Assessment of the NHIS-MDG free Maternal and Child Health program and the prospects for program re-activation/scale-up using the Basic Health Care Provision Fund in Nigeria

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This policy brief is based on a research report **Assessment of the NHIS-MDG free Maternal and Child Health program and the prospects for program re-activation/scale-up using the Basic Health Care Provision Fund in Nigeria".** The study was undertaken at the Federal level in Nigeria and is available from the BMGF, Abuja office. For more information about this publication, please contact Obinna Onwujekwe, e-mail: Obinna.onwujekwe@unn.edu.ng

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Key conclusions:

- High level advocacy by NHIS ensured the buy-in by the states. The programme likely had positive impact on the target population and helped improve the functionality of the facilities in rural areas resulting to improved uptake of services.
- Lack of political support from the State Governors after initial enthusiasm was a major factor in the collapse of the project. Use of political appointees instead of Commissioners of Health to manage the project interfered with project implementation in some States.
- There should be legislation to back up the program if revitalized to ensure that funds are appropriated and it is sustained.
- Although the state governments defaulted with payment of their counterpart funds, the federal government continued to provide the grants to fund the project, the non-payment of counterpart funding by the beneficiary states inevitably led to the termination of the project by the federal government
- The lack of baseline data was seen as a major flaw of the project design and there was no incorporation of operations/implementation research in the design which makes impact evaluation problematic
- There was lack of involvement of communities in the initial design of the programme, which inadvertently contributed to lack of ownership by communities
- Use of the Basic Health Care Provision Fund to revitalize/scale-up the MCH project

Key policy recommendations:

1) The Basic Healthcare Provision Fund (BHCPF) should be used to reactivate and scale-up the Free MCH program.
2) Involve communities and key stakeholders in the design, implementation and monitoring of programs. Wide consultation and stakeholder engagement could help in building community ownership and participation.
3) States to ensure counterpart funding for projects are included in annual budgets to ensure predictability and availability of funds.
4) Use existing institutional frameworks and structures for project implementation and fund management for pro-poor programs rather than third parties such as HMOs.

5) Integrate Free MCH programs as part of exemption schemes or CBHI component of State Social Health Insurance Schemes as part of strategies to achieve universal risk protection through a state-wide pool.
6) Federal and State Governments should show commitment by providing adequate funding in a predictable and regular manner to reduce disruptions in service delivery and ensure continuity.
7) States to explore innovative financing strategies to raise more domestic resources to increase fiscal space for financing the Free MCH and similar SDGs- financial risk protection programs for achieving UHC
8) Introduce some incentives to motivate and encourage health workers to improve their performance as well as handling additional work load
9) Use of harmonized Information Technology (IT) and biometrics system in the registration of enrollees to reduce errors and duplication of registration while ensuring that enrollees graduate out of the program as at when due.
10) Develop system for research uptake activities and use existing policy and institutional frameworks to disseminate research evidence to key stakeholders.

OBJECTIVES OF THE STUDY:

1. To examine the legal, policy, regulatory and financial basis and opportunities for the implementation of the NHIS-MCH program as well as the political, social, and economic environment of the implementation of the NHIS-MCH program
2. To review the organizational framework of the defunct NHIS-MDG- MCH program and the extent to which it supported the equitable and efficient implementation of the program (NHIS/HMO/Provider/State/LGA linkages).
3. To examine the provider, HMO, and consumer level factors that enabled or constrained program implementation and effectiveness (including human resources, service costs, the political, social and economic environment of the implementation of the NHIS-MCH program and accessibility to qualitative care).
4. To analyze and recommend options for extending coverage with an effective maternal and child health financing program

INTRODUCTION

Following the successful campaign by President Olusegun Obasanjo, Nigeria in 2005 was granted debt relief Paris Club with some tied-in conditions which included the reinvestment of the debt relief gains in the social services. The Office of the Senior Special Adviser to the Present on the Millennium Development Goals (OSSAP-MDGs) was established to coordinate the implementation of the MDGs program.

