria (89). Private health facilities usually operate for profit and are owned by private individuals, religious organizations (typically operate at a reduced fee), cooperate organizations, etc. (89). Private individuals own the majority (76%) of the secondary health facilities, and fees are usually charged at the point of service provision (89)(10). The primary health services are primarily skeletal because of the limited number of healthcare workers. The majority of people who seek care do that at secondary or tertiary health facilities (89). Government spending on health has remained below 6% GDP and 15% annual budget allocation to health (33)(34)(89). With over 40% of Nigeria below the poverty line, they spend a disproportionately higher percentage of their household income on health services and therefore experience CHE more than the rich (89).

Payment for health services can be through various options: social health insurance, private health insurance, government subsidies, taxation, or OOP (77). The OOP payment has a high propensity to lead to CHE than SHI or government subsidies that increase pool funds and mitigate CHE (77)(79). Unfortunately, Nigerians have relied on OOP payment for health in the past decade (see figure 15) (90) because the majority of Nigerians pay at the point of health service delivery

or for the drug prescribed by the public health sector at a pharmacy (91). This reliance increased the incidence of catastrophic health spending (91). In 2010, the proportion of the global population with catastrophic health expenditure stood at 10%, and 25% of the threshold of household consumption were 11.7% and 2.6%, while Nigeria was remarkably higher at 25% and 8.9%, respectively (23)(28)(29)(77). (See figure 14 for comparison with other countries)

Incidence of Catastrophic Health Spending		
Countries	10%	25%
Gabon	6.0	0.2
Kenya	6.0	1.5
Ghana	3.0	0.1
Nigeria	25.0	8.9

Figure 14: Incidence of Incidence of Catastrophic Health Spending (29)
Adapted from www.thelancet.com/action/showPdf?pii=S2214-109X%2817%2930429-1

In Nigeria, Health insurance favors the wealthy and urban population (89). Majority of the 5% of the Nigerian population who are insured live in the urban areas and are mainly employed (89). This has made access to publicly financed health services almost exclusively of the urban center, leaving the poor, who also have a higher disease burden, and live in the rural areas with fewer health facilities (89)(10). Again, user fees paid at the point of service delivery in Nigeria are the same amount for the rich and the poor, thereby creating a huge barrier to accessing health services for the poor (89). The consequences of poor access to health services include poor-quality health services, indiscriminate use of self-prescribed drugs, avoidance of treatment due to inability to pay, long-term poverty, and increased morbidity and mortality (89).

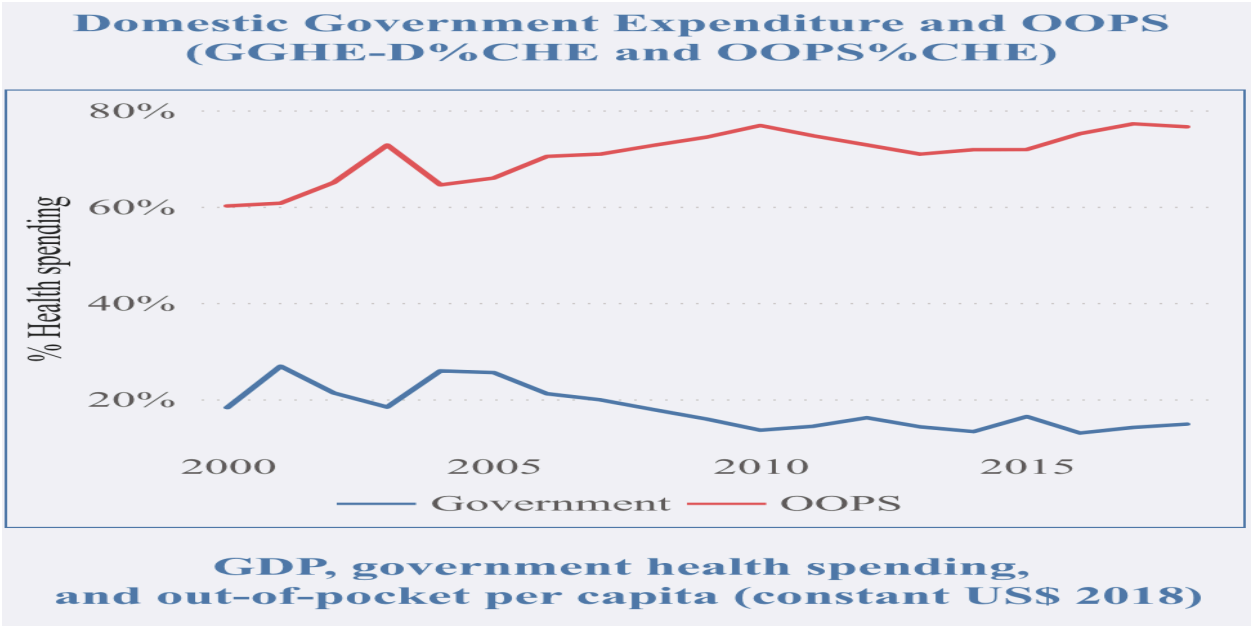


Figure 15: Trend of Out-of-pocket payment in Nigeria (33)
Source: https://apps.who.int/nha/database/country_profile/Index/en

A study measured CHE for inpatient and out-patient care for different disease conditions and reported that at 40% non-food expenditure, the incidence of CHE ranged from 6.6% to 94.3% (77). For inpatient, all patients incurred CHE; however, childhood epilepsy management at 63.6% and HIV at 94.3% ranked highest; for outpatient, TB management and type 2 diabetes were highest at 40% (77). Several studies identified a high incidence of CHE among households in the poorest quantile, those in the rural areas, where females are head of household, where an uneducated person is head of household, where an unemployed person is head of household, and those without any health insurance (see figure 16 and 17). Other determinants include the geopolitical zone (southwest Nigeria has the lowest incidence of CHE), type of health facility (private has the lowest incidence of CHE because seriously ill and terminally patients seek care at public health facilities), and type of illness suffered as determinants of CHE in Nigeria irrespective of threshold concept used (78)(79)(92) (see table 6 for determinants of CHE). Even though health insurance reduced the incidence of CHE, several households with insurance still experienced CHE at a 40% threshold (92). CHE among households with insurance was highest in North Central (29.17%), then the Northwest (25.00%), Northeast and Southeast (12.50%), and lowest at Southwest (8.33%) (92).

