Improving Financial Access to Maternal, Newborn and Child Health Services for the Poor in Nigeria

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ACRONYMS/ABBREVIATIONS

AfHEA	African Health Economics and Policy Association
ANC	Antenatal Care
ARVs	Anti-retroviral drugs
ART	Anti-retroviral Therapy
CCTs	Conditional Cash Transfers
CIDA	Canadian International Development Agency
CLMS	Contraceptives Logistics Management System
CBHI	Community Based Health Insurance
CBHIS	Community Based Health Insurance Scheme
CPC	Central Planning Committee
CSOs	Civil Society Organizations
DFID	UK Department for International Development
DHS	Demographic and Health Survey
FHI360	Family Health International
FMOH	Federal Ministry of Health
FP	Family Planning
HHA/IHP+	Harmonization for Health in Africa/International Health Partnerships and other related initiatives
HPP	Health Policy Project
HMH	Honourable Minister for Health
HMOs	Health Maintenance Organizations
HSDP	Health Systems Development Project
IGR	Internally Generated Revenue
LGA	Local Government Area
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M& E	Monitoring and Evaluation
MHOs	Mutual Health Organizations
MNCH	Maternal Newborn and Child Health
MSA	Medical Savings Account
MSH	Management Sciences for Health
MSS	Midwives Service Scheme
NHA	National Health Accounts
NHIS	National Health Insurance Scheme
NPHCDA	National Primary Health Care Development Agency
NSHDP	National Strategic Health Development Plan
OBA	Output-Based Approach
OSSAP-MDGs	Office of the Senior Special Assistant to the President on MDGs
PATHS 2	Partnership for Transforming Health Systems
PBF	Performance-based Financing
PHC	Primary Health Care
PPP	Public-Private Partnership
RH	Reproductive Health
SPHCDA	State Primary Health Care Development Agency
SSHDP	State Strategic Health Development Plan
TBA	Traditional Birth Attendant
TSHIP	Targeted States High Impact Project
THE	Total Health Expenditure
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAT	Value Added Tax
WB	World Bank
WHO	World Health Organization

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1.0 EXECUTIVE SUMMARY

Health financing and equity were the main themes of the landmark national workshop on Improving Financial Access to Maternal, Newborn and Child Health (MNCH) Services for the Poor in Nigeria, held in November 2011 in Tinapa, Calabar. The conference brought together 255 experts from all 36 Nigerian states and the Federal Capital Territory, including high-level government officials, political leaders, health care managers and planners, health economists, insurance specialists, and media representatives. These experts discussed strategies to improve financial access to integrated Maternal Newborn and Child Health (MNCH) services, inclusive of Sexual and Reproductive Health interventions, towards achieving universal health coverage. Among the various strategies discussed during the meeting were the need for advocacy and policy changes, innovation in the design and implementation of health financing schemes, strengthening the social health insurance scheme in the country, and the needed collaboration with private sector health providers. The conference organizers included three federal agencies, the African Health Economics and Policy Association, four United Nations agencies, three donor countries, and five health projects. A complete list of sponsoring agencies and all conference materials and presentations are available on the conference website at: http://www.healthfinancenigeria.org.

The government and people of the Federal Republic of Nigeria alongside stakeholders within the health sector identify health financing as a key priority area towards strengthening the national health system and achieving universal health coverage. Concerted efforts demonstrate a commitment to learn and adopt new approaches, while reviewing implementation of existing strategies at national, federal, state and Local Government Area (LGA) levels.

The workshop for Nigerian actors on improving financial access to Maternal, Newborn, Child Health (MNCH) services, including Sexual and Reproductive Health (SRH), for the poor was agreed to by key government authorities and collaborating Harmonization for Health in Africa/International Health Partnerships and other related initiatives (HHA/IHP+) partners in furtherance of on-going efforts in the country. The workshop was designed to not only strengthen the knowledge base of federal and state governments, as well as the private sector on health care financing for the poor, but also to identify key interventions and draw lessons and best practices from national, regional and developing country perspectives to inform future programming in the country.

Having provided an overview of global progress towards universal health coverage by improving financial access, the current status in Nigeria was extensively discussed based on policy analysis with regards to health financing. Existing costing, budgetary and financial tracking tools and mechanisms that could be explored to further support policy analysis were equally discussed. Under the two major themes of "More Health for the Money" and "More Money for Health", efforts in innovative financing mechanisms, exemption schemes, domestic funding processes, social health insurance and private sector involvement were reviewed, with the identification of key drivers that would facilitate progress in an

efficient yet equitable manner. Dedicated sessions on improving funding for reproductive health/ family planning programmes explored avenues of ensuring adequate funding through evidence-based budgetary and appropriation processes, as well as strategies of utilizing available funds for the delivery of quality family planning (FP) services within integrated MNCH benefit packages.

