EXPLORING UNIVERSAL MATERNAL HEALTH COVERAGE IN NIGERIA: STRATEGIES TO ACCELERATE MATERNAL MORTALITY REDUCTION

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Exploring Universal Maternal Health Coverage in Nigeria: Strategies to Accelerate Maternal Mortality Reduction

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by

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ABSTRACT

Introduction: Globally, Nigeria has one of the highest maternal mortality ratio (MMR) at 993 deaths per 100 000 live births, despite its efforts to reduce MMR. This study identified ways to accelerate MMR reduction by exploring maternal health interventions implemented before and during the SDGs from 2010 to 2024.

Methodology: Search for peer-reviewed literature between 2010-2024 was conducted in databases such as PubMed, Google Scholar, VU library, and grey literature sources. Thematic analysis of findings was done using health system performance assessment (HSPA) framework for UHC.

Results: From 2010 to 2014, five maternal-specific health programs were identified of which one is ongoing. All five programs increased maternal services utilization; whereas two achieved service coverage, two ensured financial risk protection, two increased human resource, two achieved service quality and the ongoing program strengthens routine maternal services.

From 2015 to 2024, basic healthcare provision fund (BHCPF) and vulnerable group fund (VGF) were identified with no peer-reviewed literature on their performance regarding maternal health.

Discussion: The gains of the ended programs were not sustained, and no maternal-specific health program was initiated from 2015 to 2024. Some intervention gaps identified in earlier years were addressed but state governments' commitment, funding, program awareness and engagement of beneficiaries in program design remained inadequate.

Conclusion: Based on the study findings, implementing and sustaining maternal-specific programs are recommended to accelerate MMR reduction, and enacting population control measures would sustain gains.

Additionally, further research is needed to assess the nationwide impact of BHCPF and VGF on maternal health indicators.

Keywords: maternal health, maternal care, maternal and child health, universal health coverage, Nigeria

Word count: 11,585

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LIST OF ABBREVIATIONS

ANC	–	Ante Natal Care
BHCPF	–	Basic Health Care Provision Fund
BMPHS	–	Basic Minimum Package of Health Services
CCT	-	Conditional Cash Transfer
DLI	–	Disbursement Linked Indicators
DRG	–	Debt Relief Gains
FCT	–	Federal Capital Territory
FGoN	–	Federal Government of Nigeria
FMCHP	–	Free Maternal and Child Health Program
FMOH&SW	–	Federal Ministry of Health & Social Welfare
HSPA	–	Health System Performance Assessment
LGA	–	Local Government Area
MCH	–	Maternal and Child Health
MDG	–	Millennium Development Goals
MMR	–	Maternal Mortality Ratio
MNCH	–	Maternal Newborn and Child Health
MNCHW	–	Maternal Newborn and Child Health Week
MSS	–	Midwives Service Scheme
NDHS	–	Nigeria Demographic Health Survey
NGN	–	Nigerian Naira
NHA	–	National Health Act
NHIA	–	National Health Insurance Authority
NHIS	–	National Health Insurance Scheme
OOP	–	Out-of-Pocket (expenditure)
PHC	–	Primary Health Centres
SDG	–	Sustainable Development Goals
SOML-PforR	–	Saving One Million Lives - Performance for Result
SSA	–	Sub-Saharan Africa
SURE-P	–	Subsidy Reinvestment and Empowerment Programme
UI	–	Uncertainty Interval
UHC	–	Universal Health Coverage
USD	–	United States Dollar
VGF	–	Vulnerable Group Fund
WHO	–	World Health Organization

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CHAPTER ONE

1.0   Introduction

I worked as a program manager on a maternal, newborn and child health (MNCH) program at the grassroots in a state in Nigeria from 2019 to 2023. On the MNCH program, pregnant women were saved during childbirth because complications were discovered during their ante natal care (ANC) sessions and these complications were managed until their delivery at the health facility. The pregnant women in question were able to attend the ANC sessions because their transportation to the health facility, regular ANC attendance and birthing at the facility were incentivized. The MNCH program was funded by an indigenous grant-making organization in Nigeria.

The MNCH program was domiciled in one of the states in the South-South geo-political region of Nigeria which had a comparatively high maternal mortality ratio (MMR). Based on the lessons from the MNCH program, in its first two years of implementation, the not-for-profit non-governmental organization (NGO) I worked for submitted a proposal for funding to a development partner to implement a project which would entail advocacy to the state government to pay statutorily required 25% counterpart fund contribution for the implementation of basic health care provision fund (BHCPF) in the state. The BHCPF is the national funding program to drive universal health coverage (UHC) in Nigeria and it required counterpart contribution by states to access the Fund and implement the program. We believed if the BHCPF was implemented in the state, pregnant women across all communities would easily access basic minimum package of health services (BMPHS), which is a provision of the BHCPF. We did not get the requested funding for the advocacy project but through the work done in preparation for the proposal submitted for the advocacy project, my project team knew the potential which the BHCPF held for the state and the benefits accruing to states already signed on to the BHCPF.

As of 2022, the MNCH program which was a singular effort by an indigenous NGO had been implemented in 12 Local Government Areas (LGAs) of the state's 31 LGAs. The profound state-government-recognized achievements of the MNCH program in contributing to reduction in maternal and perinatal death burden, could be regarded as a drop in the ocean in the light of the communities yet to be reached in the already visited and yet-to-be visited LGAs. My work experience on the MNCH program spurred the need to explore Nigeria's efforts on UHC for the maternal health because of the country's persistently high MMR. The MMR in sub-Saharan Africa (SSA) is estimated at 454 maternal deaths per 100 000 live births ((uncertainty interval (UI) 387 to 572)) and the global MMR is 197 maternal deaths per 100 000 live births (UI 174 to 234). These estimates pale in comparison to Nigeria's MMR of 993

maternal deaths per 100 000 live births (UI 718 to 1540). Hence, there is a need to explore the efforts at ensuring UHC for the maternal health so recommendations could be made to address identified gaps.

1.1   Background

1.2.1   Geography and Population

Nigeria is made up of 36 states, the Federal Capital Territory (FCT) and 774 Local Government Areas (LGAs) or Councils, with the LGAs further divided into 9,565 political wards. The government system in Nigeria is tiered into federal, state and local governments with each tier having a relative policy and financing decision-making autonomy, including designing policies, legislation, and financing the health sector (1). For political and administrative purposes, the states having the same culture, ethnic groups and common history are grouped into geopolitical zones. The northern and southern parts of the country have three zones apiece which are North-East, North-West, North-Central, and South-East, South-West and South-South (2). Nigeria's population of 234 million as of 2023 which had an annual growth rate of 2.5% exerts significant pressure on its health systems and socio-economic infrastructure. Notably, health indicators show disparities along the southern and northern divide of the country with the latter having worse indicators(3).

1.2.2   Health System

Healthcare services in Nigeria are provided by both the public and private sectors. The public sector providers are the federal, state and local governments who provide healthcare at the tertiary, secondary and primary levels, correspondingly. Whereas the National Council on Health (NCH) is the highest health sector policymaking body in the country, the federal government through the Federal Ministry of Health & Social Welfare (FMOH&SW) leads the design and implementation of public healthcare programs, and the lower levels of government manage the implementation of the programs(2). Health financing sources in Nigeria are comprised of government expenditure, out-of-pocket (OOP) expenditure, private/voluntary pre-payment and external health expenditure. Government expenditure accounts for 15% of current health expenditure (CHE) while OOP expenditure alone accounts for 76% of CHE. (4) (5). Worthy of note also is that in comparison to men, women, especially those at the grassroots, experience limited access to healthcare, higher levels of poverty and lower levels of education(3) .

1.2.3   Universal Health Coverage and Maternal Health

Universal Health Coverage (UHC) has a focus to ensure "*all people have access to the health care they need, when and where they need it, without facing financial hardships*". Service coverage index and financial risk protection are the indicators used to measure progress in

UHC attainment. The implementation of health interventions from a combination of inputs by multiple public and private sectors produces service coverage while access to the needed quality health services without financial hardship defines financial risk protection (6)(7). Efforts towards UHC in Nigeria started in 1999 with the establishment of the National Health Insurance Scheme (NHIS) (8), and the promulgation of the National Health Act, 2014, provided the legal framework for UHC (9).

Studies have utilized maternal health to further describe UHC. Maternal health is defined as the health of women during pregnancy, childbirth, and the postnatal period (10) and studies have notably established that services for the maternal health could be used to further define UHC; submitting that the strength of a health system reflects the state of its maternal health and that reducing maternal mortality is essential for UHC (6)(10)(11). The key factors contributing to maternal health issues in Nigeria are bleeding related to pregnancy, especially during delivery (postpartum haemorrhage); hypertension in pregnancy; and sepsis (3).

A study in Nigeria also affirms that an effective strategy to deploy in expanding financial risk protection to all parts of the population is by targeting the most vulnerable populations (12), as the Nigeria national health insurance authority (NHIA) Act included pregnant women in its definition of vulnerable group. More so, maternal and child health illnesses account for almost two-thirds of the burden of disease in Nigeria(3) and this has made Nigeria always prioritized the health of women, together with children, and specifically mentions this population for strategic attention in its recently developed Health Sector Strategic Blueprint, 2022 (3).

Analysis of Nigeria's health indicators has shown that despite the country's commitments to UHC, it has experienced slow progress in its general health status as the rates of maternal and newborn mortality are still high, in comparison to national and global averages (13).

CHAPTER TWO

2.0 Problem Statement & Justification

2.1 Problem Statement

In 2023, an estimated 700 maternal deaths occurred globally, every day, meaning a maternal death occurred in every two minutes approximately (14). A maternal death is defined by the World Health Organization as "t*he death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and the site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes*" (15).

Maternal deaths per 100,000 live births is known as maternal mortality ratio (MMR) and in 2023, there were 197 (uncertainty interval (UI) 174 to 234) maternal deaths per 100 000 live births globally. In the same year, sub-Saharan Africa (SSA) was the only region in the world with a high MMR of 454 (UI 387 to 572) maternal deaths per 100 000 live births which accounted for 70% of global maternal deaths. A pregnant woman in the region had a 400 times higher risk of dying due to pregnancy-related causes (1 in 55) than in a high-income country such as Australia and New Zealand (1 in 21 248) (14).

According to the WHO, Nigeria and three other countries; India, Democratic Republic of Congo and Pakistan, accounted for almost half (47%) of all maternal deaths globally in 2023. In addition, there were 75 000 maternal deaths in Nigeria which was the highest globally, and these deaths accounted for more than a quarter (28.7%) of all estimated global maternal deaths in 2023. Nigeria's MMR remained high at 993 (UI 718 to 1540)(14), although the Nigeria Demographic Health Survey (NDHS) reported that MMR decreased from 576 to 512 deaths per 100,000 live births between 2013 and 2018 (16)(17).

The decline reported by the NDHS might be attributable to Nigeria's National Health Insurance Scheme (NHIS) which commenced in 2005, albeit established by the 1999 NHIS Act. Studies showed that the NHIS increased access to and usage of health care facilities and contributed to reduction in out-of-pocket and catastrophic health expenditure. The NHIS also achieved increased access to and use of maternal and child health services (18)(19). However, from 2010 to 2023, the change in MMR in the country was 9.2% which showed slow progress to MMR reduction in comparison to change in regional and global MMR which were 39.2% and 40%, respectively (14).

2.2 Justification

To address maternal deaths and other development issues, the member states of the United Nations, including Nigeria, committed to 2030 Agenda for Sustainable Development and having, among other targets, a target to '*Reduce the global maternal mortality ratio to less than 70 per 100 000 live births. The UHC was set as the benchmark to measure progress towards maternal mortality reduction* (20). In the first half of the SDG period, from 2016 to 2023; MMR increased in Latin America and the Caribbean; stagnated in Northern Africa, Western Asia, Eastern and South-Eastern Asia, Oceania (excluding Australia and New Zealand), Europe and North America; and reduced in Australia, New Zealand, Central and Southern Asia and Sub-Saharan Africa. Markedly, MMR reduced in Nigeria from 1113 in 2015 to 1047 in 2020 (6), and then to 993 in 2023 (14) (*figure 1*).