Variable	Description	% of Non-Food Expenditure					
		10%		20%		40%	
		No	Yes	No	Yes	No	Yes
Socio-economic Quantile	Lowest	27.50	72.50	37.78	62.22	51.80	48.20
	Second	29.50	70.50	41.13	58.88	59.13	40.88
	Middle	34.97	65.03	50.55	49.45	64.79	35.21
	Fourth	35.66	64.34	s52.65	47.35	69.64	30.36
	Highest	45.60	54.40	59.29	40.71	73.21	26.79
Geo-political Zone	North Central	39.77	60.23	53.75	46.25	67.15	32.85
	North East	32.87	67.13	44.23	55.77	61.89	38.11
	North West	31.14	68.86	43.18	56.82	59.80	40.20
	South East	33.18	66.82	45.16	54.84	60.52	39.48
	South South	29.11	70.89	47.15	52.85	63.45	36.55
	South West	42.86	57.14	57.88	42.12	71.43	28.57
Residence	Urban	42.12	57.88	57.33	42.67	72.23	27.77
	Rural	31.47	68.53	44.48	55.52	60.17	39.83
Gender of Household Head	Male	35.48	64.52	49.30	50.70	64.61	35.39
	Female	31.19	68.81	44.24	55.76	60.51	39.49
Age of Household Head	20-40years	39.35	60.65	52.30	47.70	69.01	30.99
	41-60years	36.66	63.34	50.86	49.14	66.23	33.77
	61-80years	30.66	69.34	44.81	55.19	59.72	40.28
	81years & Above	18.75	81.25	27.84	72.16	41.48	58.52
Education of Household Head	No Education	25.00	75.00	25.00	75.00	25.00	75.00
	Nursery and Primary	30.62	69.38	44.48	55.52	61.45	38.55
	Secondary	39.49	60.51	53.95	46.05	68.53	31.47
	Post-Secondary	41.32	58.68	56.31	43.69	72.06	27.94
Employment Status of Household Head	Employed	43.40	56.60	59.28	40.72	74.06	25.94
	Unemployed	33.25	66.75	46.56	53.44	62.12	37.88
At least one Hospitalised Member	No	39.12	60.88	54.27	45.73	71.02	28.98
	Yes	2.94	97.06	5.88	94.12	11.55	88.45
Household Size	Less Than 5	36.97	63.03	49.37	50.63	64.16	35.84
	More Than 5	34.26	65.74	48.34	51.66	63.96	36.04
Health Insurance	Insured	45.79	54.21	64.49	35.51	77.57	22.43
	Uninsured	34.56	65.44	48.13	51.87	63.64	36.36
Total		34.85	65.15	48.56	51.44	64.01	35.99

Percentage of Households with catastrophic health spending according to household characteristics

Figure 16: Incidence of CHE based on Household characteristics (92)

Source: http://article.sapub.org/10.5923.j.m2economics.20180601.01.html

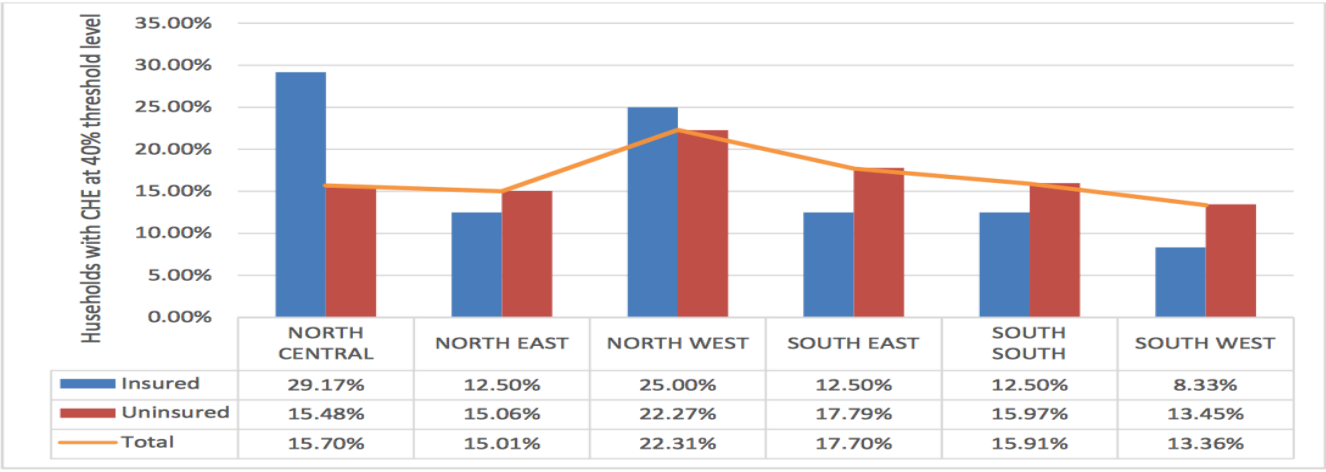


Figure 17: Proportion of Households incurring CHE by Geopolitical Zone (92)

Source: http://article.sapub.org/10.5923.j.m2economics.20180601.01.html

3.5.5 Policies to increase pooled fund in Nigeria (BHCPF And NHIS)

The financing of Basic Minimum Package of Health Care Services (BMPHS) and Emergency Medical Treatment (EMT) for all Nigerians through the primary and secondary health care services is the primary aim of the Basic Health Care Provision Fund (BHCPF) as enacted for establishment by section 11 of the NHA (25)(26). BHCPF will be realized from an annual grant from the Federal Government of not less than 1% of the consolidated revenue fund, donor funding, and innovative funds, including the private sector. This mechanism will increase the fiscal space for health sector financing, deploy resources to the frontline for health services delivery and enable Nigeria to achieve UHC in line with the health-related SDGs (25)(26). (See figure 18).

Following non-alignment of some content of an operational manual for BHCPF developed in 2018 identified by the legislative health committee, its operationalization was suspended, and a guideline that rectified the anomaly (better alignment with the NHA and precise fund administration mechanism) the "Guideline for the Administration, Disbursement, and Monitoring of BHCPF" was launched in 2020 (26)(73)(75). The guideline stipulates those resources of the BHCPF will be utilized in strengthening the Primary Health Care System, ensuring the provision of BMPHS, and provision of Emergency Medical Treatment. (See figure 13) (75).