The National Health Insurance Scheme (NHIS)-MDG Free Maternal and Child Health (MCH) program was initiated against the backdrop of Nigeria's poor performance on maternal and child health indices. The Free MCH was a special intervention to address the high mortality among women and children by increasing access to MCH services through an exemption scheme. The implementation of the program started in late 2008 with six pilot states and was scaled-up to additional states in phases two, three and a final phase. The Free MCH program ended in 2015 across the country.

However, there has been no detailed evaluation to assess the program in terms of impact, lessons learned and best practices. Rather, there is anecdotal evidence on the positive impact the

program in the health outcomes among the beneficiaries. With the signing of the 2014 National Health Act, it is imperative to explore the feasibility of reactivating the scheme through the Basic Health Care Provision Fund (BHCPF) which has provisions for free access to a basic package of health care to all Nigerians. This policy brief is devoted to the key findings of the Federal level assessment.

METHODS USED

Data collection: The assessment of the NHIS-MDG Free MCH program was undertaken in Abuja, and in two of the implementation states Niger and Imo. The federal-level study involved document review and in-depth interviews with respondents who were either involved in the implementation of the project or had provided some level of support to the project. The respondents were former and current employees of the Federal Ministry of Health (FMOH), NHIS, the National Primary Healthcare Development Agency (NPHCDA), health maintenance organizations (HMOs), civil society organizations (CSOs), Development partners (DP) and other key independent informants. Interviews were transcribed and analyzed using thematic analysis, while documents were analyzed using content analysis.

Data analysis: Interviews were transcribed and analyzed using thematic analysis, while documents were analyzed using content analysis

KEY FINDINGS

Key Actors and their roles:
The table below shows a summary of the roles and responsibilities of the key stakeholders/actors that were involved in the implementation of the project include:

S/N	Organization/Actor	Roles and Responsibilities
1	National Health Insurance Scheme (NHIS)	Regulator and initiator of the project
2	Office of Senior Special Adviser to the President on MDGs (OSSAP-MDGs)	Co-initiator and funder
3	Health Maintenance Organizations (HMOs)	Registration of enrollees, payment of providers
4	Health Facilities (public)	Provision of basic healthcare package
5	State Governments/Local Government Areas (LGAs)	Provision of counterpart funding, and technical support for project implementation and oversight
6	Beneficiary Communities	Mobilization of beneficiaries

Project implemented in the 6 Geopolitical zones: To ensure geographic equity in line with Nigeria's federal structure, efforts were made to ensure that focal states were selected from each of the 6 geopolitical zones of the country. The selection protocol did not take into consideration the disease burden or mortality rate in the selection of beneficiary states, considering that the findings of 2008 NDHS had shown that the North East and North West had the highest burden of maternal and child mortality.

Designed as a special intervention programme: The programme was conceptualized as a special intervention to address the high mortality among women and children by increasing access to MCH services through an exemption scheme. The benefit package for pregnant women covered services provided at primary care level, while complications were referred to secondary level. For under-5 children, the benefit package essentially covered primary care interventions with the exclusion of secondary care.

Publicly-owned health facilities Provided Services: Although NHIS uses both private and publicly-owned health facilities for the formal sector SHI program, only publicly-owned health facilities were used for the MCH program. A lot of the selected facilities were dilapidated and lacked essential equipment prior to the commencement of the project. Focal States delayed in meeting their obligations to renovate the selected facilities (PHCs and General Hospitals) - hence the decision to use part of the capitation to renovate and refurbish the facilities and purchase essential equipment and supplies.

Providers were paid through capitation and fee-for-service: The capitation was based on the actuarial cost of the benefit package provided under the scheme. Each pregnant woman enrolled in the program was expected to graduate 6-weeks post-partum, and a child graduates upon reaching his 5th birthday, although these rules were not strictly enforced in some circumstances. Payments were made to different states from November 2008 to September 2014. A total of 13,237,031,694.03 (thirteen billion, two hundred and thirty-seven million, thirty-one thousand and six hundred and ninety-four hundred Naira) was expended on the project by the NHIS using MDG funds. This amount does not include the investments by both the states and LGAs in the program.