Although, there was reduction in MMR, the WHO posited that the pace was slow as 1 in 13 women still die from pregnancy and childbirth causes, and this would not allow for achieving the 2030 target of less than 70 maternal deaths per 100 000 live births. Specifically, that the slow pace accounts for the dismal state of maternal health in Nigeria (21) (18). Nigeria alone accounted for about 29% of global maternal deaths in 2023(14). A large percentage of maternal deaths in Nigeria were revealed from studies to be due to preventable obstetric causes such as hypertension (27%), sepsis (20.6%), haemorrhage (17%), etc. (22). In addition, WHO has set a national target for countries such as Nigeria which had an MMR greater than 420 as its 2010 baseline to ensure the rate of MMR decline would be steeper. According to the WHO, this target would ensure no country has an MMR greater than 140 by 2030 (14).

In line with its commitment to UHC, Nigeria undertook efforts to improve the health of its population, including maternal health, through the promulgation of the Nigeria Health Act (NHA) 2014 which served as the policy framework for achieving UHC (9). Enshrined in 2014 NHA was the BHCPF which was designed to ensure equity and financial risk protection for the vulnerable populations and guarantee access to basic minimum package of health services (BMPHS) (23). To achieve improved health outcomes for its population through UHC, the NHIA Act, 2022 was established (24) as a follow on to the NHA 2014. The NHIA Act 2022 continued the implementation of the BHCPF and additionally established the Vulnerable Group Fund(24).

Beyond the efforts targeted at the health of its general population, Nigeria also implements maternal health interventions. However, conflicting MMR estimates in the past, which were either too low or too high (6)(16) (17) (21), have not allowed for the appreciable reflection of the impact of the policies and interventions targeted at maternal mortality reduction in the country. Some studies have assessed the various interventions before and close to the start of the SDG era (19)(25)(26), but there is a dearth of literature articulating the actual coverage for maternal health in terms of financial risk protection and service coverage

provided by the national government since the SDGs. Hence, the study aims to identify the policies and interventions implemented nationwide for maternal health. The financial risk protection and service coverage achieved through these policies and interventions will be identified while also assessing their strengths and weaknesses to establish their gaps. The study proposes to achieve these by conducting a systematic search of literature.

While this study recognizes that measurement of UHC involves the combination of both the supply side and demand side indicators, it does not seek to measure universal health coverage for maternal health in Nigeria. Rather the study seeks to identify the various measures by the Nigerian national government for maternal care and hence will focus on the supply side of care.
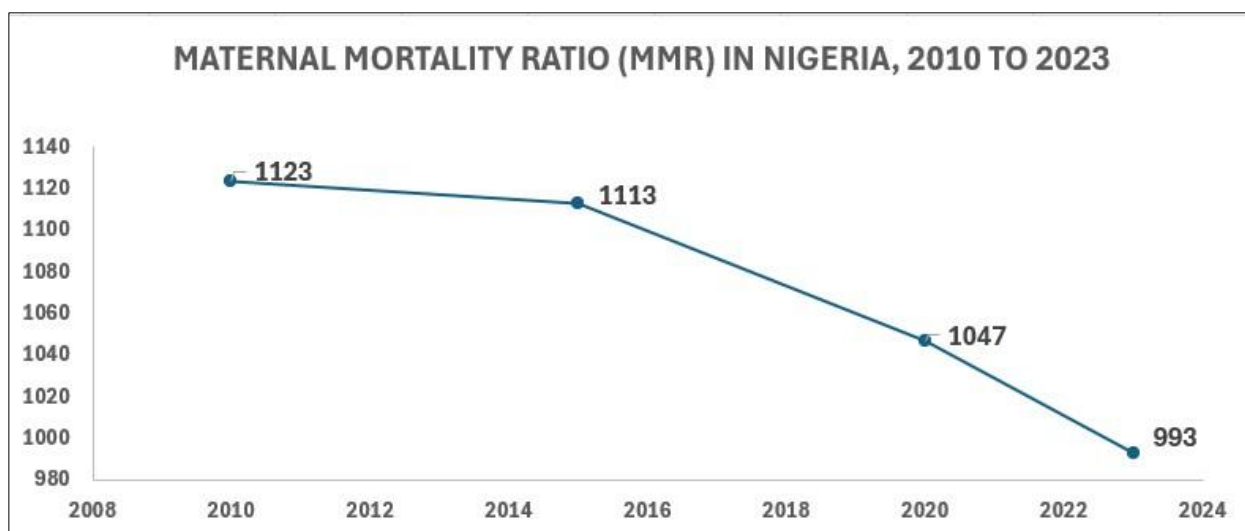
Figure 1: Trend in Maternal Mortality Ratio in Nigeria (MMR), 2010 to 2023. (2010 to 2020 (6), 2023 (14))

2.3   Objectives

2.3.1 The overall objective – To explore Universal Maternal Health Coverage in Nigeria and identify the strategies to accelerate the reduction in maternal mortality ratio.

2.3.2   The Specific Objectives;

1. To examine the measures targeted at maternal health coverage and financial risk protection in Nigeria in the last 15 years.
2. To identify and describe the gaps to maternal health coverage and maternal financial risk protection in Nigeria in the last 15 years.
3. To provide recommendations to the Federal Ministry of Health & Social Welfare (FMOH&SW) and other stakeholders on accelerating the reduction in maternal mortality ratio (MMR) based on identified gaps.

CHAPTER THREE

3.0   Methodology

This study employed a literature review methodology to identify, and provide answers to, the constraints to accelerating maternal mortality reduction in Nigeria. A literature review was selected because it is appropriate for synthesizing existing evidence on maternal health interventions in the country, identifying trends before and during the SDG years and highlighting gaps. The literature review process will also aid the articulation of recommendations based on documented outcomes. The objectives of the study guided literature searches while an analytical framework was used to organize the findings into themes. To ascertain the constraints to maternal mortality reduction, analysis of literature findings was conducted to establish efforts or non-efforts to UHC attainment for women during pregnancy, childbirth, and postpartum.

3.1   Search Strategy

Searches were conducted for peer-reviewed articles in PubMed, Vrije Universiteit (VU) online library, Science Direct, WHO Library Database and Google Scholar search engine. Further publications were identified from references cited in relevant articles and reports. Also, grey literature sources such as policy documents, and other relevant sources from the government and private institutions' websites were searched. KIT Institute five-year database of past theses was also searched for relevant articles. The key words used for the search were "maternal health", "maternal care", "maternal and child health", "universal health coverage", "Nigeria", "sub-Saharan Africa".

3.1.1   Exclusion and Inclusion Criteria

Search results were filtered with year duration of 2010 to 2024 because the duration accommodates the dates for the publication of the last three Nigeria Demographic Health Surveys (NDHS); 2013, 2018 and 2023/24, which are important sources of information for nationally documented MMR. Moreso, the year duration accommodates the 5 years prior to the SDGs and two 5 consecutive years in the SDG era. The searches were conducted majorly for articles on Nigeria and sub-Saharan Africa with exclusion criterion on relevance of topic and/or abstract with regards to maternal health in Nigeria. Only papers published in English were reviewed and only measures implemented in the SDG years or which started prior to the SDG and continued into the SDG years were captured. Studies highlighting state-owned policies, interventions or programs were excluded. The search strategy is presented in a table I in the annex.

3.1.2   Data Extraction and Analysis

Based on predefined inclusion criteria, relevant studies published from 2010 to 2024 were selected. Data extraction was done using a structured Excel template with focus on publication details, maternal health indicators, and health system domains.

The extracted data was analysed using the Health System Performance Assessment (HSPA) framework for UHC (figure 2)(27). Thematic analysis of the extracted data was based on the health system functions and sub-functions of the HSPA framework for UHC.

3.2   Analytical Framework

3.2.1   Health System Performance Assessment (HSPA) Framework for UHC

The Health System Performance Assessment (HSPA) framework for UHC (27)was utilized for the analysis. The HSPA Framework for UHC was selected as the analytical framework because it fits the purpose of this paper which is health system perspective to health care (supply side of health care) as the framework aptly covers this perspective. While some frameworks focus on both sides of health care (supply and demand sides) e.g. the Levesque model (28); some other frameworks focus on the patient's perspective of health care (demand side) e.g. the Tanahashi model (29), hence, could not be used. Moreover, the HSPA Framework for UHC makes the analysis measurable by essentially linking health system functions to health system performance/goals (27). Importantly, also, the HSPA Framework for UHC is specifically designed to uncover issues to universal health coverage/health system objectives/goals such as service coverage and financial risk protection.

3.2.2   Description of the HSPA Framework for UHC

The HSPA framework clearly defines the boundaries of a health system, thus making it appropriate for examining financial risk protection and service coverage for maternal health. This measurability makes it feasible to identify gaps by tracing performance issues to relevant components and factors on the framework. This is achievable because the framework takes into account and builds on existing frameworks and assessment tools such as Health Systems in Transition (HiT), Health System Performance Assessment (WHO/EURO), Health System Assessment Approach: A How-To Manual (USAID), etc. (27). The HSPA framework is not focused on identifying and assessing the strengths and weaknesses of the health system but assessing the performance of the health system functions; resource generation, financing, service delivery and governance, against its outlined objectives/goals. More so, the supporting literature for the framework included case studies to guide its methodological use.

The HSPA framework assesses the attainment of UHC target coverages; financial-risk protection and service coverage (quality, access, safety) and ultimately health improvement. While financial risk protection and health improvement are captured among the final goals of the HSPA framework; access, quality, and safety (including equity in service delivery and efficiency in service delivery) are captured as the intermediate objectives. The structural arrangement of the framework has three functions of the HS (stewardship, resource generation and financing) leading to the 4th function of the HS (service delivery).
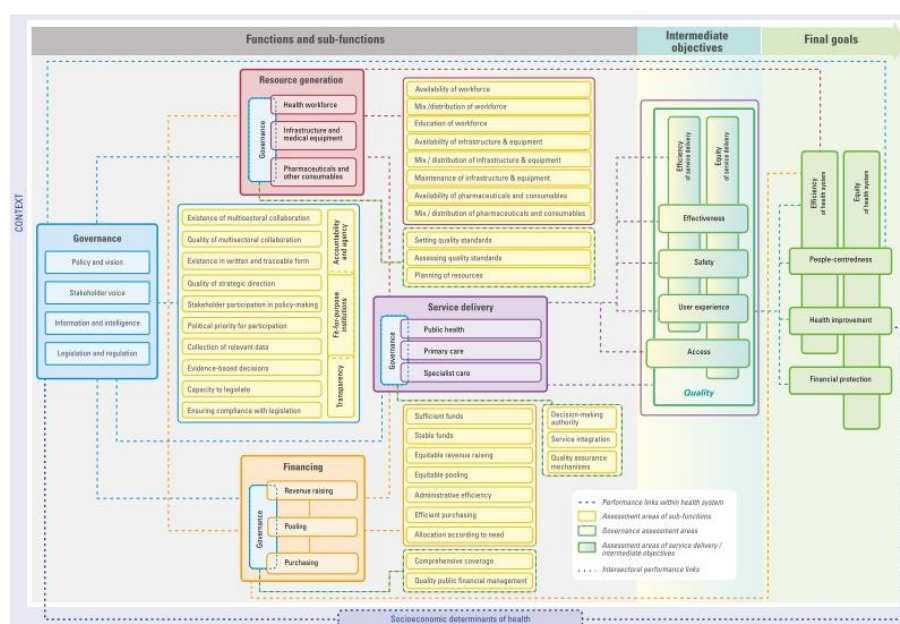
Figure 2: The Health System Performance Assessment (HSPA) Framework (27)

Each component function of the framework is comprised of sub-functions and has its performance assessment criteria. Although this study is targeted at examining the financial risk protection and service coverage for maternal health which are distinct items on the framework, the study will use all the components of the framework because of their interconnectedness and linkage to the intermediate and final goals of the health system (please see figure 3).