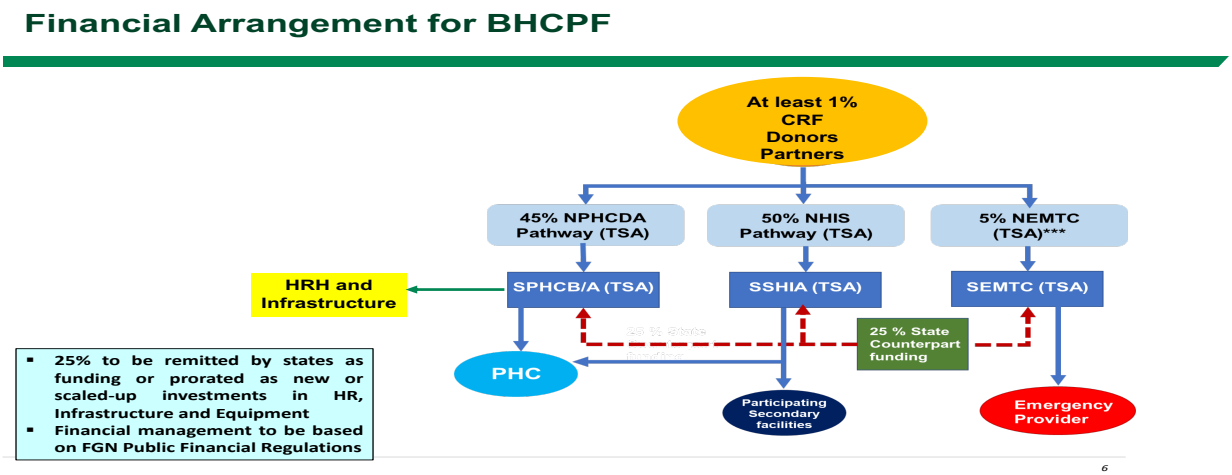


Figure 18: Financial Disbursement Pathway for BHCPF (75)
Source: BHCPF Guideline 2020; NPHCDA

The 2020 BHCPF guideline aims to leverage the National Strategic Health Development Plan (2018 -2022) to move Nigeria toward attaining UHC and the health-related SDGs(26). For this funding mechanism to become functional, State and Local Government Areas levels are required to contribute 25% counterpart fund for any project to be carried out at the PHC level. Only ten states and the Federal capital territory have keyed into this program in 2020, and the only fund released by the Federal government was in 2018 (US$1340 million) (75)(87)

Chapter 4: Discussion

From the findings, Nigeria has innovative and strategic policies for attaining UHC, such as the NHA, NHP, PHCUOR, BMPHS, BHCPF, and NHIS. These policies and strategies are similar to those obtainable in other MLICS; however, they are not without challenges.

4.1 Health Policies and Strategies driving progress towards UHC

NHA 2014 drives changes in the health policies aimed at achieving UHC and health-related SDGs. All the principal national health documents, including the NHP, and NSHDP which focused on strengthening health systems and ways of achieving respectively, are enshrined in the act. Also, the BHCPF, which allows for effective delivery of BMPHS for PHCs, is inclusive. All respondents for the SSI affirmed NHA forms the bedrock of new health policies and equally stimulates the amendment of the existing policies. A respondent said:

> *The NHI is going through an amendment to make it a mandatory scheme because of the provision of the NHA participant*

The provisions within the NHA are in tandem with the UN position (domestic funding for health, reduction of reliance on OOP, and improvement of efficiency in health management) on achieving UHC and financial risk protection. The participants also shared this view; however, there are impediments to achieving UHC through the provisions of the Act. One participant stated:

> *"Until punitive laws like anti-gay laws are removed some people will still be marginalized and it will delay attainment of UHC."*

With the provision of the NHA, and apart from health policy documents developed, operationalization is always a challenge. Thus, this affects the translation of available policy into deliverables, which will affect the attainment of UHC. Often, information and functions are misappropriated. The emergency fund from BHCPF originally set apart for emergency treatment of Nigerians, has been used to purchase ambulances that formerly have been appropriated for within the statutory budget allocation. Many Nigerians, therefore, tend to incur catastrophic costs for emergency treatments. In other words, financial risk protection is not achieved while many die because they could not afford these treatments. A respondent affirmed:

> *''There are lot of policy issues in the NHA but with respect to UHC, the section that deal with financing is the BHCPF and we noticed that there was no budgetary allocation until 2017/2018 when what was released was not up to one percent."*

Some of the policies did not conform with the NHA, like the BHCPF 2018 guideline for disbursement, which was suspended due to the non-alignment of its content with the already available NHA. Also, the current PHCUOR operationalization is still very skeletal, with many other components of the NHA not addressed. Including the strategy for health human resources development, restriction of medical tourism with public funds, the establishment of quality certification standard committee, and activation of NTHIS (88). Another respondent acclaimed:

> "It has been seven years since the passage of this legislation, the operationalization has been on the paper and lips of government."

Although the policies are there, the operationality of these policies seems ineffective because Nigeria lacks political will. More so, the political system of states been autonomous in disbursement and management of funds further impedes the implementation of policies and strategies (38). Thus, implementing these policies depends on the respective state governments, who also decide whether to access the BHCF. The release of funding for this program is also erratic, the only disbursement was in 2018, and the COVID-19 situation has worsened. Also, the political divide in Nigeria has a negative impact as opposing political parties see the program as that of the ruling party. In Ondo state, for example, the then governor, a medical doctor, pledged to UHC commitment and thus supported the provision of efficient and accessible MCH service, which significantly reduced the MMR to 84% in 16years from the year 2000 (745 to 112 per 100,000 live births) (95). However, only ten states in Nigeria have committed to UHC since BHCPF was released in 2018.
One of the participants supported this and said:

> ''up to 33 states are in the process of accessing the fund.''

The PHCUOR aimed at taking services to the people is still poorly implemented. Firstly, 48% of Nigerian residing in rural areas have just 35% of health facilities available to them, implying that there are many indirect costs associated with seeking care during the fourth round of assessment using implementation guidelines by NPHCDA in 2018. States like Akwa-Ibom had 0% performance, Edo and Kogi had 18% and 25% performance, respectively. Enrolment into the program has been challenging for states. Most respondents supported this. One of the SSI participants noted:

> *"Enrolment is facility based and not all political wards have facility as required by PHCUOR. So, wards PHCUOR, the inhabitant we move to next ward this reduced not just enrolment but access to care."*

Even with states that have accessed the BHCF, running an equitable program as required in the NHA is questioned. Another participant asserted:

> *''Even though the NHA has galvanized the state to create the SHIS to enable them access the BHCPF it is however regrettable that they are not running other programs different from BHCPF: there is a particular number of people the BHCPF is to cover in a state, and this is far less than the number of indigent and vulnerable."*

There must be a formidable measure in ensuring states who access these funds manage them equitably and efficiently for the set objectives towards attaining UHC. Many of the respondents also clearly reaffirmed this as a means of monitoring and evaluation of the states. If we must achieve UHC, all services will have to be rendered to ensure access and financial protection for Nigerians. A respondent stated:

> *''we cannot achieve UHC without making health insurance mandatory and as it in the law it is not mandatory."*

4.2 Health System factors

A functional health system is meant to provide effective health coverage and financial protection at the core of UHC (19). This study finds that the Nigerian health system is organized along the three tiers of government: the primary, secondary, and tertiary health care levels. The NHA 2014 recognized the public, private or traditional health institutions and mandated FMOH to coordinate activities by setting a minimum standard of practice. States are, however, to authorize the practice. At the federal level, policies compliant with attaining UHC are available but at the States compliant with federal policies is varies; usually, progress is at the discretion of the State government.