The Nigerian Government, led by the Honourable Minister of Health, had in its delegation the Permanent Secretary and officers of the Federal Ministry of Health, the Executive Secretary and officers of the National Health Insurance Scheme (NHIS), as well as, the acting Executive Director and officers of the National Primary Health Care Development Agency (NPHCDA). Also in attendance was the Chairman of the Senate Committee on Health and members of the Senate and House Committees on health.

Participating also were, State Commissioners for health, Directors and officers from State Ministries of Health as well as, management and technical officers from development partner agencies – Canadian International Development Agency (CIDA), Department for International Development (DfID), Family Health International (FHI360), Health Policy Project (HPP), Management Sciences for Health (MSH), Partnership for Transforming Health Systems (PATHS 2), Targeted States High Impact Project (TSHIP), United Nations Population Fund (UNFPA), United Nations Children's Fund (UNICEF), United States Agency for International Development (USAID), World Bank (WB) and World Health Organization (WHO) – in addition to Civil Society Organizations operational in the health sector; all of who provided both policy and technical perspectives on the workshop theme.

During the workshop, insights on policy perspectives for improving financial access were highlighted and deliberated upon. Sharing of experience on best practices, lessons learnt and identification of key drivers extended beyond the Nigerian context and featured experts from international and regional levels, who contributed knowledge from developing countries within and outside the African region.

To achieve "More Health for Money", the workshop agreed that strong health systems are essential for improving access and delivering services at low cost to the society. To this end: Efficiency was noted as important and all actors are expected to identify measures to ensure value for money and equitable resource allocations are achieved in the health system. Detailed costing was underscored as a primary action to be undertaken as part of programme design, with sources of funding (at least in the medium term) clarified before commencement of implementation. Improved coordination of partners was noted as important, alongside intensified efforts to reduce corrupt practices and increase accountability. Results based monitoring and impact evaluation of all health programmes in the country were identified as critical with routine expenditure tracking at Facilities, LGAs, State and Federal Level included in HMIS indicator list. Equally, the workshop

encouraged sustained efforts by all stakeholders to get the National Health Bill signed into law.

Equally, to achieve "More Money for Health", it was proposed that: health professionals should build broad coalitions to lobby for at least 15% budgetary allocation to the health sector (meeting the Abuja declaration), while ensuring also the annual health budget provides at least $31.63 per person per year in line with the National Strategic Health Development Plan (NSHDP) cost estimates. A national framework to guide resource mobilization efforts is required in the country, inclusive of potential sources such as taxes, % of VAT, PPP, while encouraging national and state assembly members to use part of the constituency project funds to purchase insurance premiums for indigent constituents. Community-based health insurance was noted as very important for achieving universal coverage in Nigeria and was agreed to be pursued vigorously. Involvement of politicians in articulating strategies to address financing challenges in the health sector was encouraged, particularly the inclusion of universal health coverage with specific roles and responsibilities of all tiers of government in the revised national constitution. In addition, improved budget implementation targeted at implementation of high impact and cost effective interventions was noted as critical with progressive improvement in strengthening of transparency & accountability mechanisms within government institutions.

The knowledge and experiences generated through the workshop will be disseminated widely using various strategies, to ensure that the technical and policy deliverables from the workshop are used for evidence-based policy making, strategy formulation and guide implementation by the three tiers of government in Nigeria. The deliverables are therefore expected to contribute to improved design, planning, implementation, monitoring and evaluation of health financing strategies that would enhance access quality MNCH services by the poor, assist in meeting pro-poor indicators in the National and State Health Plans, and ultimately support Nigeria to achieve universal health coverage for MNCH services, including SRH.

2.0 BACKGROUND

Nigeria accounts for 2% of the world's population yet contributes 10% of global maternal mortality and, together with 5 other countries, bears 50% of the global child mortality burden. Out-of-pocket expenditure on health is high at about 70%, with almost half the population living below a dollar a day. High expenditure on health needs increases the vulnerability of the poor to slip further into poverty, with the impact on the poorest households likely to be more severe. Poverty analysis indicates that majority of the poorest households reside in the three Northern zones, an area where the health indicators are lagging behind. Adopting equitable health financing strategies that are sensitive to the needs of the poor, and the differential MDG progress in the country, is therefore critical.

The Nigerian government, being firmly committed to fast tracking progress towards the MDGs and other national development challenges, has developed a National Strategic Health Development Plan with corresponding federal and state plans, as well as signed the Health Country Compact on mutual accountability for measurable results with its development partners. The Health Plans acknowledge the need for health financing policies, strategies and mechanisms that are equitable and reflect commitments to increase the proportion of Nigerians in the bottom two quintiles that are covered by any risk-pooling mechanisms from present levels estimated at about 10% to 30% by 2015. This is in addition to reducing the percentage of out-of pocket expenditure for health from its current level of about 70% to less than 50% by 2015.