3.2.2.1   Service Delivery

For this paper, regarding target population, both individual and collective health services targeted at the maternal population were analyzed. Because the Basic Minimum Package of Health Services (BMPHS) is meant to be a primary care which could be offered at the primary facility level of the secondary facility level, the health service type consumed by the maternal

population would be both preventive and curative care whose mode of provision is inpatient and outpatient care.
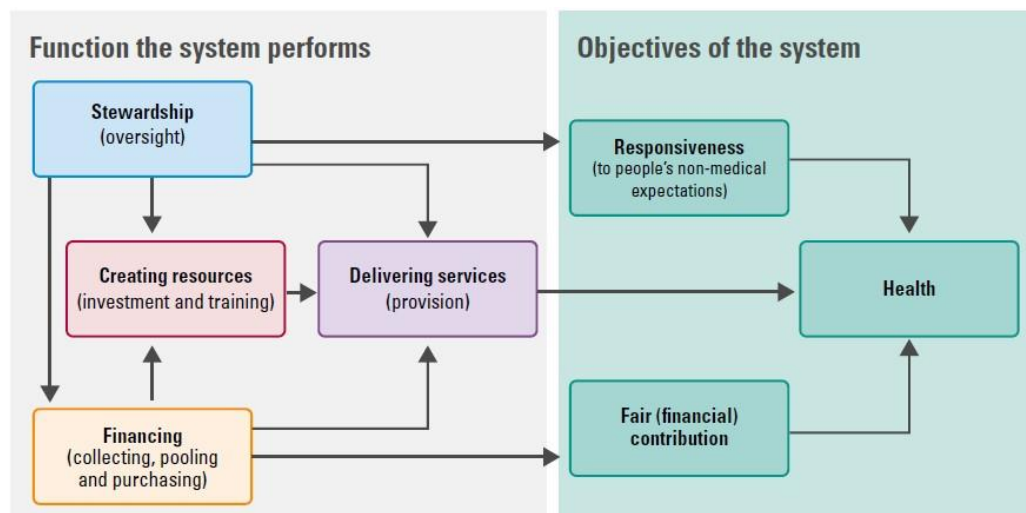
Figure 3: Relationship between the health system functions and its objectives (27)

Also, although public health, primary care and specialist care are the three sub-functions of the healthcare service delivery, only primary care sub-function was utilized because this study focuses on UHC which is at the primary care level.

3.2.2.2 Governance

As a core HS function, it impacts directly on the other functions. It has 4 sub-functions in the framework namely; policy & vision, information and intelligence, legislation & regulation, and stakeholder voice. The study utilized the 4 subfunctions.

3.2.2.3 Resource Generation

The sub-functions of the resource generation are health workforce, infrastructure & medical equipment, and pharmaceuticals & other consumables. The study utilized all the 3 subfunctions.

3.2.2.4 Financing

Resource mobilization, pooling and purchasing are the sub-functions of the financing function which were all utilized for the study.

CHAPTER FOUR

4.0   STUDY RESULTS

4.1   Measures for Maternal Health Coverage and Financial Risk Protection

4.1.1   Governance/Stewardship Measure

Nigeria's vision and strategic policy frameworks for its maternal population were expressed in various policy and legal documents. These documents specifically mentioned the maternal population as a focus. Timeline overview of the governance measures is provided in figure 4.

I.   **National Health Act (NHA), 2014** (9)- section 11 of the NHA established the BHCPF. One of the objectives of the BHCPF was to reduce out-of-pocket expenditure by 30% and increase financial risk protection. 50% of the BHCPF was earmarked for the provision of Basic Minimum Package of Health Services (BMPHS) (23).The BMPHS has components for maternal health.

II.   **Guidelines for the Administration, Disbursement and Monitoring of the BHCPF, 2020** (23): the document defined the components of the BMPHS. Pregnant women were prioritized for cost-effective interventions and services. The provisions for pregnant women in the BMPHS included health education and disease control; family planning education, essential nutrients; Primary level care; antenatal care, postnatal services, and secondary level care Basic and Comprehensive Emergency Obstetric Care and Gynaecological Intervention.

III.   **The National Health Policy (NHP), 2016** (30): served as a framework for the development of Nigeria's health sector recognized the high burden of maternal mortality in the country. The policy prioritized reducing the risks associated with pregnancy and childbirth through the promotion of comprehensive obstetrics care at all levels, as one of its policy objectives.

IV.   **National Strategic Health Development Plan II (NSHDP II), 2018-2022** (2): the Plan has four Strategic Pillars with Pillar 2 focused on increased utilization of essential package of health services (EPHS). The EPHS has its priority number four dedicated to reproductive, maternal, newborn, child, adolescent health and nutrition (RMNCAH+N).

V. **National Health Insurance Authority (NHIA) Act, 2022** (24) – Section 59 of the NHIA Act included pregnant women in its definition of the vulnerable group in the country. Section 13 subsection 7 of the Act mandates each federating state in Nigeria to ensure pregnant women and other vulnerable persons are provided for in their individual State health insurance and contributory scheme. Section 3q further stated that the basic health care needs of pregnant women should be provided for in conjunction with the NHIA. The Act stated explicitly in Section 13 that pregnant women should be exempted from payment of premiums for coverage in the State health insurance schemes.

In addition, section 25 of the Act established a vulnerable group fund (VGF) which according to section 26 subsection 2 was established to subsidize the cost of providing health care services for pregnant women and others through the health insurance coverage. The VGF was to be funded by the BHCPF and other funding sources.

VI. Other documents: the thrust of the government regarding governance of its health system in providing health coverage for women during pregnancy, childbirth, and the postnatal period are also expressed in the policy documents and guidelines which summarized in table 2 in the annex.

GOVERNANCE MEASURES

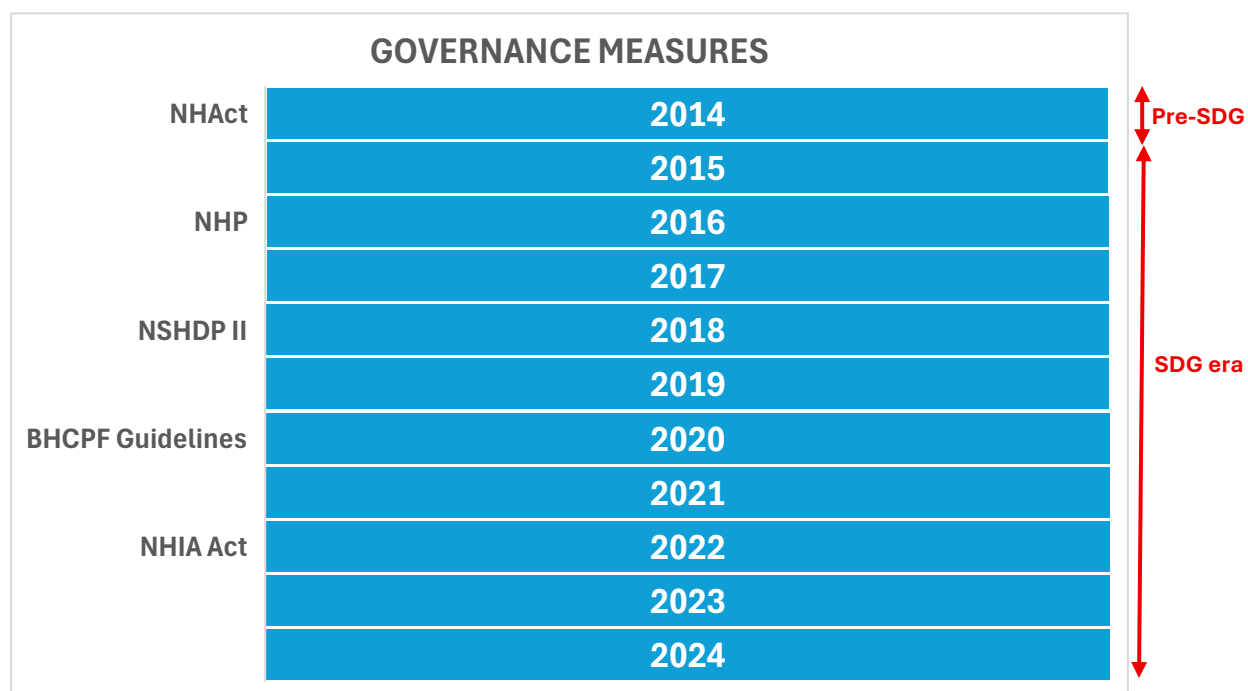|		
NHAct	2014	Pre-SDG
	2015	
NHP	2016	
	2017	
NSHDP II	2018	
	2019	SDG era
BHCPF Guidelines	2020	
	2021	
NHIA Act	2022	
	2023	
	2024	

Figure 4: Timeline overview of governance measures for maternal health (compiled by author))

4.1.2 Service Delivery Measure

This measure describes the interventions and programs implemented by the government at both the primary and secondary care levels. The timeline overview of service delivery measures are presented in *figure 9*.

I. **National Health Insurance Scheme- Millenium Development Goas- Free Maternal and Child Health Program (NHIS-MDG FMCHP)**

Utilizing the funds from its Millenium Development Goals (MDG) Debt Relief Gains (DRG) program, Nigeria implemented a free maternal and child health program (FMCHP) from 2009 to 2015. The program was called NHIS-MDG FMCHP and was jointly implemented by the NHIS, office of the MDGs and 12 states of Nigeria. The program started in 6 states and was later expanded to 12 states in the 2nd phase. The first 6 states were Bayelsa, Gombe, Imo, Niger, Oyo & Sokoto while the second set of 6 states were Bauchi, Cross River, Jigawa, Katsina, Ondo, and Yobe (31). Funds from the program were expected to be matched by counterpart contribution by the participating states. Through the pooled funds, pregnant women and children less than 5 years were provided with free health care services at accredited primary and secondary health facilities. An estimated 1,500,000 pregnant women and children were covered on the project with the women graduating from the program at 6-weeks post-partum and the children upon reaching their 5th birthday. The FMCHP ended with the MDGs in 2015 (32).

The free MCH program led to an increase in the functionalities of the PHCs in the participating states which resulted in an increase in utilization of maternal services (31). The project was also reported in a study to be pro-poor and equitable. However, the increase in utilization of services was reported not to have had a significant impact, necessarily, on the quality of service. The finding on increased service utilization was corroborated by another study in one of the participating states, which established that uptake of ANC services improved by 21% while facility deliveries improved by 16% (32)

II. **Subsidy Reinvestment and Empowerment Program Maternal and Child Heath Conditional Cash Transfer (SURE-P MCH CCT)**

In 2012, sequel to the partial removal of fuel subsidies, Nigeria established the Subsidy Reinvestment and Empowerment Programme (SURE-P) to efficiently manage financial resources from the subsidies' removal. Part of the funds from SURE-P was utilized to implement a Maternal and Child Health program, SURE-P MCH, across the 36 states of the country and the FCT. SURE-P was implemented from October 2012 to April 2015 and

achieved health system strengthening and an increased demand for services through conditional cash transfer (CCT) to pregnant women (33)(34). The program trained and deployed midwives and community health extension workers (CHEW) to participating health facilities across the 36 states and the FCT, while also strengthening the skills of existing health workers (35). Primary health centres (PHCs) were renovated, MNCH medicines, consumables & equipment were supplied, and boreholes were installed to provide portable water at the health facilities. The program was implemented in clusters in each state with each cluster comprising of 4 PHCs being linked to a referral secondary health facility (36). A total of 1,000 health facilities were renovated and designated as SURE-P MCH facilities. The first set of 500 health facilities were designated by October 2012 while the second set of 500 were designated by November 2013 (37).

The program was comprised of two fundamentally, the health system strengthening component alone called SURE-P MCH and the component which comprised both the health system strengthening and the CCT called SURE-P MCH CCT. SURE-P MCH started in October 2012 while CCT payment started in March 2014 (33)(34). Both components of the program were not implemented in all parts of a state, while some parts benefitted from the SURE-P MCH CCT, others in a state benefitted only from SURE-P MCH. More so, the program was not evenly implemented across all states of the federation. The implementation of the program was fashioned to respond to the rates of maternal and child mortality across the country, with the North-East and South-West regions having the highest and lowest rates, respectively (37). The CCT component of the program was designed for each pregnant woman to receive up to NGN5000 (approximately USD30) based on completing a set of co-responsibilities which were; registration at the facility for ANC, attendance of subsequent ANC sessions, delivery at a public health facility and receiving post-natal care. NGN1,000 was transferred to the pregnant woman after registration at the facility for ANC, while the remaining amount was paid based on the completion of the co-responsibilities (*Figure 6*) (37).