> *Since we started NHIS, it is after the creation of the BHCPF that the States are beginning to show interest because of the money in it for them.*

Although the Nigerian BMPHS is comparable to that of Gabon, Ghana, and Kenya that have made considerable progress toward attaining UHC (51), however, access to these services in Nigeria requires OOP of up to US$ 99 to access comprehensive MCH services and US$ 5.52 for FP. Immunization services, when offered by private health facilities, also come with high costs (55). These costs and other opportunity cost limits Nigerian from having access to services and increases CHE or even prevent sick people from seeking care. Ghanaian's also pay some OOP to access services, but the average is much less compared to Nigeria's, MCH at US$ 8.6 and FP at US$3.03. For Gabonese, a study found that some wealthy people pay for services and that HCWs offer them express service to the detriment of those getting it for free. Health facility distribution in Nigeria also contributes to the disparity in access to BMPHS. The study found that 75% of health facilities are mostly secondary and tertiary facilities in the urban area. The PHC in the rural areas are also not supported through budget allocation and, therefore, even when available, do not offer expected services. These factors cause urban versus rural disparity in essential services coverage. One of the participants confirmed that BMPHS for PHC is less than what NHIS BMPHS covers.

What NHIS offers as BMPHS is more than what you have in the BMHPS of BHCPF: BHCPF BMHPS is for primary health centers like testing and treatment of malaria, hypertension, and maternal and child health issues, but in HNIS, provision of secondary and tertiary services is included. So, each program has its MPHCP like the formal sector program for oil companies can even air lift a patient, but of course, the premium is different

Another factor identified as causing disparity is the maldistribution of health care workers. Most of them prefer to stay in an urban area with basic amenities and career progression opportunities (38). There is no incentive package from the government to motivate rural health workers. The non-operationalization of the following (strategy for health human resources development, restriction of medical tourism with public funds, establishment of quality certification standard committee, and activation of NTHIS) contribute to inaction in the delivery of services at a health facility. Poor gatekeeping and poor referral reduces access to health services and causes wastage and inefficiency as ailments that should be handled at PHC are treated at secondary facilities causing increase waiting time, non-provision of essential specialized services to those most in need and fatigue to health providers (10). Because of insurance coverage and the use of community health workers to deliver services at the doorstep of clients in Ghana, Gabon, and Kenya, the disparity in services coverage is minimal. In fact, in some services, rural populaces are better served: in Ghana, the rural met need for contraception is 31.1 against 28.7 in an urban setting (74).

An estimated 11 million Africans are pushed into poverty due to high OOP. Nigeria, a low, middle income with about 40% of its population living below the poverty line, has the highest percentage of OOP at 76.6% when compared with other countries with similar GDP per capita (Zimbabwe (24.4% OOP) and Ghana (37.7% OOP) and even lower GDP per capita (Rwanda (10.5% OOP), Kenya (23.6% OOP), Lesotho (16% OOP)). The SHI contribution to annual THE for Nigeria was the lowest, 0.76%, compared to other African countries that operate SHI scheme (Rwanda (9.4%), Ghana (3.13%), Gabon (14.9%)). Also, Nigeria's government health spending ranked low (14.9%) when compared to Ghana (38.9%), Lesotho (58.1%), Rwanda (31.5%), and Cote d' Ivoire (28.8%), just above Comoros (9.3) and Sierra Leone (9.7%). These figures are a demonstration that the health sector is not prioritized. About 25% of Nigerians experience CHE compared to 3% for Ghana and 6% for Gabon at a 10% house consumption threshold.

Even at the 25% household consumption threshold, 8.9% of the population compared to O.2% for Gabon and 0.1 for Ghana experienced CHE. It means that Ghana and Gabon program is offering financial protection to its citizens. The study also found that some households will not seek care in Nigeria because they lack the capacity to pay. There were conflicting data on whether CHE is more at Private or public health facilities. The argument for more in public facilities opined that seriously ill people and those with terminal illnesses are mostly managed at the public health facility. At the same time, those for private said that they are profit-oriented while public run at low cost. Other causes of high CHE in Nigeria include the poor insurance coverage limiting pooling of funds as only about 5% of Nigerians are insured. There is also no active SHI for the poor, indigent, vulnerable, and hard to reach as in Gabon and Ghana. The study also found that 100%

of inpatients incurred CHE with the management of HIV comorbidity, ranking highest at 94.3%, demonstrating that only ARV is offered free in Nigeria.

Several studies identified a high incidence of CHE among households in the poorest quantile, those in the rural areas, where females are head of household, where an uneducated person is head of household, where an unemployed person is head of household, and those without any health insurance. Other determinants include the geopolitical zone. Even though health insurance reduced the incidence of CHE, several households with insurance still experienced CHE at a 40% threshold. CHE among households with insurance was highest in North Central (29.17%), then the Northwest (25.00%), Northeast and Southeast (12.50%), and lowest at Southwest (8.33%) (92). The challenges Nigeria is facing is enormous, despite lofty policies, the persistent poor funding of health, only committing a third of the Abuja Declaration for over a decade now, cost of services, the opportunity cost for health-seeking, high level of poverty, and an urban-rural disparity are critical hindrances to progress towards UHC.

4.3 Policies and strategies of other LMICs that have made remarkable progress towards attaining UHC

Gabon and Ghana have witnessed a decrease in OOP from 28% to 25.5% and 40.6% to 37.7%, respectively, between 2012 to 2018. While Nigeria's OOP has increased from 72.8% to 76.6% within the same period. The recommended OOP for countries aiming to attained UHC is 20%. Gabon's and Ghana's OPP reduction were attributed to the institutionalization of mandatory SHI and innovative funding mechanisms for the schemes. Gabon's scheme is funded from a special levy on telecom revenue, while Ghana's source of revenue is 2.5% VAT on luxury goods. Both mechanisms have allowed the governments of both countries to increase their spending on health at 62% and 38%, respectively, for Gabon and Ghana in 2018. The NHIS has been in place in Nigeria since 2005, but participation is voluntary, and only 5% of Nigerians, mostly federal government workers, are insured. Despite being enrolled in health insurance, the household in Nigeria still incurred CHE. The introduction of the BHCPF financed from 1% consolidated revenue has not improved the share of government spending since 2014.