Current efforts by the government to address health financing challenges have included efforts to improve multi-year budgetary processes linked to strategic results and the recently passed National Health Bill by both chambers of the National Assembly which will ring-fence

additional resources from the consolidated fund of the federal level account. This fund will be targeted at scaling up primary health care services and extending national health insurance to all Nigerians, amongst other clarifications of statutory roles of the tiers of governance within the health sector. Also, the National Health Insurance Scheme, in partnership with the Office of the Senior Special Assistant to the President on MDGs, is implementing a maternal and child health exemption project targeting pregnant women and children under five years with primary health care services. Several states have equally launched free maternal and child health schemes with varied levels of coverage and benefit packages, while some community-type financing schemes and/or equity funds exist at various levels of implementation in some states.

In recognition of the aforementioned efforts, as well as the governance context, national health system and size of the country, the need to ensure continued commitment of federal, states and LGs to improve financial access to health services by Nigerians is considered critical, while promoting buy-in of the private sector and CSOs. Therefore, providing sustained and long-term technical assistance and creating platforms for cross learning amongst states, as well as, between national entities and regional/developing country initiatives are some of the agreed collaborative areas between the Nigerian government and its development partners.

It is also noteworthy that the Nigerian government has continued to engage in various national and international consultations in order to garner experiences and best practices towards improving financial access to quality MNCH services for the poor in the country. These have included study tours and visits to Ghana, Kenya, India, and Rwanda; participation of a country delegation at the HHA Regional Workshop on Financial Access for the Poor conducted for West and Central African countries in November 2010; as well as national and zonal consultations on Primary Health Care financing, to mention a few. The national workshop on improving financial access to MNCH services for the poor in Nigeria was therefore a further step to harness existing knowledge and draw from best practices to inform and further strengthen health financing policies and strategy implementation in Nigeria.

Objectives of the Workshop

The objectives of the workshop were to:

i. Foster inter-state sharing of experiences on health financing policies to improve health services for the poor and individuals without formal sector health insurance;
ii. Disseminate knowledge and evidence from implementation of health financing strategies that target the poor in African and other developing countries, which

have implications for Nigerian states;
iii. Document lessons learned and best practices (focusing on the how) and develop realistic and actionable technical recommendations to policy makers, private sector, CSOs and development partners (also related to the 'how'); and
iv. Initiate an inter-state learning platform that promotes knowledge sharing on implementation of health financing policies and strategies, which will be linked to institutional technical support.

Many country and state examples presented during the workshop showcased innovative measures to increase health service coverage, as well as promote equity and efficiency in resource use. All presentations made in the course of the workshop were selected based on the following principles:

i. Nigeria-specific initiatives and attempts at improving financial access for the poor to Maternal, Newborn and Child Health (MNCH) services, including SRH;
ii. Analytical pieces of work and discrete studies carried out at the country level that focus on MNCH services, including SRH;
iii. Considering the timing of the workshop, presentations sought to build on existing knowledge and evidence to improve implementation and/or inform new strategies;
iv. Showcased regional and international experiences on financing MNCH, including SRH services that are relevant to Nigeria and sub-Saharan Africa;
v. Featured areas that will get political traction and buy-in, i.e. building on what government can deliver in the immediate, short, medium and long-term; and
vi. Each area of work highlighted lessons learned, best practices, key drivers and limitations, as may be applicable.

Technical presentations were also organized within the workshop agenda to answer four main questions that target financing of Maternal, Newborn and Child Health, including SRH services and as articulated in the Nigeria National Strategic Health Development Plan (NSHDP) namely:

a. Current Status: *What is the current status of universal health coverage and financial access by the poor, particularly women and children in Nigeria today when compared to selected countries in Africa?*

b. More Health for the Money: *What can Nigeria do to use existing domestic and external funds more efficiently to achieve better health results?*

c. More Money for Health: *What can Nigeria do to mobilize additional resources for health in order to expand access to the poor and attain universal health coverage?*

d. Taking Action: *What actions needs to be taken by government actors and its stakeholders to improve efficiencies of existing funding and also mobilize additional resources in order to expand access for the poor and attain universal health coverage?*

The ensuing sections of the report provide descriptions, key drivers, potential challenges and recommendations for implementation in Nigeria.