The design of the project which included incentivizing the use of public health facilities and services through CCT achieved its purpose as there was 93% enrollment for ANC by pregnant women within the first 2 trimesters. It was reported that as at December 2014, more than 40,000 pregnant women were enrolled on the project and NGN108,330,635.00 had been disbursed to the eight pilot states plus the FCT-Abuja (33). A study reports that the program brought about improvements in care quality (37).

Co-responsibilities	Requirements	Value	Receiving cash support
Resgistration and 1st ANC visit	Each programme beneficiary is required to register for the CCT and receive her 1st ANC consultation	NGN1,000	1st installment
2nd, 3rd & 4th ANC visits	Each programme beneficiary is requested to make at least 3 additional ANC visits during the course of her pregnancy for focused ANC	NGN1,000	Pro-rated/2nd installment
Skilled birth delivery	Each programme beneficiary is encouraged to have a facility-based delivery under the supervison of a skilled birth attendant	NGN2,000	2nd installment
Postnatal care/immunization/family planning advcice	Each programme beneficiary is required to make a postnatal visit to the PHC centre within the first week after delivery. The postnatal care will include a checkup for the baby and the mother, the baby's first immunizationa, and family planning advice for the mother	NGN1,000	2nd installment

Figure 5: SURE-P MCH CCT Co-responsibilities and benefits (33)

III. **MNCH Week**

In 2010, the 53rd session of the National Council on Health (NCH), approved the biannual implementation of the maternal newborn and child health weeks (MNCHW) in all states of Nigeria after it was successfully piloted in two states in 2009(38)(39). The program was aimed at contributing to health system strengthening by improving health service delivery and utilization, on one part, and on the other part, to improve outcomes for women and children by increasing coverage of MNCH interventions (39). The MNCHW were approved by the NCH to hold annually in May and November (38), and mothers and children aged 0 to 59 months are the beneficiaries. Just as in other countries, the MNCHW started out as child health days (CHDs) which were introduced by UNICEF and WHO in 1999 (38).

The National Primary Health Care Development Agency (NPHCDA) is the lead institution responsible for implementing MNCHW, which were still implemented in 2024. It provides implementation guidance, sets the national dates for the program, develops key documents, including the MNCHW Guidelines and Training Manual, and facilitates national-level microplanning (38).

At the state level, the MNCHW are implemented by State Primary Health Care Development Agencies (SPHCDAs), with resources from State Ministries of Health and development partners such as UNICEF, WHO, Save the Children (SC), Vitamin Angels (VA), Helen Keller International (HKI), Micronutrient Initiative (MI), World Bank and United Nations Population Fund (UNFPA). States were expected to align with the national dates but could also implement them according to close alternatives. The training for health workers is conducted at state and LGA levels. An overview of partnership responsibility for MNCHW implementation in the states is provided in the table following (38).

MNCHW IMPLEMENTATION PARTNERS	
Partner	Role within MNCHW
National Primary Health Care Development Agency	Implementation and training guidelines, monitoring, overall coordination, social mobilization, resource mobilization
Federal Ministry of Health	Technical support, training, monitoring
State level authorities	Procurement of drugs, supplies, training, social mobilization, monitoring
Donors	Resource mobilization
UNICEF	Resource mobilization, technical support, social mobilization, procurement of drugs, supplies and equipment
Implementing partners	Procurement of drugs, supplies, training, monitoring. Contribute to development/review of guidelines and technical documents

The NPHCDA recommended 19 interventions for MNCHW which are targeted at strengthening the routine services at Primary Health Centres. SPHCDAs domesticate the interventions according to their local needs (38)(40). Some of the maternal interventions of the MNCHW are ANC, tetanus toxoid, and HIV Testing Services (HTS) for pregnant women; counselling on Family Planning and Prevention of Mother-to-Child Transmission of HIV for nursing women; and sensitization on family planning, sanitation and feeding for women (40).

The estimated annual expenditure on the project from 2010 to 2015 was USD 86.5Million. An impact evaluation of the programme conducted in 2016 informed that the programme did not contribute to coverage neither did it improve maternal health outcome (38). The program not achieving increase in maternal interventions coverage was corroborated by a 2023 study, which though suggested that only the utilization of family planning increased (40).

IV. Saving One Million Lives – Performance for Result (SOML-PforR)

The Federal Government of Nigeria (FGoN) launched the saving one million lives (SOML) initiative in 13 states in 2012 to improve MNCH services(41). At the start-off, the programme prioritized providing technical assistance to the states for data generation and for data-informed policy and programming.

In 2015, sequel to obtaining a credit facility of USD500M from the World Bank, the FGoN redesigned SOML by incorporating World Bank's performance-for-results (PforR) instrument. The new programme called SOML-PforR was implemented in all the states and the FCT and was designed to spur health sector changes through transparency and result-oriented governance (42). The programme implementation arrangement had a steering committee (SC), a Technical Consultative Group (TCG) and a Program Management Unit (PMU) (43)(44) and its distinct health pillars were immunization, malaria control, nutrition, prevention of mother to child transmission of HIV, delivery of essential medicines to address common childhood ill-nesses, and strengthening of MCH delivery platforms (45).

Disbursement-Linked Indicators (DLIs) were agreed upon by the Federal Ministry of Health & Social Welfare (FMOH&SW), the state governments and the World Bank before the start of the programme. While the managers of the programme in the states were allowed to domesticate the programme as they deemed fit to respond promptly to the agreed indicators, the disbursement of funds was directly linked to the DLIs (43). The DLIs served for measuring the performance of the states vis-a-vis their individual baselines on quality and quantity of care at the health facility level. The programme rewarded states for improvement in performance and the DLIs used were; i) Increase of utilization of high impact Reproductive Child Health and Nutrition Intervention; ii) Increase of quality of high impact Reproductive Child Health and Nutrition Intervention; iii) Improvement of Monitoring and Evaluation systems (M&E) and data utilization iv) Increase of utilization and quality of maternal and child health through private sector involvement v) Increase of transparency in management and budgeting of Primary Health Care (PHC) (42)(44).
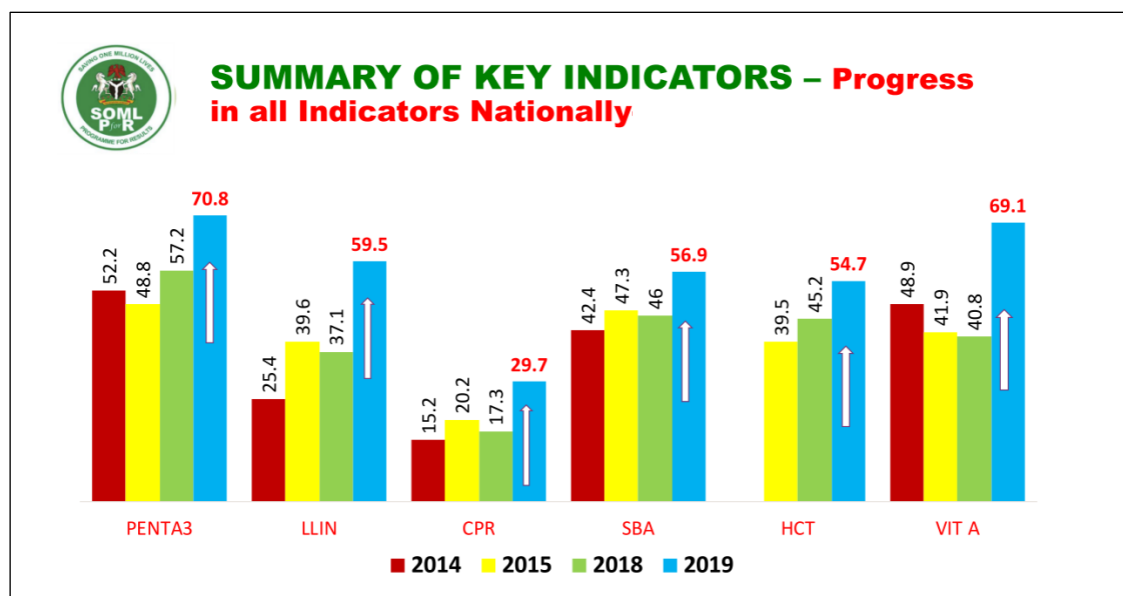
Figure 6: Summary of key indicators on the SOML-PforR program, 2014 to 2019 *(43)*

PPENTA3: third dose of pentavalent vaccine, LLIN: long lasting insecticide net, CPR: contraceptive prevalence rate, SBA: skilled birth attendance, HCT: HIV Counselling & Testing, VIT A: vitamin A

The first disbursement to the 36 states and the FCT was in 2016 with each state receiving USD1.5 million as seed funds for basic healthcare services and infrastructure. The 2016/17 multiple indicator cluster survey (MICS) established that only 12 states recorded improvement, and they were duly provided with additional funds as incentives. Aside this, each of the 36 states and the FCT were given USD 1.0 million loans to sustain program gains. A total sum of USD378,999,955 was disbursed, about 76% of the credit facility from World Bank, while the balance of USD 121,000,045 was partially terminated and rechannelled by the Nigerian Government (43). The program achieved significant improvements in MNCH indicators (42)(43)(45)(46) as summarized in *figure 6*. Nationally, including in the 2 regions in the country experiencing insecurity at the time, the North-East and the North-West, there was also improvement in the quality of care (*figure 7*). The 2021 MICS and 2019 Lot Quality Assurance Sampling (LQAS) by the NPHCDA established that there were improvements in the six key indicators used to assess the performance of SOML PforR (43). Despite these achievements, the programme came to a sudden end in mid-2020 because the Nigerian government did not sustain it beyond the donor-funded duration (45).

Trends in Quality of Care Index Scores
National and Zonal ——— 2016 & 2019

	Clinical Competence (out of 30)		Drugs and Equipment (out of 20)		Readiness to Provide SOML Services (out of 15)		Supervision (out of 20)		Financial Mgt/HMIS (out of 20)		Total Scores (out of 100)	
	2016	2019	2016	2019	2016	2019	2016	2019	2016	2019	2016	2019
National Average	8.5	14.0	5.9	10.0	6.1	8.7	8.6	13.2	4.7	5.8	33.8	51.7
Zonal Scores												
North Central	8.3	12.1	5.9	8.0	5.7	7.6	6.9	13.6	4.6	5.2	31.4	46.5
North East	10.0	15.5	7.6	11.3	5.6	9.5	9.6	16.0	6.0	7.0	38.8	59.3
North West	8.1	16.7	5.0	11.8	5.9	9.4	12.3	15.8	4.8	5.7	36.1	59.4
South East	9.3	17.0	5.8	13.0	7.5	10.7	6.4	12.4	3.8	7.8	32.8	60.9
South South	9.7	12.1	6.3	9.1	6.9	8.6	5.4	10.9	4.1	4.1	32.4	44.8
South West	6.6	11.7	5.7	8.6	6.3	7.3	7.2	10.6	4.5	6.1	30.3	44.3

Figure 8: Trends in quality-of-care index score on the SOML-PforR program (43)

V. Midwives Service Scheme (MSS)

In response to survey findings that established that up to half of primary health facilities did not have a single midwife (35) the federal government launched the MSS in December 2009 (36). The program had a goal to double the proportion of births attended by skilled birth attendants (SBA) by 2015. A central element of the MSS was the hiring and placement of unemployed, retired, and newly graduated midwives in government-run primary health centers (PHCs) located in rural and underserved areas. The midwives were selected through a nationwide recruitment process. They were assigned to designated PHCs for an initial period of one year, which was extended based on satisfactory performance. The initial phase was financed using debt relief funds provided under the 2009 Appropriations Act and was intended as a joint effort involving the federal, state, and local governments (35).

The upper age limit for the recruitment of midwives was set at 60 years. After the initial nationwide recruitment process, 2,488 midwives were deployed to 652 selected primary health centres across the 36 states and the Federal Capital Territory (FCT) under the scheme. Of those deployed, 45% were unemployed midwives newly recruited into the program, 44% were basic midwives completing their required pre-registration community service, and 11% were retired midwives (35). The federal government handled the recruitment and deployment of the midwives, provided them with a monthly stipend of NGN30,000 (about 150 USD), and equipped the clinics with essential midwifery kits which contained essential items needed for deliveries such as instruments, sutures, gloves, and cord clamps); basic

equipment such as blood pressure apparatus and weighing scales; some essential drugs, and facility/community registers for record keeping (35)(36). State governments gave midwives extra allowances of NGN20,000 per month and handled monitoring and supervision, while local governments provided an additional allowance of NGN10,000 along with free housing for the midwives within the local community (36).