The prevalence of CHE in Ghana, Gabon, and Kenya at 10% or 20% household consumption is way below that of Nigeria (see table 5 above). And the inequity in BMPHS access is closing out while that of Nigeria is widening. These characteristics may be attributed to the operationalization of their SHI and means of service provision. Ghana's, Gabon's, and Kenya's SHI have a package for the poor, indigent and vulnerable, and its content is the same with those who pay a premium. In the provision of their services, apart from operating the PHCs, they also have community health workers that deliver services at clients' doorsteps. It is noted that immunization coverage and modern contraceptive use are higher in Ghana's rural areas compared to urban areas. Population coverage is also not strictly skewed against the poor as obtainable in Nigeria. On the other hand, Nigeria's recent effort is centered around strengthening PHCs and delivering BMPHS through PHC. The content of this PHC BMPHS is different from that of regular NHIS's and members are required to pay a premium and register in a PHC near them.

According to one of the participants in SSI, this has created a problem as only a few PHCs have been activated, and the distance to them is usually far. This leads to high costs for transportation, decrease access to service and increase OOP.

The cost of accessing services is cheaper in Ghana and Gabon when compared to Nigeria. The cost of FP is about US$ 5.52 in Nigeria and US$3.03 in Gabon. All the countries experienced stock-out of health products like immunization, FP products, but the reason for the stock out is varied; in Nigeria, it was mostly attributed to lack of funding or late release of the fund, while in Gabon, it was attributed to inadequate manufacturing capacity and marketing practices. Gabon received no external aid in 2018, their SHI accounted for 14.9% of THE, ranking higher among most African countries except for Algeria, and share of government spending on health was 9.7% compared to 6% recommended for LMIC and was categorized to have high service coverage and low OOP by Hera Right to health Development assessment. All the participants of the SSI believed that these countries are doing better than Nigeria because of the compulsory nature of their SHI and the commitment of their government. One participant said that stability in the management of the SHI program contributed to their progress, unlike Nigeria, where there is always a change of management every three years.

4.4 Relevance of the framework

The WHO's three-dimensional framework for UHC used for this analysis was a perfect match. It showcased that countries with policies that drive the effective provision of BMPHS so that the indigent, vulnerable, rural dwellers and special population target have equal access to health services and are protected financially are on their way to achieving UHC.

4.5 Strength and Limitations

This study has strength in that it is the first study in my search to examine the impact of the NHA 2014 and other recent health policies on essential services coverage, population coverage, and financial protection on Nigeria's path to UHC. Most studies focused on OOP, equity in service provision, and achieving UHC through NHIS. This study will provide stakeholders with clear evidence of the need to fast track progress towards UHC in Nigeria and other countries with similar challenges. It will critically look at the policies and strategies and compare it with best practices. Again, the combination of literature review and SSI to triangulated results of finding adds to this study's rigor but promoted neutrality and objectivity.

However, there were some limitations. Data comparing population coverage for Ghana, Gabon, and Nigeria were of different years based on when the DHS was last conducted. So, findings may not be the same if the same year data were used. All the participants for SSI were males, and this may have limited the nature of information if a woman who had used the services was interviewed. Again, all the participants in SSI operate at the Federal level, and therefore priceless experience from States stakeholder to either agree or refute the finding was missed. Apart from the PHC BMPHS available on the BHCPF document, the study did not access what is contained in

the NHIS package and what is really offered in the health facilities and therefore cannot assess of participant opinion the NHIS BMPHS package has more content. The analysis of the essential service coverage dimension concentrated on reproductive, maternal, and child health issues.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATION

5.1 Conclusion

Achieving Universal Health Coverage entails all people having access to needed promotive, preventive, curative, and rehabilitative health services where and when they need them without financial hardship. This concept has become a developmental principle and at the core of the SDGs. For countries to achieve UHC, its health system must be strengthened to deliver effective health services and offer financial protection to its citizen. However, the key barrier to achieving UHC lies in over dependence on OOP and donor funds, poor domestic resourcing and inefficiency associated with the use of available resources for most MLICS including Nigeria. Nigeria enacted the NHA as a tool to provide a legal framework for achieving UHC. Other health policies are also based on the ACT including NHP, NSHDP II, and BHCPF guidelines which all outlined Nigeria's primary strategies to attainment of UHC. These strategies include PHCUOR, strengthening SHI at the Federal and State levels and the dedication of 1% from consolidated revenue to funding of the BHCPF by the federal government. Funds are also expected from donors and earn marked taxes.

Even with the establishment of these policies and strategies, Nigeria's progress has stalled. The OOP is at 76.7%, and over 25% of the population experiences CHE at 10% of household consumption. Only 10 States are participating in the in the BHCPF program. The PHCUOR program is also facing similar challenge of implementation, even though the fund for its implementation resides with the NPHCDA, states need to pay 25% counterpart fund, and therefore even during the fourth round of assessment some states like Akwa-Ibom scored 0.0%. The need to pay about US$22 to benefit from the BMPHS has an implication in a country where over 40% live below N137,430 (US$381.75) per year as many will not be ready to forgo that amount except, they are sick. The NHIS been voluntary have limited enrolment, only 5% of Nigerians are enrolled since 2005 the scheme commenced. Human resources for health are also concentrated in the urban area. Essential health services and population coverage is skewed against the poor and Nigeria's focus is on delivery services through the PHCs. Emergency services health services coverage is at 20%. Average cost of access an essential service is costlier in Nigeria compared with Ghana especially using OOP (for FP US$ 5.52 for Nigeria and US$ 3.03 for Ghana). The gate keeping and referral system in Nigeria is also poor and majority of those that seek care bypass the PHCs causing long waiting time and wastage of resources at the secondary facilities.

Nigeria with a GDP per capital of US$ 2,153 is comparable with Ghana and higher than Kenya and Rwanda but government of these countries spend more on health than Nigeria at 14.9%, Furthermore, government spending as a share of GDP was 4.4% which is below recommended 5%. Nigeria government needs to spend more on health to reduce OOP and the number of people suffering CHE. The activation has the potential of correcting inequity that abound in the Nigeria health system. Countries like Gabon, Ghana, Kenya, and Rwanda have demonstrated that making progress towards UHC is possible in LMICs. Gabon is leading the race with government spending at 62% and government share of GDP spending at 9.7% with reduction of OOP to 25%. The percentage of their population falling into poverty on 10% spending of household consumption income is low 6%. The funding of their SHI through earmarked taxes have ensured stability in the management of the SHI and is propelling them towards attaining UHC. The targeting of the poor by the GIS program and having access to the same BMPHS as those who pay premium have

increased the essential services and population coverage. Also, the use of community health workers who deliver services at the doorstep of citizen reduced disparity in urban versus rural settler. UHC is a process and growth are inevitable, the target set by UN of OOP at 20% have been achieved by developed countries and all countries including Nigeria need to push towards achieving UHC.