3.0 IMPROVING FINANCIAL ACCESS TO MNCH SERVICES FOR THE POOR IN NIGERIA

In tracking the evolution of health financing systems, a general trend can be observed showing a decrease in out-of-pocket expenditure for health services at the point of use in favour of pooling mechanisms for pre-payment systems as country per capita GDP increases. Achieving universal health coverage by improving financial access has become a global target for health systems. However, this must be seen as a holistic process, where all components of the health system must be strengthened to achieve improved health outcomes.

Various strategies to improve financial access to health services for the poor have been tried in different countries, with consensus that no single mechanism can meet all countries' needs or all the financing needs of any given country. Each country must therefore develop a coordinated way of utilizing different strategies to meet the specific needs of target populations, particularly as international experience shows that integrated health financing systems perform better than fragmented ones.

Health Equity Funds (HEFs) constitute a demand-side financial mechanism to improve access to priority public health services for the poor. Available evidence suggests that HEF can effectively improve access to health services for the poor and protect them from the burden of health care costs. HEFs have been implemented in some developing countries, including Senegal and Cambodia. The Cambodia experience was donor-funded, however, the same approach can be implemented with domestic resources. On the other hand, the proposed Senegalese model involves a community-based insurance scheme as the execution agents, with state funding for free health care schemes of different kinds paid into a National Solidarity Fund that would fund the CBHI schemes to ensure the free provision of health care to specific target groups.

Progressive Universal Health Coverage is Achievable in Nigeria. The Government of Nigeria over the years has committed huge resources to improve access to health care services through various initiatives and schemes. Notwithstanding, the goal of achieving universal health coverage for the over 160 million population has remained elusive. However, evidence from some developing economies (such as India, Brazil, Mexico, and Rwanda) with similar socioeconomic indices show that progressive universal health coverage can be achieved with a minimum package of cost-effective and evidence-based interventions for the poor and vulnerable population groups. These countries have been able to improve universal health coverage through an integrated health financing strategy that combines different types of health insurance schemes with other supply and demand side interventions rather than a fragmented approach.

While free health care schemes are a common option for countries, sustainability remains a major concern. However, exemptions for specific groups can be useful as an equity intervention. Sierra Leone piloted a tax-funded free health care scheme and recorded challenges with drug shortages and refusal of health workers to relocate to rural areas, despite incentives provided. Many countries have tried to implement fee exemptions. However, in many cases there was no prior evidence-based design process, including costing and situation analysis studies, before adopting the policy. Recent assessments and evaluation reports indicate these schemes have resulted in unrealistic expectations from the schemes and, more often than not recorded poor performance.

There is also a growing interest in pooling mechanisms to purchase health services in many countries, especially social health insurance schemes, with Community-based health insurance schemes (CBHI) increasingly becoming important as they provide coverage for rural and informal sectors.

Medical Savings Account (MSA) is an account into which funds are contributed and used to pay for a variety of an individual's medical expenses, such as an insurance copayments or deductibles.

Medical Savings Accounts work best if implemented as part of a compulsory primary insurance scheme, otherwise the healthy are selectively attracted to join, which also leads to equity challenges. Cost reductions were observed with households having MSAs in South Africa, and these cost reductions rose as the age of beneficiaries increased.

Nigerian states may therefore wish to consider exploring a combination of Social health insurance (SHI) schemes and MSAs, as well as, *ensure that realistic* and *actionable* technical guidance, inclusive of cost analysis, are available to policy makers and programme managers.

3.1 CURRENT STATUS

What is the current status of universal health coverage and financial access by the poor, particularly women and children in Nigeria when compared to selected countries in Africa?

Informed by high out-of-pocket expenditures and poor health indices, Nigeria's health financing policy developed in 2006 as part of the Health Sector Reform Programme (2004 – 2007) included strategies which are still relevant for programming today. The health reform agenda provided a starting point for the country's push towards improving financial access for the poor and attaining universal health coverage. However, challenges have been encountered in the implementation of the health financing policy as there is still no legal/constitutional mandate for roles and responsibilities for health care delivery at each level of goverment., There is also poor investment and low public spending on health considering that health is not just a social issue, but also a part of the national economic and development agenda. Slow progress has been recorded in achieving universal health coverage, inclusive of establishing and strengthening social safety nets, as well as, developing prepayment schemes, including social health insurance. In addition, there is insufficient awareness about the potential impact of pre-payment financing schemes, which spread risk and pool funds, and there is very little action on issues of health care equity and financial protection.

To address these challenges, it is agreed that a constitutional amendment for health is required that will be binding at federal, state and LGA levels. In addition, clear action needs to be taken to strengthen institutional management and fiduciary systems that support the health system. There is need to identify, adapt and scale up financing schemes which have proven beneficial in pilot phases, inclusive of implementation of Social Health Insurance through the NHIS, community-based health care financing schemes to reach the informal sector and exploring public-private partnerships; all to ensure that there are no financial and physical barriers to accessing health care services. There is also a need to improve the use of evidence-based planning processes, such as the use of impact evaluations to inform policy and programming.