The facilities chosen for the MSS operated within an efficient two-way referral network using a cluster model. In this setup, four primary health care (PHC) centers capable of offering basic essential obstetric care were grouped around a general hospital equipped to deliver comprehensive emergency obstetric services. A total of 815 health facilities participated, including 652 PHC centers and 163 general hospitals. Each PHC center was staffed with four midwives to guarantee round-the-clock skilled birth attendance and the continuous delivery of maternal and child health services. The number of facilities allocated to each of the six geopolitical zones was determined by the level of maternal mortality in the zones. Nigeria was categorized into three regions based on maternal mortality ratio (MMR): very high MMR (Northeast and Northwest), high MMR (North Central and South South), and moderate MMR (Southeast and Southwest). The Northeast and Northwest zones each had six clusters per state, the South-South and North-Central zones had four clusters per state, while the Southwest and Southeast zones had three clusters per state (35).

States in the northeast and northwest zones, identified as areas with 'very high' maternal mortality, each received 24 facilities. States in the north-central and south-south zones, categorized as having 'high' maternal mortality, were allocated 16 facilities each. Meanwhile, states in the southwest and southeast, considered 'moderate' mortality zones, were each assigned 12 facilities. Every MSS facility was connected to a general hospital designated as its referral center (36).

An assessment of the program one year into its launch indicated that there was general improvement in MNCH services in rural regions that typically had limited access to skilled birth attendants like midwives. A 2016 assessment however, concluded that the project only successfully induced pregnant women for ANC in its first year, while overall it showed no evidence in institutional deliveries or skilled birth attendance, the program's primary objectives (36).

VI. BHCPF Program:

The BHCPF program was launched in 2018 (23) and it was designed to operationalize UHC through the provision of a BMPHS, with funding drawn from 1% of the consolidated revenue fund (CRF), and with contributions from donors, private sector and other sources. 50% of the BHCPF was earmarked for provision of BMPHS through the NHIA gateway; 45% for

health facility strengthening through the NPHCDA gateway; and 5% for emergency treatment services through the National Emergency Medical Treatment Committee (NEMTC) gateway. The BMPHS of the BHCPF had maternal health package embedded in it. The BHCPF operated an interplay of oversight and feedback across the national, state, local and community levels of authority (*figure 8*) and expected 25% counterpart contribution from the state entities of the gateways.

The FMOH&SW's State of the Nation Report, 2024 establishes that of 30,628 health facilities, 8,195 (27%) are supported by the BHCPF. The Report further provides that the BHCPF-supported facilities out-performed the non-BHCPF supported facilities regarding ANC visits. Specifically, that ANC 4th visits recorded in the supported facilities doubled the number recorded in the non-supported facilities. Also, that the supported facilities recorded ANC visits up to the 8th visit more than the non-supported facilities.

After its start off, the disbursement to states in 2019 was financed by the World Bank and only 3 states were disbursed to. The arrangement with the World Bank was thereafter suspended and the BHCPF was funded by 1% CRF solely. By 2021, 14 states had been disbursed of the 36 states and the FCT participating in the program (47).
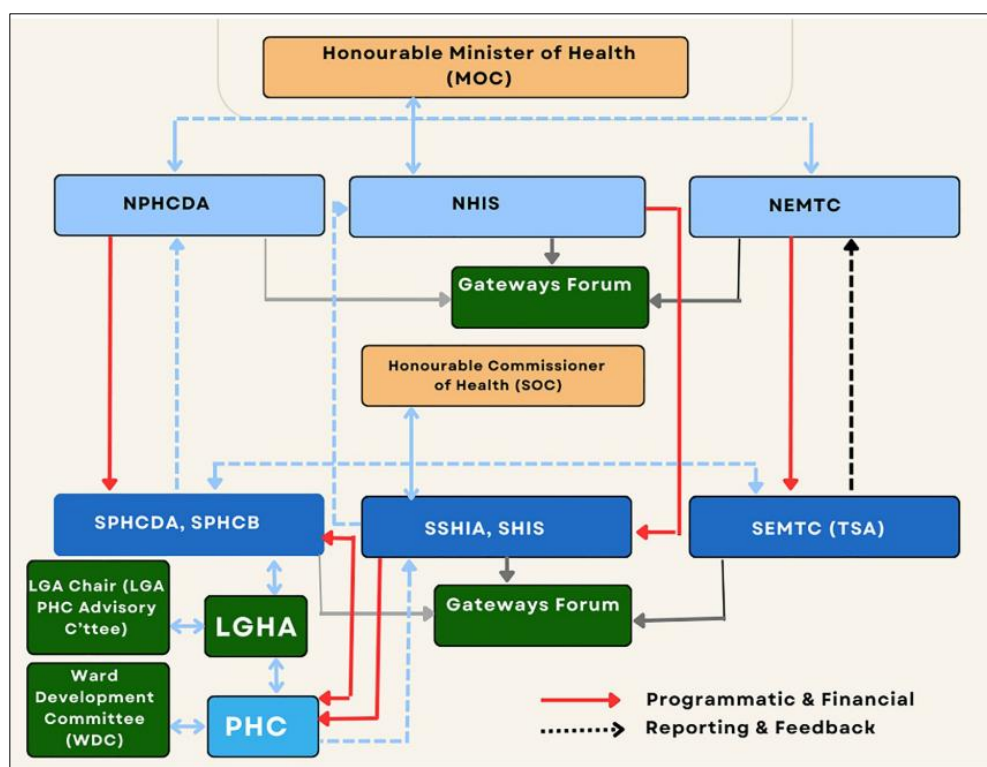

Figure 8:   Governance Structure of the Basic Health Care Provision Fund (23)
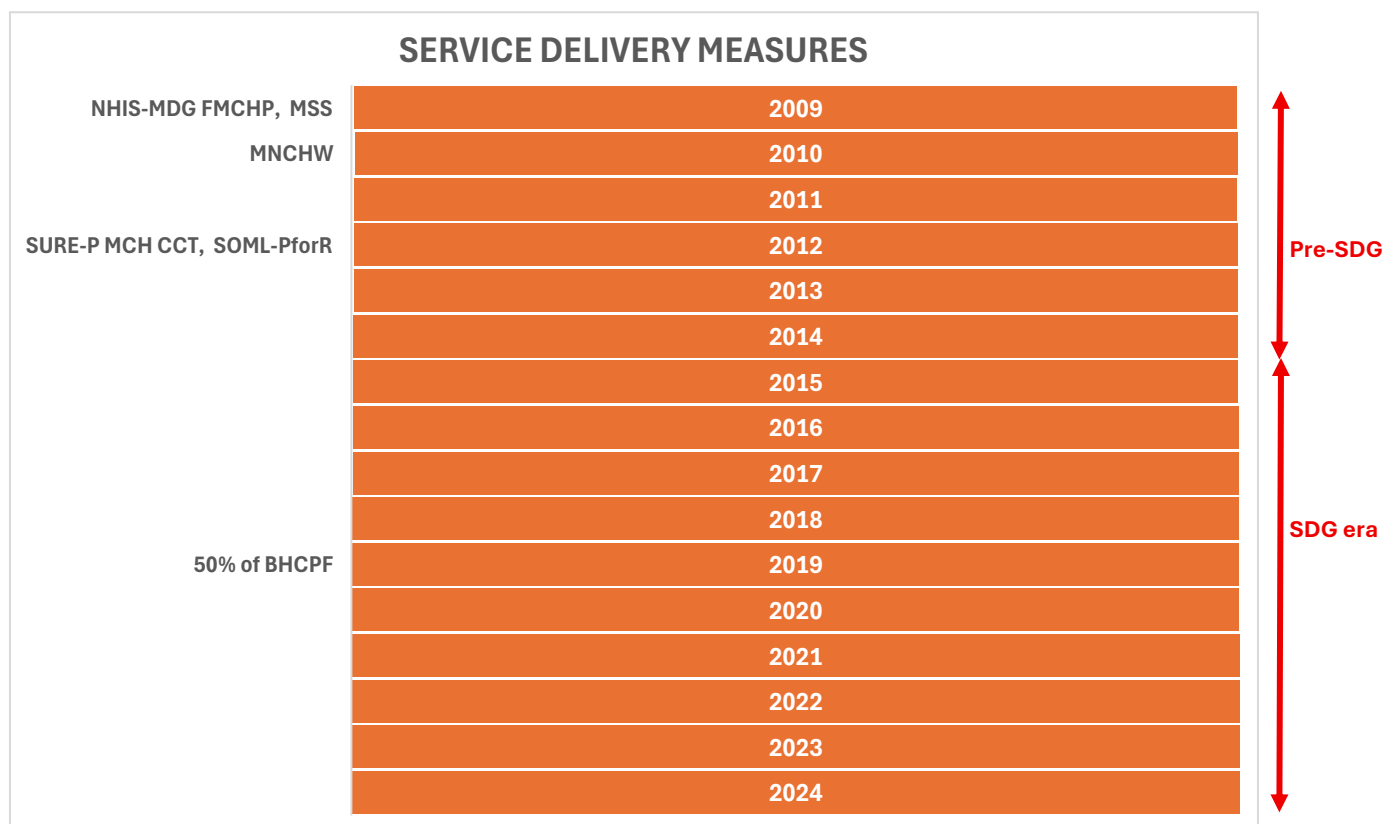
Figure 9: Timeline overview of service delivery measures for maternal health (compiled by author)

4.1.3 FINANCING MEASURE

The revenue raising, pooling and strategic purchasing efforts by the government for maternal health are described in the financing measure. A timeline overview of the financing measures is provided in *figure 10*.

I. BHCPF: The BHCPF was designed as the revenue source for provision of Basic Minimum Package of Health Services (BMPHS), health system strengthening and provision of emergency medical services (23). The BHCPF was earmarked to be drawn from 1% of the Consolidated Revenue Fund (CRF), and with contributions from donors, private sector and other source. A major component of the BMPHC is maternal package. 50% of the BHCPF was earmarked for provision of BMPHS; 45% for health facility strengthening; and 5% for emergency treatment services through the NHIS, National Primary Health Care Development Agency (NPHCDA), and National Emergency Medical Treatment Committee (NEMTC) gateways, respectively, (23) and 25% counterpart contribution was expected from the state entities of the gateways. However, the Nigerian Centre for Disease Control (NCDC) has now been included as 4th gateway to receive part of the funds for emergency treatment (47).

BHCPF payment mechanism was direct facility financing (DFF) with monthly prepaid capitation for primary care providers and fee-for-service (FFS) for secondary care providers (48). In 2024, the 36 states and the FCT received a total of NGN 43,632,306,339 as BHCPF disbursement (3).

II. VGF: the VGF was established by the NHIA Act, 2022. The revenue mobilization sources for the VGF as established by the Act included the BHCPF, health insurance levy, special funds allocated from the government, NHIA council investment, grants, donations as well as gifts (24) (8). The vulnerable group established in the NHIA Act, 2022 included pregnant women.

III. **NHIS MDGs-FMCHP**: A grant of about NGN13 billion was obtained from the debt relief gains for the MDGs-FMCP and disbursed to the NHIS by the Office of the Senior Special Assistant to the President on the Millennium Development Goals (OSSAP-MDGs), The NHIS, in turn, disbursed to the participating states through each state's project implementation structure (32). On the MDGs-FMCHP, pooling entailed an earmarked 60% contribution of the project cost from the federal government and 40% contribution by the states. The implementation committees thereafter disbursed to the health facilities through the PHC coordinators at the LGA level. The representatives of NHIS and the State Government were the signatories to the project account in the states, while the implementation committee managed the project accounts (32). The MDGs-FMCHP used only public health care providers at the primary and secondary levels. Health Management Organizations (HMOs) were the purchasing agents who paid primary care providers capitation for each user and fee-for-service for users referred to secondary facilities. The capitation fee was reduced to N350 from N550 because it was argued that since public providers were engaged, the cost of maternal care was already being subsidized by the state governments (32).