Project helped improve uptake of MCH services: The improvement in the state of facilities and availability of services helped to increase the confidence and willingness of the communities to access essentials services at the primary health care facilities in beneficiary communities.
Although there were staffing issues, there were cases where some nurses and midwives who occupied administrative positions at the LGAs requested transfers back to PHCs.

Implementation challenges and lessons learnt

The study highlights the key lessons and implementation challenges which were identified by the respondents based on their experiences on the field and these have implications for both the revitalization of the program and scale-up of the project.

Top-down approach in design/ Inadequate Stakeholder Consultations: The manner and circumstances under which the program was conceptualized and managed did not give much room for inputs from sub-national level and beneficiaries of the project. Wider stakeholder consultation may likely have improved the design, and ensure synergy and alignment with similar interventions such as the MSS program which was also funded by OSSAP- MDG and was being implemented by NPHCDA during the same period as the NHIS-MCH program in some of the focal states

Lack of Political Support and Interference by State Governors: Use of political appointees instead of Commissioners of Health to manage the project interfered with project implementation in some States. Lack of political support from State Governors after initial enthusiasm was a major factor in the collapse of the project.

Corruption and Sharp Practices: There were also incidences of alleged corruption by some of the HMOs, who either over-registered the number of enrollees to raise the admin costs they got from NHIS. The use of fee-for-service as provider payment mechanism appeared to be a disincentive to

HMOs which retained the money or delayed referrals from primary to secondary facilities. Some respondents were of the view that NHIS could have purchased services directly from providers without using third parties like HMOs. There were incidences of delays in payment of providers by HMOs. However, HMOs helped to build the capacity of PHCs in fund management. Some HMOs were slow in approving/authorizing request for referrals for secondary care.

Non-payment of Counterpart Funding by States: State governments defaulted with payment of counterpart funding. Although the federal government continued to provide the grants to fund the project, the non-payment of counterpart funding by the beneficiary states inevitably led to the termination of the project by the federal government. Despite advocacy efforts by the top management of NHIS to state governors, their commitment did not change. The over-dependence of states on the funding from Federal Government affected the continuity and sustainability of project.

Public Finance Management Bottlenecks: The release of the grants from the federal government to the states also experienced some bottlenecks. The initial grant for the pilot was through statutory releases, which made it not subject to budgetary delays. However, subsequent releases from the federal government were through the annual budget appropriation by the National Assembly which has its peculiar challenges. The delays in release of the budget and the need to return unused funds by the 31st of December implied that funds earmarked for the project were inevitably returned back to the treasury. As the project was scaled-up from the initial pilot phase, the amount of money budgeted by the federal government reduced with time.

Data Quality Issues; The lack of baseline data was seen as a major flaw of the project design and there was no incorporation of operations/implementation research in the design which makes impact evaluation problematic. In addition, there were no research-uptake activities and no end of project dissemination was conducted to share the outcome/impact of the project and lessons learned to stakeholders. In addition, the lack of data on service utilization made monitoring of project impact and outcome problematic

Inadequate Skilled Manpower: The program unlike similar interventions like MSS or SURE-P MNCH did not recruit any new or additional health workers. Manpower was lacking in most places and there were health workers with low capacity to deliver the needed services in some facilities. Since health workers in the focal health facilities had to deliver the benefit packages, some facilities could not cope with the increased work load, although some ad-hoc staff were hired to provide non-clinical services.

Infrastructural Upgrades improved Service Delivery: At the commencement of the program, most of the health facilities lacked basic amenities and equipment needed to provide the basic package of services to be accessed by the beneficiaries. To address the infrastructural gaps, the capitation fees paid to facilities were used to bridge the gaps and upgrade of the facilities.

Centralized procurement found to be useful Centralized procurement in some states helped to standardize quality of drugs and commodities. Supplies to facilities in hard-to-reach areas were sources of challenge in some states.

Involve Communities to improve Ownership and Participation: There was lack of involvement of communities in the initial design of the programme, which inadvertently contributed to lack of ownership by communities. However, the communities supported the programme after initial skepticism as they saw that government was committed to delivering the services by providing the

needed resources. Some respondents think that involving the communities from the outset would have helped in getting their buy-in and ownership of the project:

Improvement in demand and utilization of MCH services at the facilities*:* The programme may have contributed to the reduction of mortality among pregnant women and children under-5 in the beneficiary communities but accessing this empirically might not be possible due to lack of baseline data on pattern and trend of utilization of services by beneficiaries.