3.1.1 Policy analysis

Equity analysis of the National Strategic Health Development Plan: An equity analysis of the National Strategic Health Development Plan indicates that the Plan broadly addresses equity-related issues. The plan has an emphasis on Primary Health Care, which is more equitable than emphasizing secondary or tertiary care. The priority areas within the Plan include clear interventions to address inequity in geographic access to services, distribution of health workers including to remote and rural areas, and financial safety nets for poor and vulnerable groups.

There are, however, challenges in enhancing the influence of the equity content of the plan. While primary health care is less pro-rich than secondary or tertiary care, it is not always pro-poor in itself. Secondly, universal health coverage is most equitable after it has been fully achieved asthe roll-out phases for universal health coverage can actually produce *greater* inequity. These challenges can be addressed through a proactive strategy of progressive universalism that features a determination to ensure that the poor gain at least as much as the rich at every stage of the roadmap to universal health coverage. Specific efforts in this regard would be required by all stakeholders, and as guided by evidence.

Bottleneck analysis of Lagos State Strategic Health Development Plan: In Lagos State, a bottleneck analysis was carried out towards developing an investment case for health. This evolved from evidence-based advocacy to government to foster an understanding of the disparity between the rich and the poor in terms of use of basic health services, as well as, to know the needs of implementing health services with an equity focus, and ascertain resource requirements to achieve health-related MDGs. It identified the root causes of ANC bottlenecks as lack of financing for ANC outreach programmes, fees charged for other lab costs, non-financial costs to patients, human resource gaps for ANC services and Skilled Birth Attendance, coupled with low levels of return visits due to financial and non-financial barriers faced by women.

Considering that the health sector is often seen as a consumer of resources, not as an investment that benefits the broader economy, efforts to harness the entire economy towards improving access to health service are key. A key challenge noted in the state is that many health services are provided in the private sector but most service utilization data or interventions tracked are largely gathered from the public sector. It is therefore important to increase collaboration with the private sector in data reporting, paving the way for private sector-delivered interventions to complement public health sector services. Secondly, the lack of coordination between the federal and state governments needs to be addressed to ensure harmonization towards the same goals. While human resources in health (HRH) has been identified as a bottleneck, the challenges encountered by Lagos State was noted to be more of a HRH mal-distribution challenge and less of an absolute shortage in numbers of the skilled health workforce.

An equity perspective on the National Health Bill provisions: Looking at the Nigeria National Health Bill through an equity lens, it was noted that an attempt had been made to address equity concerns in health access for target populations. Two sections of the Bill dealt with equity provisions: a) the eligibility for user fee exemption to be decided by the Minister of Health and will include the range of health services that are exempt for categories of persons, and vulnerable groups; and b) the establishment of a Primary Health Care Fund to support provision of basic health services and drugs from 2% of the consolidated revenue funds of the federal level

account, serving as additional funding to the health sector.

However, challenges include the fact that the interventions cannot be effectively delivered only in the public sector facilities if the desired impact on health outcomes are to be achieved. There is also need to consider that the total health risk for the population cannot be solely financed through the PHC funds as provided in the Bill. In addition, the Bill makes provision for the PHC Fund to be utilised for providing services for all Nigerians, regardless of social status, which is not equitable. The PHC fund was therefore proposed to be considered as additional funding for health that can be used to target the poorest and vulnerable groups within the population. These therefore complement regular budgetary provisions by government.

Findings of primary health care financing stakeholder consultations: In exploring options for improved primary health care financing, the National Primary Health Care Development Agency conducted a series of consultations across the six geopolitical zones in Nigeria. These showed that communities have a strong desire to be involved in health financing policy development and implementation processes. A variety of options were selected by different zones, highlighting the fact that there is no single mechanism that suits all contexts. These included social health insurance, demand side interventions such as conditional cash transfers and voucher schemes, results-based financing targeting performance incentives for health providers, , and efficient use of resources at all levels.

Institutionalization of National Health Accounts in Kenya: Drawing from external experiences, Kenya's institutionalization of the National Health Accounts estimation was noted as a mechanism that was improving accountability in the health sector, while also providing powerful evidence for advocacy. Sustainability of data collection on health expenditure was achieved through integration with regular surveys like the Kenya Demographic and Health Surveys and the Kenya AIDS Integrated Survey (KAIS). The Kenya NHA had provided information to support negotiations with the Ministry of Finance for increased funds which led to achievements of greater predictability of the allocation of resources for health. However, there were some challenges reported as Kenya relies on externally funded staff and operational funds for the conduct of its NHA and still faces difficulty in obtaining expenditure data from private sector providers.