5.2 Recommendation

Based on the findings of this study, the following recommendations if implemented, will help ensure that Nigeria will make the required progress towards the attainment of UHC.

5.2.1 Federal Government and Policy Makers (agencies of government, private sector, and civil society)

5.2.1.1 Increase Health spending by Government

Prioritization of health spending is essential in attaining UHC. For the government to achieve this, there must be a strong commitment to the 2001 Abuja Declaration of allocating 15% of the annual budget to health. This will improve the share of government GDP spending on health and reduce the OOP. Also, efficiency on the government's part in releasing the 1% consolidated fund contribution to the BHCPF will further accelerate the implementation of programs already planned for.

5.2.1.2 Legislate Earmarked fund for health

Since earmarked revenues have been implemented in countries with similar contexts like Nigeria, to generate adequate funds, especially from telecommunication companies, such innovative steps can be adopted in Nigeria. With the country's massive telecommunication population and growth, proper legislation on these companies will ensure the regular availability of funds for effective health system strengthening. This will also ensure the delivery of quality health services and the attainment of UHC.

5.2.1.3 Strengthen the SHI

SHI can be effective in achieving UHC. Membership to SHI will have to be made compulsory; thus, more funds will be pooled with increased risk-sharing. Poor and vulnerable people should be included to register free but pay about 20% co-payment when they access services. In this way, prompt access to services and equity is ensured. Also, a strategy to ensure the enrolment of the

informal sector will need to be strategic as the 5% currently on insurance are from the formal sector.

5.2.1.4 Fast-track of the Implementation of PHCUOR and incorporation of community health services provision

PHCUOR is in line with the principle of UHC but in few states. Thus, the government needs to fast-track its implementation in every political ward in Nigeria and its contribution to BHCPF. Proper advocacy could be made to ensure state and local governments actively participate in the BHCPF program. This will ensure consistency in counterpart funds payment and ultimately ensure the provision of services, especially in rural areas, and attainment of UHC. The members of the legislative houses can also deploy their constituency project into instituting this laudable project. The project can be combined with community health services to reduce inequity in services coverage, as seen in Gabon and Ghana.

5.2.1.5 Access impact of BHCPF SHI on service coverage and financial protection

Since BHCPF SHI has commenced in some states and there is data to validate the effectiveness, adequate monitoring and impact evaluation are required. This will form the basis for the generation of baseline data on the implementation of the policies, serve as an advocacy tool for states, and thus, possible scale up to other states.

5.2.2 States and LGAs

5.2.2.1 Establishment of SSHI and Alignment with BHCPF SHI

The states should establish their social health insurance scheme to run their equity fund and align to the federal government BHCPF. This will increase enrolment, pooling, and risk-sharing. It will ensure that the vulnerable and indigent have access to health services and are protected financially. States participation in the BHCPF program will also fast-track the actualization of PHCUOR.

5.2.2.2 Increase Budget Allocation for Health:

The respective states in Nigeria will have to meet the 15% budgetary allocation as demanded by the Abuja declaration. With the states' commitment, efficient running of the BMPHS will be achieved in the different States and PHCs. Thus, ensuring attainment of UHC in Nigeria.

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Annex

	Primary Level Care	Secondary Level Care
1	General Consultations with prescribed drugs from accredited PHCH facility	Consultation with prescribed drugs from accredited Secondary Health Care facilities
2	Education and Disease Prevention i. Family planning education (use of safe period, pills, condoms, etc.) ii. Dental health iii. HIV, AIDS, Tuberculosis, Malaria iv. Immunization v. Vitamin A Supplementation vi. Essential Nutrients, especially for children and pregnant women vii. Basic Hygiene and Sanitation (personal, domestic, food and environmental)	Hospital Admission: i. Medical admission: 15 days maximum, cumulative per year ii. Surgical admission: 20 days maximum, cumulative per year
3	Surgery i. Minor surgical procedures: ▪ Incision and drainage ▪ Laceration suturing ▪ Minor burns ▪ Simple abrasions ii. Minor wound debridement iii. Infant circumcision iv. Impacted faeces v. Urinary retention	Surgery i. Major lacerations ii. Sprains and undisplaced fractures iii. Appendicectomy iv. Herniorrhaphy v. Hydrocelectomy vi. Testicular Torsion vii. Excision of lipoma, atheroma, etc.
4	Primary eye care ▪ Basic examination and visual acuity ▪ Conjunctivitis ▪ Parasitic and allergic ailments	Emergencies occurring outside the usual residence or accredited health care provider

	▪ Simple contusion, abrasions, etc.	
5	Paediatrics i. Child Welfare Services: ▪ Growth monitoring ▪ Routine immunization (as defined by the NPHCDA) ▪ Vitamin A supplementation ▪ Nutritional advice ▪ Health education, etc. ii. Uncomplicated malnutrition iii. Helminthiasis iv. Common childhood illnesses: ▪ Malaria ▪ Diarrhoeal disease ▪ Schistosomiasis ▪ Upper respiratory tract infections and ▪ Uncomplicated pneumonia v. Uncomplicated urinary tract infections (UTIs) vi. Simple otitis media, pharyngitis vii. Childhood exanthemas, simple skin diseases and infestations, viral illnesses (i.e. mumps), etc. viii. Anaemia, not requiring blood transfusion	Laboratory Investigation i. Genotype ii. Lumbar puncture iii. Urea, electrolyte, creatinine iv. Liver Function Test v. Ketone bodies vi. Microscopy, culture, sensitivity (urine, blood, stool, sputum, wound, urethral, ear, eye, throat, aspirate, cerebrovascular spinal fluid, endoscopy cervical swab, high vaginal swab) vii. Occult blood in stool viii. Skin snip for microfilaria ix. Acid fast bacillus for Tuberculous Bacillus (blood) x. Gram stain xi. Mantoux test xii. Blood groupings, cross matching xiii. Hepatitis B surface antibody screening xiv. Confirmatory test for HIV xv. Full Blood Count xvi. Platelets, reticulocyte count xvii. Platelets concentration xviii. Blood transfusion services, up to 3 pints of safe whole blood or blood products xix. Radiology (X-ray of chest, abdomen, skull, and extremities, dental) xx. Abdominopelvic and obstetric scan
6	Internal Medicine (Adult) i. Scheduled routine basic medical examination ii. Simple infections and infestations ▪ Malaria ▪ Upper respiratory tract infections ▪ Urinary tract infections ▪ Gastroenteritis ▪ Primary ear, nose, and throat infections ▪ Diarrhoeal diseases ▪ Enteritis and typhoid fever • Schistosomiasis • ▪ Helminthiasis	Obstetrics and Gynaecology I. Basic and Comprehensive Emergency Obstetric Care ▪ Preterm and pre-labour Rupture of Membrane (P/PROM) ▪ Hypertensive diseases ▪ Bleeding ▪ Postpartum haemorrhage ▪ Eclampsia ▪ Caesarean section ▪ Operative management for ectopic gestation ▪ Intra-uterine foetal death ▪ Puerperal sepsis ▪ Instrumental delivery High risk delivery (1st delivery, after the 4th delivery, multiple delivery, mal- positioning and mal-presentation, any other complications)