IV. **SURE-P MCH CCT** was implemented from 2012 to 2015, and had an annual budget of over NGN100,000,000 (USD 602,410). The scheme incentivized uptake of antenatal, delivery, and post-natal services at designated PHCs through a CCT to pregnant women (33). On the program, benefitting pregnant women were paid one-off cash support of NGN5,000 (approximately USD30) spread across the fulfilment of four sets of co-responsibilities. The pregnant women qualified for the cash support after pregnancy confirmation and registration at a participating facility (33).

V. **SOML – PforR -** the FGoN obtained a credit facility of five hundred million United States Dollars (USD500M) from the World Bank (43). The program automatically selected public primary health centres (PHCs) for services across the 36 states in Nigeria and the FCT (45). Performance-based financing (PBF) was used in the program as grants to states were renewed based on their performance on six key indicators and on a quality-of-care index (44). USD1.5 million was disbursed to all the states at the onset of the program (42) and states were rewarded with more funds in the second round based on actual improvements in the disbursement-linked indicators (45).

FINANCING MEASURES

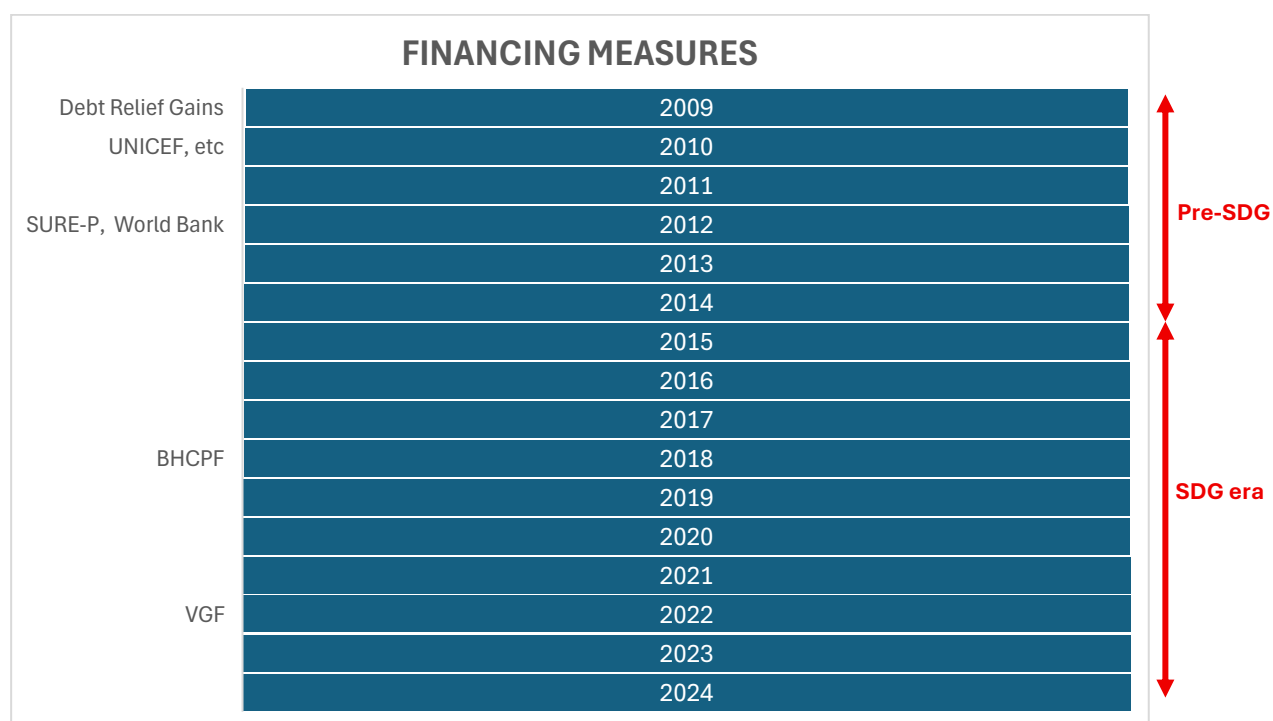|	
Debt Relief Gains	2009
UNICEF, etc	2010
	2011
SURE-P, World Bank	2012
	2013
	2014
	2015
	2016
	2017
BHCPF	2018
	2019
	2020
	2021
VGF	2022
	2023
	2024

Pre-SDG (2009–2014)

SDG era (2015–2024)

Figure 10: Timeline overview of financing measures for maternal health (compiled by author)

4.1.4   RESOURCE MOBILIZATION MEASURE

This measure entails government efforts at ensuring the availability of health workers, healthcare infrastructure, equipment, pharmaceuticals and consumables for maternal healthcare in the country. A timeline overview of the resource mobilization measures is provided in figure 11*.*

I.BHCPF - According to the NHAct, 2014, 45% of the BHCPF is allocated to the NPHCDA. Of this allocation, 20% is designated for essential medicines, vaccines, and consumable supplies; 15% is reserved for the provision and upkeep of primary health care facilities, equipment, and transportation; and 10% is earmarked for developing human resources for primary health care (23). As of 2024, out of 30,628 health facilities, 8,195 (27%) were supported   by   the   BHCPF   (3).

II. MSS – The core purpose of the MSS program was a nation-wide recruitment of midwives as a collaborative effort among the federal, state, and local governments. Unemployed, retired and newly graduated midwives were hired and placed in public primary health centres located in rural and underserved areas. With an upper age limit of 60 years, a total of 2,488 midwives were recruited and deployed to 652 selected primary health centres across the country. The initial engagement of the midwives was a one-year period which was subject to extension based on satisfactory performance (35).

23.

The federal government recruited, deployed and paid the midwives NGN30,000 per month and provided them with health insurance coverage (35). The state governments gave the midwives extra allowances of NGN20,000 while the local governments provided an additional allowance of NGN10,000 along with free housing for them within the local community (36). A total of 815 health facilities participated, including 652 PHC centers and 163 general hospitals. Each PHC center was staffed with four midwives to guarantee round-the-clock skilled birth attendance and the continuous delivery of maternal and child health services (35)(36).

Health facilities on the program were equipped by the federal government with essential midwifery kits which contained items such as delivery instruments, sutures, gloves, and cord clamps. The primary health centres were also provided with basic equipment such as blood pressure apparatus and weighing scales; some essential drugs, and record keeping tools (35) (36).

The secondary health facilities for referrals on the MSS program were upgraded by the state governments to provide comprehensive emergency obstetric and newborn care. The upgrade included provision of basic equipment and supplies such as drugs and other consumables, ambulance services, steady electricity and potable water supply, stationery, and security for health workers and equipment (35).

III. The NHIS MDGs FMCHP program did not recruit new or additional health workers. Existing health workers were retrained to provide earmarked project services. The gap on unavailability of basic amenities and equipment established at the program onset was addressed using the capitation paid to the facilities (32). Centralized procurement of drugs and commodities was employed by some states on the NHIS MDGs FMCHP program. Joint procurement by the NHIS and Population Council was also employed in some states for the provision of magnesium-sulphate which was used for managing pregnancy complications (32).

IV. SURE-P MCH CCT program trained and deployed midwives, community health extension workers (CHEW) and village health workers (VHW) to participating health facilities across the 36 states and the FCT. The program also strengthened the skills of existing health workers (35) (37). The federal government recruited the health workers while the state governments were tasked with contributing to their salaries and the local governments with providing accommodation for them (37). Primary health centres (PHCs) were renovated, MNCH medicines, consumables & equipment were supplied, and boreholes were installed to provide portable water at the health facilities. The program was implemented in clusters in each state with each cluster comprising of 4 PHCs being linked to a referral secondary health

facility (33). A total of 1,000 health facilities were renovated and designated as SURE-P MCH facilities. The first set of 500 health facilities were designated by October 2012 while the second set of 500 were designated by November 2013. 100 ambulances were also procured for selected clusters with earmarked deployment of each ambulance to the most rural health centre in the cluster (37).

V. SOML-PforR program: PHC workers were trained on improving the quality of MCH service delivery. Funds received on the program were used to purchase maternal health service delivery items such as insecticide-treated nets, maternal delivery kits, routine prenatal care drugs, sulphadoxine-pyrimethamine for IPTp, urinalysis strips, HIV test kits, hemoglobin testing reagents, feto-scopes, examination lights, sterile scissors, cord clamps, and forceps. Additionally, the PHCs were equipped with basic equipment and provided with essential drugs (42).

RESOURCE MOBILIZATION MEASURES

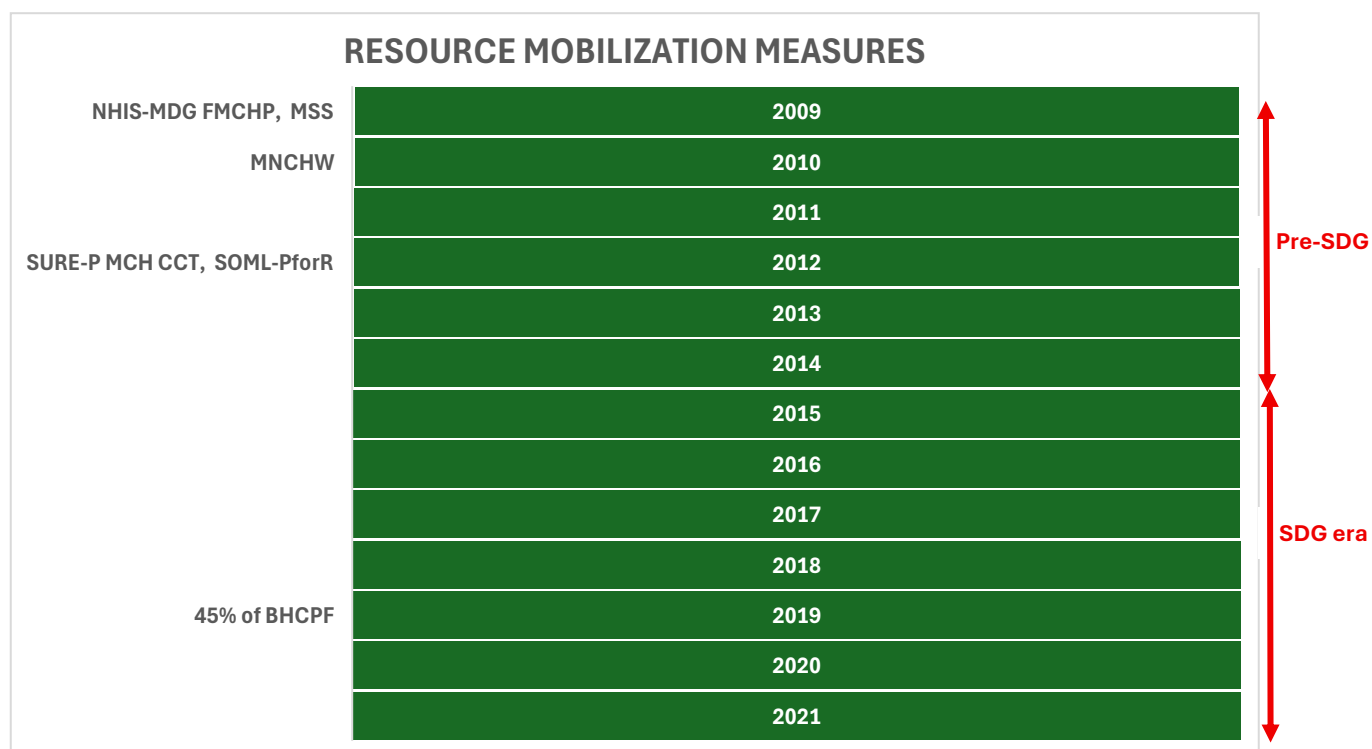| Label	Year	Era
NHIS-MDG FMCHP, MSS	2009	Pre-SDG
MNCHW	2010	
	2011	
SURE-P MCH CCT, SOML-PforR	2012	
	2013	
	2014	
	2015	SDG era
	2016	
	2017	
	2018	
45% of BHCPF	2019	
	2020	
	2021	

Figure 11: Timeline overview of resource mobilization measures for maternal health (compiled by author)

4.2 Gaps to Maternal Health Coverage and Financial Risk Protection

4.2.1 GOVERNANCE GAPS

I. Policy and Vision

Limited commitment by the government and less coordination among health ministries, apart from inadequate resources, were marked as the factors that fundamentally hampered the implementation of public policy programs, including health (40). Likewise, weak governance was stated to have marred the smooth implementation of the MNCHW at the state and local levels. Another study also recognized that health workers were demotivated and became less committed due to a lack of support and political will from the local governments (LGs) (49).