Considering the potential policy implications for Nigeria, it was agreed that increased efforts must be made to establish an evidence-based investment case for health when advocating to economic planners and policy makers, as well as in the processes of scaling up implementation of

health financing strategies. It is equally important that health financing strategies should be designed to address both demand- and supply-side barriers to accessing health care.

Improving Efficiency in the Allocation and Use of Health Resources (more health for money): In a bid to reduce wastage of resources and improve allocative and technical efficiency in the health sector, efforts should be made to ensure that resource allocations for essential health programs are evidence-based, through the institutionalization of MTEF and MTSS processes for budgeting at the federal and state levels. In addition, government and development partners are encouraged to explore the principles of Performance /Results-based Financing in the ensuring efficient use resources in health service delivery. Advocacy to states and/or strengthening such processes in the states are critical. To further ensure efficiency, efforts should also be made to institutionalize routine tracking of resources allocated to the health sector using a country-owned resource tracking system.

Costing and budgeting tools at the decentralized level

Various costing tools are readily available and have been used extensively in the health sector. Many of these were designed for use at national levels, but have been adapted to suit sub-national systems. The majority of the tools require a bottom-up or input approach to costing. A review of 13 major costing tools can be found on the website of the Partnership for Maternal, Newborn and Child Health, which indicates for each tool, a description, links to the tool download, technical documentation and user manuals, as well as, contact information for developers/focal persons. In addition, an interactive costing tool guide is available to assist in selection of the appropriate tool for the costing study. The tools reviewed can be found atwww.who.int/pmnch/topics/economics/costingtools, while the Interactive Costing Tool Guide can be found at http://apps.who.int/pmnch/topics/costingtool/.

3.2 MORE HEALTH FOR THE MONEY

What can Nigeria do to use existing domestic and external funds more efficiently to achieve better health results?

Good health at low cost in the face of scarce resource can be achieved by strategic resource allocation of funds through budgeting and appropriations, which reflect allocative and technical efficiencies and equity concerns. Nigeria is not a donor-dependent country with its vast resources; however, the health system is plagued by inefficiencies due to leakages, as well as inappropriate resource allocation and inadequate utilization of allocated funds. These challenges were noted at national and sub-national levels, i.e. state and LGA levels.

3.2.1 Innovative Financing Mechanisms

Performance-Based Financing in three states in Nigeria: In a bid to improve service quality, Adamawa, Ondo and Nasarawa States are piloting a Performance-Based Financing model with the aim of increasing service delivery of high-impact MNCH interventions at PHC facilities through the provisions of incentives for performance by health workers. The intervention is being piloted at three levels: (i) the health facility, where payments are made to individual facilities based on quantity and quality of services provided;; (ii) . at the Local Government Area, where disbursement of funds will be linked to specific outputs or outcomes that have been agreed between the state government and the LGA and these will be evaluated quarterly; and (iii) at the State level, where disbursement of funds will be linked to indicators agreed to between Federal Government and the state government. It is important to note that LGAs within the three states that are not implementing PBF will receive operational support and strengthened supervision which will not be conditional on quality and quantity of service provision.

To date, pre-analytical studies that have been conducted include an analysis of PHC performance in the three states, mapping of health facilities, political economy and institutional analysis to determine possible political issues, human resource study, public expenditure reviews, and financial management assessments.

The potential challenges include the effectiveness of the verification process to ascertain the quality and quantity of reported services. In addition, mechanisms to deal with potential demand-side barriers to health service utilization considering the PBF scheme's dependence on user fees need to be considered to achieve the desired impact. Concerns remain about the sustainability of the models, which are implemented based on a World Bank loan and do not appear to tackle any structural reform within the health system.