Revitalization & Scale-up of Programme Desirable: Respondents unanimously supported the idea of using the BHCPF to revitalize/scale-up the MCH project.

POLICY RECOMMENDATIONS FOR RE-ACTIVATION AND SCALE-UP

Based on the findings from the study, the following recommendations have been proposed in line with the health systems building blocks.

Governance and Accountability

1. There should be legislation to back up the program to ensure that funds are appropriated and it is sustained.
2. Involve communities and key stakeholders in the design, implementation and monitoring of programs. Wide consultation and stakeholder engagement could help in building community ownership and participation.
3. States to ensure counterpart funding for projects are included in annual budgets to ensure predictability and availability of funds.
4. Use existing institutional frameworks and structures for project implementation and fund management for pro-poor programs rather than third parties such as HMOs.

Financing

1. The Basic Healthcare Provision Fund (BHCPF) should be used to reactivate and scale-up the Free MCH program.
2. Integrate Free MCH programs as part of exemption schemes or CBHI component of State Social Health Insurance Schemes as part of strategies to achieve universal risk protection through a state-wide pool.
3. Federal and State Governments should show commitment by providing adequate funding in a predictable and regular manner to reduce disruptions in service delivery and ensure continuity.
4. States to explore innovative financing strategies to raise more domestic resources to increase fiscal space for financing the Free MCH and similar SDGs- financial risk protection programs for achieving UHC
5. Removal of bottlenecks in the provider-payment mechanisms to ensure that health facilities are paid promptly and that guidelines and payments for referrals to higher levels of care are strictly followed and duly monitored.
6. Explore the possibility of introducing results-based financing in the payment of health facilities.
7. Program managers and implementers should adhere to public finance management guidelines and build capacity of heads of facilities on basic finance and accounting.

Human Resources for Health

1. Consider recruiting more health workers when planning/implementing the Free MCH program that targets a large number of beneficiaries and will lead to increased demand for MCH services.
2. Introduce some incentives to motivate and encourage health workers to improve their performance as well as handling additional work load.

3. Explore Innovative approaches to the delivery of care to maximize and increase the productivity of available human resources.
4. There should be continuous professional development and capacity building of health workers to deliver the approved package of care.
5. HMOs if used in the project should integrate capacity building of health workers in project management and related skills.

Health Management Information System

1. Registration and verification should be done concurrently using existing Health Management Information Systems, and strengthen them if weak rather than using external agents for registration of enrollees.
2. Use of harmonized Information Technology (IT) and biometrics system in the registration of enrollees to reduce errors and duplication of registration while ensuring that enrollees graduate out of the program as at when due.
3. Strengthen the HMIS for collection of routine data with results metrics and realistic set of indicators for tracking and measuring the performance of the program.

Service Delivery

1. Consider some form of incentives to communities to mobilize and sensitize community members to participate in the program.
2. Set-up a system that encourage health workers in admin positions at the LGA level to routinely participate in the provision of clinical services at the PHCs.
3. Incorporate secondary and tertiary facilities within project catchment areas in the design and implementation so as to ensure their cooperation and participation through mentoring and capacity building of primary care facilities.
4. Standard operating procedures to guide the delivery of benefit package by health workers at the primary care level.

Medicines and Technology

1. Harmonize the logistics and procurement management system and ensure drug purchases are done using stock forecasts to reduce the frequency of stock-outs.

Community participation and Ownership

1. Communities should be mobilized and adequately sensitized to understand their roles and responsibilities in the design and implementation of programs
2. Involve community members in the monitoring of projects
3. Involve the legislators (being representatives of the people) to ensure that adequate legislations and oversight are put in place for the sustainability of the programs.

Research for Health

1. Develop a strong implementation/operations research system to generate evidence for continuous improvement of the program
2. Incorporate impact evaluation in the project design.
3. Develop system for research uptake activities and use existing policy and institutional frameworks to disseminate research evidence to key stakeholders.

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