II. Intelligence and information

The selection of participating states on the NHIS-MDG FMCHP was not based on epidemiological data and disease burden but on maintaining a political regional balance. This was clearly at variance with the target of the project which was to reach vulnerable groups (32).

A report established that lack of accurate data had made it impossible for some state and local governments to respond adequately to health issues, because they were not aware of the issues on the MNCH (39).

On the SURE-P MCH CCT program, timely program responses were delayed by limited monitoring and evaluation arising from lack of a structured plan (33).

III. Stakeholders' voice

A study established that there was a top-down approach by the Nigerian government on the MNCHW which caused low turnout of targeted beneficiaries, emphasizing that the gatekeepers of the beneficiary communities were not involved in the policy-making process. The study however, admitted that there was limited research and data on the issue as it seemed that low turnout for the MNCHW was more pronounced among women from a particular religious faith. The reasons the women gave for non-attendance included lack of support from husbands (such as permission, financial support, transportation, or

encouragement), distrust of free government services, concerns about women interacting with men, and religious beliefs. (38).

In addition to the non-consultative process in the project design, poor social mobilization also contributed to low awareness of the MNCHW campaign among targeted beneficiaries. A survey which involved 5,389 households established that more than half had never heard of the MNCHW, and only 12% of mothers in two other states were aware of the program. The study attributed the issues to insufficient health funding, which is a consequence of poor federal administration (49).

Inadequate social mobilization was also identified by another study as the reason for late presentation of women with high-risk pregnancies to health care facilities. The study opined that the country's slow progress in maternal mortality reduction in certain region may be linked to a higher proportion of high-risk births occurring at MSS primary health care facilities The study explained further that most women who attended antenatal care at the health facilities still chose to deliver at home. Insinuating that the increase in facility-based deliveries at MSS centers was likely made up of women with high-risk pregnancies who arrived too late for effective, life-saving interventions during pregnancy or for their newborns (35).

On the design of the BHCPF, it was reported that despite its wide stakeholders' consultative process, beneficiaries were left out and there was low awareness among the citizenries (47).

4.2.2 SERVICE DELIVERY GAPS

Weak administration was identified as the reason for poor distribution of funds on the MNCHW project as only 10% of allocated funds was received by the implementation committee in one of the states (49). Inadequate funding resulting from poor administration hindered campaign outreach as only 40% of facilities in one of the project states engaged a town announcer for campaign purposes (40). Weak administration also caused delays in fund release to the SURE-P MCH program implementation unit which in turn brought about unpredictable and irregular payout of the CCT. Some women reported not receiving their entitlements while some said they received only the first instalment and were awaiting the second (33) . Inadequate provision of security at on the SURE-P MCH CCT payout events was expressed to have compromised the safety of both the funds and disbursing staff.

On the SOML-PforR , protracted report reviewing and submission caused delay in the release of funds which also led to loss of funding by some states. Moreso, the Terms of Reference (ToR) drawn for independent verification agents (IVA) was ambiguous. The TOR was eventually revised but only towards the end of the program and hence had less usefulness. There were also communication and coordination issues between the State Ministry of Health (SMOH) and the State Primary Health Care Board/Agency (SPHCB/A) (43)

The LGs who oversee the PHCs and are the closest to the grassroots get a quarter of health funding from the federation account. The states also get a quarter, while about half of the health funding is held at the federal level. However, there was less accountability and poor coordination because these funds were not specifically committed to the health sector, and because the LGs and states were not required to submit financial reports to the federal government. Consequently, the health system in the country is less coordinated and marked by differing health outcomes (35).

4.2.3 *RESOURCE GENERATION GAPS*

I. Human Resources for Health (HRH)

A study established that more than 65% of maternal deaths take place during childbirth (50) which makes skilled birth attendance quite imperative. Low supply of healthcare workers was reported to have impacted negatively on the quality of health services and health education on the MNCHW in a state. While the state targeted 60% of relevantly skilled healthcare providers in its urban areas, only 9.5% were engaged (38).

Insufficient coordination and communication among health workers was stated to have hampered MNCHW implementation. Health centres in one of the project states were reported not to have standardized staffing structures which prevented teamwork of their staff with redeployed nurses and doctors (49).

The health workers on the SURE-P MNCH CCT were reported to have experienced additional workload due to increased MNCH service demand and completing of CCT reporting tools (33).

A study recognized low retention of midwives, arising from inconsistency in payment of salaries and insufficient housing, as a challenge on the MSS project (36). The study however, stated further that this challenge alone could not have accounted for low skilled birth attendance, but that other components of quality of service might have discouraged skilled birth attendance (36).

II. Infrastructure, Medical Equipment, Pharmaceuticals and other Consumables

A study on PHC survey data showed that infrastructure often remained substandard, and there were persistent shortages of drugs and supplies. Only 44% of facilities assessed were rated as "good" by project staff in terms of building condition (with options being poor, fair,

or good). Many PHCs also struggled with basic utilities: 35% of MSS PHCs reported having no electricity. The availability of essential medicines and basic equipment was also lacking. Clinics were given a point for each piece of functional equipment, with a median score of 13 out of 22. On average, PHCs stocked only about half of the essential medicines and 21 % of PHCs did not have any of the drugs (36).

Shortages in medical supplies and equipment were reported in many states on the MNCHW program. The shortages were because of delay in delivery of these supplies from both the national and state levels to the point of use, the primary health centres (38). In a state most essential commodities were either missing or insufficient (49) while in the urban areas of another state only 42.9% of health facilities had the necessary drugs and consumables (40). Similarly, in a third state, the majority of facilities lacked adequate materials for behavioral change communication, and activities were postponed due to late deliveries (51). These supply gaps and delays frustrated beneficiaries, reduced participation, and undermined both the effectiveness of the program and the trust beneficiaries had in government initiatives.

4.2.4 FINANCING GAPS

On the BHCPF, donor funding of the BHCPF ceased after the government entities for the implementation of the BHCPF (NPHCDA and the NHIA) rejected the blending of donor funds with 1% of the federal government CRF. The BHCPF implementation had an initial arrangement through which donors could contribute directly to BHCPF implementation, thus making them decision-making stakeholders on the BHCPF. Sequel to the rejection of co-mingling of funds, as of 2021 funding of the BHCPF relied solely on 1% of the CRF. The government entities opined that unmingling of funds would promote government ownership (47).

A study expressed reservations on the continuity of the MSS project beyond its initial three-year duration due to a lack of sustained funding (35).

While limited access to health facilities and low rates of SBA were identified as the causes of the persistently high maternal mortalities and morbidities in the country, insufficient and poorly utilized funding of MCH programs have been reported as the underlying issues (31).

A study reported that state governments, in particular, inadequately funded health projects and this coupled with inefficient financial management caused implementation challenges on the SOML-PforR program. Notwithstanding that the program was designed to spur increase in health spending among the state governments (43).

Lack of imprest funds on the SURE-P MCH CCT was reported to have impeded the consistency in state steering committee (SSC) meetings, thus preventing the committee from effectively performing its roles (33).

CHAPTER FIVE

5.0   DISCUSSION

This paper had an objective to identify the various national-level originating measures targeted at service coverage and financial risk protection for women during pregnancy and childbirth and postpartum in Nigeria. Using the HSPA Framework for UHC, the measures were analysed into four themes namely; governance, resource generation, financing and service delivery. Also using the themes, the gaps to service coverage and financial risk protection for maternal health in Nigeria, which is the second objective of this paper, were analysed. Summarily, this study analysed the measures by the Nigerian national government before and during the SDG era from 2010 to 2024 to understand the reason(s) for the minimal output achieved for maternal mortality reduction.

5.1   *Measures Identified*

On governance, the country provided a lot of guidance and direction in the SDG era through several documents such as the 2016 National Health Policy, 2018 National Strategic Health Development Plan II, 2020 BHCPF Guidelines and the 2022 NHIA Act. In comparison, the 5 years prior to the SDG had majorly the 2014 NHA. The thrust of the government showed that its policy making were evidence-informed as the documents referenced were a built up of preceding ones, such as the NHA, 2014 and the NHIA, 2022. In reference to maternal health, while the NHA mentioned women as a focus, the NHIA was specific about pregnant women and additionally made provisions for free/subsidized health care for this population through the VGF. The national government is emphatic on providing documented guidance and direction for maternal health; however, these have not translated to service coverage and financial risk protection through maternal-specific programs since the SGDs.

In contrast to governance, service delivery for women during pregnancy and childbirth and postpartum enjoyed more robust maternal-specific health programs in the pre-SDG' years. In the 5 years to the SDG, while five maternal-specific heath programs were identified, (NHIS MDGs FMCHP (2009-2014), MSS (2009 – 2016/2017), SURE-P MCH CCT (2012-2015), SOML PforR (2012-2020) and MNCHW (2009 to date)), no single national maternal-specific health program was initiated since 2015. The maternal-specific health program identified between 2015 and 2024 were the ones which extended from the pre-SDG years. More so, while all the programs in the pre-SDG period were targeted at achieving service coverage through health system strengthening (health facilities upgrade, provision of maternal delivery kit, provision of essential medicine, consumables, and supply of health workers), only the NHIS-MDGs FMCHP and SOML PforR achieved service coverage.

While the MSS and SURE-P MCH CCT programs also recruited health workers specifically for maternal health, the NHIS MDGs FMCHP and the SURE-P CCT incorporated financial risk protection into maternal health coverage. Specifically, the NHIS-MDGs FMCHP provided health insurance while the SURE-P MCH CCT transferred monies to the beneficiaries to cover cost of transportation to the PHC and out-of-pocket expenses. Also, the SOML-PforR achieved service quality. Although, the different programs individually achieved health system intermediate objectives (coverage, quality, access) and goal (financial risk protection), these gains were not consolidated and sustained.

Notably, in the post SDG period, an all-encompassing BHCPF was launched in 2018. The Fund which is non-maternal health specific has maternal care package as one of its major objectives. The Fund is encompassing because it has two health system functions as its inputs while the remaining two health system functions serve as inputs for health care service delivery. The BHCPF was established by the NHA, 2014 (governance), has 1% of the CRF as its funding source (financing) and is designed to provide BMPHS (service delivery) and health system strengthening (resource generation). However, the Fund did not measurably prioritize maternal care, and its implementation has been a subject of bureaucratic and leadership interests (52). Although the 36 states and the FCT now implement the BHCPF, only 14 states were implementing as of 2021 and only 3 states implemented in 2019 . More so, the BHCPF implementation is exposed to the discretionary actions of state governments based on their willingness and ability to pay the statutorily required 25% counterpart fund contribution (52).

On financing, during the pre-SDG years, the government mobilized major revenues for maternal-specific care both domestically and externally, including an annual budget of over N100,000,000 on SURE-P MCH CCT program more than USD 370 million disbursed by the World Bank on the SOML PforR. Whereas on the non-maternal specific BHCPF, the major funding source was the 1% of the CRF, as donor funding ceased after the NPHCDA and the NHIA rejected the blending of domestic and donor funds for BHCPF. In addition to the BHCPF, the NHIA Act, 2022 established a maternal-focused VGF but its implementation could not be assessed through literature review. This showed dwindled financing for maternal health as evidenced in non-initiation of a maternal specific program by the national government since the SDGs. This might partly be a consequent of the COVID-19 pandemic as corroborated by a study on the impact of COVID-19 pandemic in SSA which established that MCH services were delayed or decreased in the region because of COVID-19 pandemic (53).

In contrast to the three other measures, resource generation received attention both in the pre-SDG years and since the SDGs. More so, the ongoing MNCHW has made it imperative to mobilize resources for maternal health during its implementation.