	• ▪ Skin infections and infestations (i.e. chicken pox) and fungal diseases (i.e. tinea versicolor, Malassezia furfur, tinea capitis, etc.) • ▪ Bites and stings (snakes, scorpions, bees, spiders, etc.) first aid and emergency management, not including antivenom serum iii. Management of simple anaemia (not requiring blood transfusion) iv. Routine screening and referral for diabetes mellitus, hypertension, and other chronic diseases v. Simple arthritis and other minor musculoskeletal diseases routine treatment vi. Sickle cell disease (SCD) routine management vii. Allergies	II. Gynaecological Intervention ▪ Hysterectomy for ruptured uterus, uncontrollable postpartum haemorrhage, procidentia etc.
7	HIV/AIDS and Sexual Transmitted Diseases Voluntary Counselling and Testing (VCT)	HIV/AIDS Opportunistic infections as defined in the HIV Treatment Protocol
8	Mental Health Management i. Anxiety neurosis counselling and referral ii. Psychosomatic illnesses iii. Insomnia iv. Drug abuse identification	Physiotherapy i. Post-traumatic rehabilitation ii. Palsy within 15 days of initial treatment, maximum of 5 sessions iii. Post-cerebrovascular accident therapy within 15 days, maximum of 5 sessions
9	Maternal, Neonatal and Child Health (MNCH) Services i. Antenatal care ▪ Routine antenatal clinic ▪ Routine drugs for the duration of pregnancy ▪ Routine urine and blood tests ▪ Referral services for complicated cases	Paediatrics i. Severe malnutrition ii. Severe infections and infestations: ▪ Severe malaria ▪ Diarrhoeal disease with moderate to severe dehydration ▪ Upper respiratory tract infections ▪ Severe pneumonia ▪ Enteric fever ▪ Septicaemia

	ii. Postnatal services ▪ Eligible live births up to 6 weeks from date of birth (cord care, eye care, simple neonatal infections) iii. Delivery services ▪ Spontaneous vaginal delivery by skilled attendant, including repair of birth injuries and episiotomy ▪ Essential drugs for Emergency Obstetric care (EmOC)	▪ Meningitis ▪ Severe measles iii. Severe urinary tract infections iv. Severe anaemia requiring blood transfusion v. Childhood non-communicable diseases vi. Neonatal infections (i.e. neonatal sepsis) vii. Neonatal conditions: ▪ Birth asphyxia ▪ Neonatal jaundice ▪ Child from diabetic mothers
10	First Aid and Emergency Services i. Airway assessment and use of airway adjuncts ii. Basic airway aspiration and clearance iii. Breathing assessment and use of simple equipment to aid and monitor breathing (i.e. ambu-bag) iv. Pulse oximetry v. Bleeding control using compression dressing vi. Haemodynamic stability assessment vii. Intravenous (IV) line viii. Fluid resuscitation ix. Basic cardiopulmonary resuscitation x. Unconscious patient assessment and basic management xi. Small laceration suturing (where resuscitation is not required) xii. Fracture and cervical spine immobilisation	Internal Medicine (Adult) i. Moderate to severe infections and infestations ▪ Severe malaria ▪ Meningitis, septicaemia ▪ Complicated respiratory tract infections ▪ Complicated typhoid fever ▪ Tuberculosis ▪Bites and stings (snakes, scorpions, bees, spiders etc.) emergency management, including antivenom serum ii. Non-communicable diseases ▪ Diabetes and hypertension ▪ Severe musculoskeletal conditions ▪ Sickle cell disease crisis ▪ Cardiovascular conditions, renal diseases (i.e. nephritis, nephrotic syndrome), liver diseases (i.e. hepatitis, amoebic liver abscess) iii. Severe anaemia
11	Basic Laboratory Investigation i. Malaria Parasite ii. Urinalysis iii. HB/PCV iv. Stool microscopy v. Urine microscopy	

	vi. Pregnancy Test vii. Blood Glucose Test viii. Sputum for AFB	

Adapted from guideline for BHCPF 2020

Okorie Gideon

Sorochi,

Master's Student

on ICHD,

2020/2021.

KIT Research Ethics Committee
Mauritskade 63, 1092 AD Amsterdam

Request for Ethical Clearance Waiver

I am writing to request a waiver regarding ethical clearance for my study "Attaining Universal Health Coverage through Innovative Policies: A review of Nigeria's National Health Act and Strategic Health Policies", which I am conducting in Nigeria remotely from The Netherlands. This study is in fulfillment of my Master of Public Health at KIT Royal Tropical Institute, the Netherlands.

The essence of this study is to identify health policies that are driving the attainment of Universal Health Coverage (UHC) in Nigeria. The identified policies and the health systems will be critically analyzed with a focus on their contribution to fulfilling the goal of UHC: financial protection, defining a basic package of services and effective health service coverage. This study will present Nigeria's score card on UHC and advance concrete recommendation from evidence based policies and strategies.

One of the key method in this study is semi-structured interview that will enable triangulation of secondary data findings extracted from existing literature. The participants, five in number will be drawn purposively from strategic civil society organizations and government agencies involved in UHC policies and programs. The agencies are: National Primary Health Care Development Agency, National Health Insurance Scheme, Nigeria Youth for UHC coalition, Federal Ministry of Health, Health Committee of National Assembly and FCT Primary Health Care Development Agency. The Key Informant interviews will be administered remotely from The Netherlands (either by telephone or meeting platforms, e.g. Zoom or Teams). The interviews will be recorded after consent of the interviewees has been obtained. Based on the reasons enumerated below, I am requesting the KIT Research Ethics Committee to grant a waiver for this part of the study.