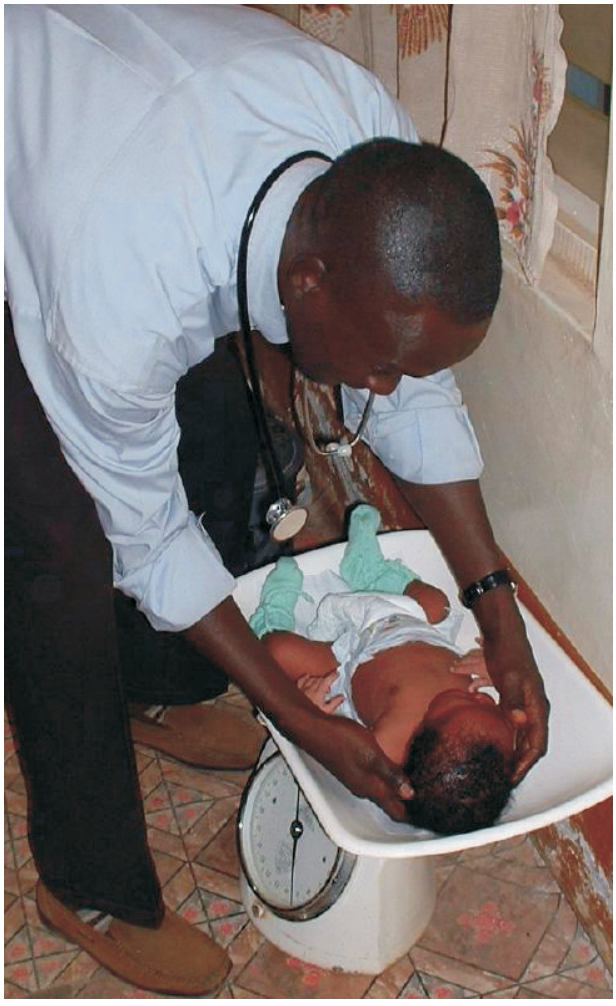
Equity funds in Kebbi State: In Kebbi State, an equity fund was established to provide access to care for poor women and children in Ambursa community. The equity fund was funded through contributions collected from mosques, town associations, membership contributions and philanthropic donations from individuals. A five-member committee was set up to manage the funds and to identify eligibility criteria for individuals and health initiatives to be supported. A total of about 1,200 women and children were recorded as beneficiaries, with utilization of ANC services increasing significantly from 2,400 visits in 2008 to more than 4,000 visits in 2010. Within the same period, routine immunization visits increased from 3,000 visits to more than 5,000 while utilization of facility deliveries and family planning services improved to a lesser degree. Additional midwives had been deployed to the primary health facility in the locality through the Midwives Service Scheme (MSS) to improve staffing.

Despite its self-starter efforts and successes, challenges facing the community scheme included dependence on voluntary contributions as the primary funding source, lack of a baseline assessment at the commencement of the scheme, non-systematic data collection processes to generate more evidence that demonstrates results, lack of performance incentives for personnel, and insufficient skilled manpower such as laboratory scientist, pharmacy technicians, etc. to provide integrated quality services that meet the increased demand. Other issues to consider include the systematic remuneration of committee members to prevent corruption and mechanisms to address moral hazard, to mention a few.

In order to improve the performance of the equity fund, the State should ensure that the technical capacity for managing the Fund is improved, the eligibility criteria clearly defined and more sustainable revenue streams identified to fund the implementation.

Zamfara State basket funding system for PHC services: Zamfara State created a basket fund which pooled different health revenue sources, in order to address the inadequate level of funding and delays in disbursement of existing funds, all of which were hitherto identified as major factors for the poor routine immunization service performance in the state.

The revenue breakdown for the basket fund was noted as follows: 70% from the 14 LGAs in the state, 20% from the State government, while the remaining 10% is generated from development partners. The State operates a central account for the fund which is managed by an account officer in the MoLG, and the 14 LGAs operate individual accounts in the same bank. To ensure that health officers are not solely in charge of managing the funds, joint responsibilities and signatories are held by the P.S or DPHC MOH; P.S or DPHC Ministry of Local Government (MoLG) and WHO State Coordinator representing development partners. The funds are primarily targeted towards routine immunization services, specifically vaccine distribution, generator and cold chain maintenance, outreach services, community mobilization, supportive supervision by State and LGA integrated teams, and data quality assessment. Supplemental immunization services are covered by the fund, specifically procurement of additional interventions or commodities and supervision by LGA teams and district heads. s well as Maternal health services are equally covered by the fund, specifically the provision of monthly allowances for midwives to carry out outreach ANC services, supervision and mobilization of communities.



Regular data quality audits are carried out, in addition to the establishment of a process for integrated supportive supervision in all the 14 LGAs and the state level. This has led to an improvement in field operations with vaccination rates with DPT coverage increasing from 40% in 2009 to more than 60% in 2011 alongside a decline in polio cases. There are still challenges with meeting financial guidelines of partners (which is tied to their continued contribution to the fund) and managing the expectations of stakeholders.

The NHIS/MDG Maternal and Child Health Scheme: The National Health Insurance Scheme has implemented an exemption scheme for Maternal and Child Health services for three years utilizing funds from the Debt Relief Gains. This has been implemented in 12 states over a two-phase period. The benefit package covers primary health services for children under 5 years of age, basic antenatal services, primary maternal health services and secondary care for pregnant women. Capitation fees were paid to Health Maintenance Organizations (HMOs) for Health Care Providers delivering primary care, while fee for service is paid for secondary care. The NHIS is responsible for the accreditation of facilities and quality assurance is a shared responsibility of the HMOs, NHIS, and the State MOH. Over 1.5 million women and children in 608 LGAs are enrolled with more than 1,200 facilities rehabilitated and equipped to provide quality health services under the scheme.