Considering the different health system objectives achieved individually by the pre-SDGs maternal health programs, the design of the BHCPF could be regarded as an all-purpose program. The BHCPF h is comprised of essential care package for all Nigerians and contains

essential components of traditionally vertical programs such as HIV, TB, etc, which could commendably be regarded as a measure to reduce fragmentation of various health funding sources and health programs. Still, maternal care should have been given the specific attention it deserved as contained in the SDG 3.1 (14), just as it has worked measurably in past programs in the country and is obtainable in the health landscape of many low-middle-income countries like Nigeria (54).

Also, the stance of the NPHCDA and the NHIA to maintain government ownership and accountability of the BHCPF by rejecting co-mingling of donor funds with local funds, with subsequent cessation of the donor fund, is seemingly patriotic. However, co-mingling could possibly have been used by the NPHCDA and the NHIA to achieve greater accountability and transparency as achieved on the World Bank-funded SOML PforR program, and not necessarily seen as a means to diminish local ownership. A study on external funding for maternal care also routes for private and bilateral funding and suggests the development of a coordination mechanism for different funding sources (55). Another study however, critiques that transitioning from development assistant for health (DAH) could adversely impact on health system and outcomes when not adequately prepared for (56). Still, donor funding for health care and specifically for maternal care should not be jettisoned because of bureaucratic and leadership interests, especially at a time when Nigeria's present macroeconomic outlook has been adversely impacted by global decline in oil prices (57). Additionally, donor funds were statutorily indicated as a source of funding for the BHCPF in the NHAct, 2014 (9). This should thus provide further guidance and serve as a leverage to design measures to ensure continuity of donor funds for the BHCPF.

5.2 Gaps Identified

Many of the project-specific gaps identified during the pre-SDG period were extensively addressed in the period after the onset of the SDG. However inadequate commitment from state governments, low funding, low awareness of programs and low engagement of beneficiaries in program design persist.

Weak administration, weak coordination, and less accountability which were cited across the pre-SDG maternal health programs, except on the SOML PforR program, were considered in the design of the BHCPF. The BHCPF operates an interplay of oversight and feedback across its national, state, local and community levels of authority which ensures strong coordination and accountability. Delay in release of project funds which was attributed to weak administration in the pre-SDG maternal health programs had been taken care of as it is only occasioned in the BHCPF when a state delays in meeting the requirement for BHCPF implementation. Commitment from state governments was still, however, subject to their willingness to prioritize healthcare funding coupled with their capabilities in the context of their states' local needs (47). This commitment thus impacts directly on health funding level. As of 2022, only the 14 states which had paid counterpart contributions and met some other requirements had been onboarded for BHCPF implementation (58).

Still persisting as an issue in both periods is the less representation of beneficiaries in the design of programs and more specifically, in the latter period, low awareness of the BHCPF among beneficiaries (47).

From the foregoing, it could arguably be posited that the slow progress in the reduction of maternal mortality in the country from 1113 maternal deaths per 100 000 live births in 2015 to 1047 deaths per 100 000 live births (6) and then to 993 deaths per 100 000 live births in 2023 (14) was premised on the non-initiation of maternal-specific health delivery programs since the commencement of the SDG. The FMOH&SW, however, hinted at the launch of Nigeria's national maternal mortality reduction innovation and initiatives (MAMII) in late 2024 (3). Although the 2023 NDHS did not provide information on the country's current MMR, it highlighted slow progress in maternal health indicators. ANC by skilled provider increased from 61 to 67 and then decreased to 63; delivery by skilled provider increased from 40 to 45 and then slightly to 46; and postnatal check during first 2 days after birth increased from 40 to 42 and then to 43. Additionally, there were no published literature on the assessment of the performance of the BHCPF with regards to maternal health coverage and financial risk protection, nationally.

5.3   Implications of the Study

The scientific evidence on non-initiation of maternal-specific programs in the country since the SDGs which is suggested by this study as the reason for slow reduction in MMR can be useful for policy decisions by the FMOH&SW for targeted maternal health interventions. It also calls for the need for further research to assess the nationwide impact of the implementation of BHCPF and VGF on maternal health indicators, especially since the commencement of the BHCPF in 2018.

5.4   Limitation

This study might not present the current situation in the SDG years between 2021 to 2024 because it could not locate peer-reviewed articles on maternal-specific interventions in the country. More so, no published studies could be accessed which assessed the impact of the BHCPF on maternal health indicators nationally except for studies which explored its financial feasibility (31) and predicted its cost effectiveness (59). This study relied on grey literature and specifically on the FMOH&SW's 2024 State of the Nation Report to assess current situation. The report by the FMOH&SW showed improvement in maternal health indicators in BHCPF-supported PHCs compared to the non-BHCPF supported PHCs.

CHAPTER SIX

6.0   CONCLUSION & RECOMMENDATIONS

6.1 Conclusion

This study aimed to explore maternal health interventions implemented before and during the SDG era from 2010 to 2024, and to identify existing gaps. A significant contrast established by this study between the pre-SDG years; 2010 to 2014, and the SDG era; 2015 to 2024, was the non-initiation of a maternal-specific health program in the latter period. Also, that the intervention gaps pertinent to both periods were low commitment from governments, low funding, less representation of beneficiaries in the design of programs and low program awareness among beneficiaries. The major finding from this study could explain the slow progress to MMR reduction and thus makes the implementation and sustenance of maternal-specific programs imperative. This is in consonance with the recommendations by a study on ending maternal mortality (60).

6.2   Recommendations

Based on the findings of this study, the following recommendations are made to accelerate MMR reduction.

1. **Increased Health Funding**

- The NPHCDA and the NHIA (formerly NHIS) with oversight by the FMOH&SW should fashion out mechanisms to blend donor funds with domestic funding without wearing down government ownership of programs. This will help to shore up more funding for the BHCPF.

- The FMOH&SW together with the Ministry of Communications, Innovation and Digital Economy; National Communications Commission, and Ministry of Finance should lobby the Senate and the Presidency for the introduction of a telecom tax which will be dedicated to health funding, and especially for maternal health. Introduction of telecom tax was used by Gabon to achieve free access to health for about 50% of its population, especially the poor households (61).

2. **<u>Targeted Interventions</u>**

▪ The FMOH&SW should design a nationwide free insurance package specifically targeted at maternal health. One of the contributing factors to Kenya's attainment of 25% reduction in MMR from 708 in 2000 to 530 in 2020, was targeted maternal health interventions (62).

▪ The NHIA should develop and implement guidelines for the VGF to include specific & measurable focus for the maternal population.

▪ The NPHCDA and the NHIA should redesign the BHCPF to have a component which prioritizes maternal care, and the implementation of the BHCPF maternal care package should not be at the instance of the other general package. At the present, if the general package was not earmarked for implementation, automatically its maternal care component would not be implemented.

3. **<u>Increased Commitment from State governments</u>**

▪ The federal government should place state governors on the Maternal and Perinatal Death Surveillance and Response (MPDSR) reporting dashboard to promptly update them on maternal deaths in the country to galvanize a stronger commitment. Tanzania achieved 80% reduction in MMR, from 849 in 2000 to 238 in 2020, and attributed it to a well-coordinated MPDSR which involved health personnel and '***high authority***' (63), amongst other factors**.**

▪ To achieve effectiveness on the MPDSR reporting, the NPHCDA, with oversight by the FMOH&SW, should review MPDSR implementation to make it more community based.

▪ In addition, the MPDSR bill passed by the 9th Senate in 2021 should be reintroduced by the present Senate for the President's assent.

4. **Beneficiaries' Engagement**

▪ Beyond microplanning, the FMOH&SW, SMOH and the LGs should actively engage beneficiaries in the design of maternal programs.

▪ Also, FMOH&SW, SMOH and the LG should regularly conduct program awareness campaigns on masses-inclined media outlets.

5. Sustaining   Maternal   Care   Gains

- To sustain gains on maternal care and MMR reduction, the federal government should put in place population control measures backed by legislation and policies (8). Nigeria's fertility rate which is 4.8 children per woman (64) will continually place unattainable demand on more health system resources if not checked.

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ANNEXES

ANNEX I - Overview of Identified Maternal-Specific Programs

Program	Duration	Sponsor	Scope	UHC objectives/HS Goals		In comparison with the other projects		Status	Remark
				Intermediate objective **WHO** **(1)Access, (2)Coverage, (3)Quality & (4)Safety)**	**Final Goals** **WHO** **(1)Health improvement (level & equity), (2)Responsiveness/User-experience, (3)Social & financial risk protection, (4)Improved efficiency**	**Common features**	**Unique feature**		
1. NHIS MDGs FMCHP	2009 – 2015	Debt relief funds	12 states	1–Yes 2-YES 3 - NO	3-YES 4 - YES		Has an insurance component. Implemented only in 12 states	Ended with MDGs in 2015	
2. SURE-P MCH CCT (engagement of HCWs)	NON CCT: 2012 – 2015 CCT: 2014 - 2015	SURE-P	Nationwide	1-YES, 2 – NO 3 – YES	3-YES 4-YES	Targeted at service coverage	Has CCT	Ended in 2015	Had a strong component of social & financial risk protection.
3. MNCH Week	2009 - pilot phase 2010 – present	Domestic funds + development partners (UNICEF, WHO, etc)	2009 -2 states 2010-nationwide	1-ACCESS (FP only) 2-NO	1-NO		Still ongoing. Serves as a booster activity for MNCH every year	ongoing	

4. SOML-PfroR	2012 - initial phase 2015-2020	2015 – World Bank funding	2012 -13 states 2015- nationwiide	1-YES 2-YES 3-YES	1-YES 3-YES 3-YES		Specifically achieved quality in service delivery	Ended in 2020	Had a very strong component of M&E. Made it easy to establish if quality was achieved.
5. MSS	2009	Debt relief funds under the Appropriation Act	nationwide	1-YES (in its 1st year) 2-NO	1-NO 2- 4- PARTIALLY YES		Had an insurance package for the engaged health workers. Incorporated as a strategy into other progranms	Ended in 2015	Project scope was based on epidemiology and disease burden. Had the strongest resource generation health system functions

Annex II   -   Tables

Table I: Search Strategy

Topic/object] Problem/issue terms (OR)		What I want to know about my topic/object?] Factors-related terms (OR)		Where is it?] Geographical scope terms (OR)
Maternal health		Interventions		Nigeria
Maternal care		Programs		Sub-Saharan Africa
Maternal and child health		Universal health coverage		
		Services		
		Service coverage		
		Insurance health schemes		
		Financial risk protection		

Table II – Additional Documents on Government Measures

S/N	ADDITIONAL DOCUMENTS ON GOVERNANCE MEASURES FOR MATERNAL HEALTH
1.	Health Sector Strategic Blueprint, 2022
2.	National Policy on Maternal, Infant, and Young Child Nutrition (MIYCN) in Nigeria
3.	Kangaroo Mothercare KMC) Operational Guideline
4.	Nigeria Family Planning Blueprint (2020 – 2024)
5.	Antenatal Corticosteroids Use in Preterm Birth Final Edition
6.	National Maternal and Newborn Health Commodities Quantification
7.	National Safe Motherhood Strategy
8.	Nigeria Maternal Newborn Health Commodities Quantification and Funding Requirements
9.	Postpartum Facilitator Training Manual
10.	Postpartum Participants Training Manual
11.	FMOH&SW & SW Technical Requirements and Specifications for Local Production of Calibrated Drapes for Management of Postpartum Haemorrhage (PPH)
12.	National Guidelines for the Management of Pre-eclampsia/Eclampsia in Nigeria
13.	National Strategic Framework for Elimination of Obstetric Fistula
14.	National Behavioural Change Strategy Fistula in Nigeria
15.	A Plan for Integrating Postpartum Family Planning into MNCH

Declaration for Use of Generative AI (GenAI)

Check the box that applies to your completion of this assignment:

☐ I confirm that **I have not used** any generative AI tools to complete this assignment.

☒ I confirm that **I have used** generative AI tool(s) in accordance with the *"**Guidelines for the use of Generative AI for KIT Institute Master's and Short course participants".*** Below, I have listed the GenAI tools used and for what specific purpose:

Generative AI tool used	Purpose of use
1. ChatGPT	Expand my search for information. Check my work and give feedback for improvement.
2. Perplexity	Expand my search for information. Check my work and give feedback for improvement.