1. The research questions explore only knowledge of participants derived from their professional experiences including roles played during planning, enacting and monitoring

of the implementation of policies and programs helping Nigeria to move toward achieving UHC.

2. There will not be any psychological or socioeconomic implication to participants. Participants are free to not respond to any of the question without explanation
3. The purposively selected participants will be sent an informed consent ahead of the interview through an email and their voluntary consent obtained before the administration of the data ?collection tool. They may reserve the right to decline or withdraw at any point without any consequence.
4. The data collection tool was developed by Okorie Gideon taking into consideration the objectives of the study and key dimensions of the WHO's UHC conceptual framework that will be used in the analysis as reviewed by my thesis and academic advisors.
5. Only the researcher will have access to data generated from this study as all information will be password, and treated confidentially. Also, publication of contributions by key informants will be anonymous.
6. The conduct of this research will adhere to all principles of the Helsinki Declaration

Find below, the data collection tool and the informed consent form.

I hope to have informed the committee adequately to enable their informed decision on this request.

Okorie Gideon Sorochi
MPH Student

Hermen Ormel
Academic Advisor

Data Collection Tool
Semi-structured topic guide for stakeholders working in the UHC

1. Policy, strategies and progress toward attaining UHC

    a. In your opinion, describe the level of operationalization of the National Health Act 2014
    b. Among other policies to drive the attainment of UHC as stipulated in the National Health Act 2014 were the establishment of the Basic Health Care Provision Fund (BHCPF) and Primary health Center in every political ward (Primary Health Care Under one Roof) (PHCUoR). In your opinion, how committed are the Federal and State Governments to the implementing these program?
    c. What are the successes and the challenges in the implementation of the BHCPF and PHCUoR?
    d. Another key program by Government is the establishment of the National Health Insurance Scheme and State Health Insurance Scheme. To what extent do you think these programs have contributed in helping Nigeria make progress toward UHC?
    e. What successes and challenges have you observed in the implementation?

2. For nations to attend UHC it is expected that they invest in strengthening the Health systems comprising of the health workforce, governance, service delivery, infrastructure, essential medicines and financing. Functional health systems will ensure effective service coverage and protection of citizens from financial hardship due to medical expenses.

    a. Can you evaluate the Government's effort toward meeting the 15% Abuja budget declaration and / or other financial commitments toward achieving UHC?
    b. In the concept of UHC, to what extent do you think the basic health benefit package as contained in the BHCPF is satisfying the health need of Nigerian's?
    c. In your opinion, how much support in the concept of UHC (primary health care under one roof) are the primary health centers receiving from government compared to secondary and tertiary health facilities?
    d. How will you describe the efficiency in the use of available resources in meeting the health need of Nigerians?
    e. To what extent do you think people use their money to pay for health services they receive at the point of service and what is the impact on their finance?

3. Countries like Rwanda, Gabon, Ghana, Brazil etc. are progressing better than Nigeria in attaining UHC. In your opinion what are they doing better than Nigeria?

4. What do you believe Nigeria can do to move faster toward achieving UHC?

Informed Consent Form

This is an 'informed consent form' for participation in semi-structured interviews for a study named "Attaining Universal Health Coverage through innovative policies: A review of Nigeria's National Health Act and Strategic Health Policies" which in being conducted by Okorie Gideon as his thesis for MPH at KIT Royal Tropical Institute, the Netherlands. This informed consent form has two parts: Part 1 provides information on the objectives of the study and the conditions for your participation while part 2 is the certification for voluntary participation that will need your signature.

Part 1: Information

Introduction: My name is Okorie Gideon, a Master of Public Health student at KIT Royal Tropical Institute, the Netherlands. As part of my degree requirement, I am conducting a study titled "Attaining Universal Health Coverage through innovative policies: A review of Nigeria's National Health Act and Strategic Health Policies." You have been chosen to participate in this study on the basis of your involvement in the processes of the UHC program in Nigeria. This informed consent form sent to you ahead of the interview through your email is to ensure that you have clear information about the purpose of the study. It provides you the opportunity to seek clarification on any issue regarding the study before or during the interview. Also note that your participation is voluntary and that you have the right to opt out at any point without giving reason.

Purpose: The purpose of this study is to review strategic health policies and strategies instituted by Nigeria to guide her progress toward attaining UHC, ascertain implementation status and make recommendation of best practices that will fast-track progress towards UHC. To achieve this I have designed a questionnaire / KI interview tool that seeks to explore your opinion on the appropriateness of the policies and strategies put in place and on progress / challenges in their implementation to drive the attainment of UHC in Nigeria. I also explored health systems influence and progress made so far in attaining UHC. Your responses will help validate my preliminary findings from literature. Your professional views and experiences will assist in ensuring that the findings of the study are validated and lead to effective recommendations. I am are grateful for your support.

Discomfort and Risk: Your contribution to the questions is to validate my preliminary findings. I therefore seek your professional perspective. Kindly note that your acceptance for participation is completely voluntary and that you have the right to withdraw at any moment.

Duration of participation: This interview will last for about one hour. You have the right to stop the interview, seek clarification or withdraw from the study at any point. Non-acceptance to participate or withdrawal will be of no consequence to you.

Confidentiality: Your responses from the interview will be strictly confidential and will be analyzed with responses from other participants. Use of your responses is strictly for the above

stated objective. Apart from the informed consent form with your name, other documents or materials will be number coded. No other person apart from the researcher will have access to your information.

Benefit and Compensation: Your contributions will assist in strengthening Nigeria's progress toward achieving UHC. There will be no direct compensation.

Dissemination of result: The result will be available to stakeholders and any interested person. It will also be in KIT Royal Tropical Institute e-library

Contact person: Reach out to Okorie Gideon via +2348171579335 or gsorochy@yahoo.com

Part II: Certificate of Consent

I have been invited to participate in the study "Attaining Universal Health Coverage through innovative policies: A review of Nigeria's National Health Act and Strategic Health Policies." I read and understood the information including the objective of the study. Questions and clarifications I sought have been satisfactorily handled. I therefore consent voluntarily to be a participant in this study.

Name of Participant.....Signature.....
Date.....

I confirm that the participant was allowed to ask questions about the study, and all the questions and clarification sought by the participant have been addressed to the best of my ability. I also confirm that the participant has voluntarily consented to participating in this research. The participant is in possession of a copy of this Informed Consent Form

Name of Researcher.....Signature.....Date.....