Several issues need to be considered in the scheme in order to improve its performance. There was no baseline assessment carried out prior to commencement of implementation, thereby making it difficult to measure improvement in service utilization and impact on health outcomes as a result of the scheme. The main source of funding for the scheme is the MDG-DRG funds which will possibly cease to exist in 2015. This raises issues of the sustainability of the scheme if left solely to state governments to fund. The exemption scheme addresses some demand-side constraints but does not address challenges related to human resources for the health facilities. However, the scheme creates an opportunity for synergy with other existing MCH programs and other health programs such as Midwives Services Scheme and Roll- back Malaria programme.

Free MNCH implementation in Jigawa State: Jigawa State introduced a policy to provide free maternal and child health services in the state in 2008. This was implemented through two schemes complementary to one another. Jigawa State runs a deferrals and exemption (D&E) scheme managed by the Gunduma Health Board. The State-run D&E scheme is implemented in 15 health facilities, including 12 secondary level hospitals. A local committee determines eligibility for deferrals and exemptions based on need. Health facilities submit invoices to the Gunduma Health System Board for reimbursement on a fee-for-service basis. The State spends NGN 11 Million per month on the D&E scheme. This activity has been included in the state budgets from 2009 to 2011.

In addition, the NHIS MDG exemption scheme for Maternal and Child Health services commenced in 2010 with 6 of the state's 27 LGAs, but an additional 7 LGAs have been included and the government of Jigawa State provides counterpart funding to the NHIS scheme**.** All health facilities within each LGA are included in the scheme. The coordination mechanism for the NHIS scheme comprises an Implementation Committee that manages the scheme and a Steering Committee that approves expenditures and appoints HMOs. An assessment carried out in mid-2011 indicated an increase in health facility visits from 1.9 million in 2009 to 2.7 million in 2010, a 17% increase in facility deliveries, and a 51% increase in ANC services utilization from 2009 to 2010.

Some challenges have been identified such as a wide variation in prescribed regimens/protocols despite having operating guidelines in the state. The Drug Revolving Fund needs to harmonize with the NHIS scheme, which is an important source of funding, otherwise it could become insolvent. The delayed payments from the State Free Program have contributed to insolvency issues with the Drug Revolving Fund because the DRF becomes depleted while awaiting reimbursement. In addition, reimbursement rates vary significantly and were not always appropriate. Other issues to consider in implementation include ensuring better coordination between the state MOH, NHIS, HMOs and the Gunduma Board state scheme, as well as, standardization of protocols, supervision, monitoring and evaluation to ensure adherence to existing guidelines.

Some measures to improve the performance of the schemes in Jigawa State include reviewing the reimbursement rates that reflect appropriate cost for services delivered and which take into account variation in cost of health services in the localities, as well as, the difference in cost between services for pregnant women and those for children under five years of age. A capacity assessment should be carried out for each health facility and the HMOs, and measures to build technical capacity to support the schemes should be implemented. There must be appropriate oversight of the HMOs within the NHIS scheme. Knowledge of the programs within the community needs to be improved. There is need to build in a framework for evaluation of the schemes and establish an ethics committee.

User fee retention at health facility level in Ethiopia: In Ethiopia, the government implemented a reform to retain user fees at health facility levels. Prior to the intervention, Ethiopia experienced a shortage of operational budgets, shortage of essential drugs, misallocation of funds, low participation of private sector, lack of protection mechanisms for the poor, and lack of risk pooling mechanisms. The reform process involved creating a health care and financing strategy, as well as, developing and adopting relevant legal frameworks. The components of the reform program were revenue retention and utilization at health facility level, while a fee waiver and exemption scheme was introduced requiring the involvement of communities in identifying poor people as beneficiaries. Establishment of governing boards, outsourcing of non-clinical services, and the establishment and operation of private wings in health facilities were also included in the framework. In addition, the national health insurance and community based health insurance were introduced in the reform process. Measures to improve financial management were introduced, including appointment of accountants; training of staff; establishment of accounting, auditing, and reporting systems; regular supportive supervision; involvement of all stake holders; and appointment of professional managers as chief executive officers of health facilities.

Following the implementation of the reform program, there was increased availability of essential drugs, increased operational budget, improved quality of services and service utilization, increased motivation of health workers and ownership, and improved management capacity.

3.2.2 Reproductive Health/Family Planning

Various options of achieving more efficient use of existing funds for Reproductive health programmes, inclusive of family health services were demonstrated..

Equity funds for family planning services in Ondo State: Ondo State piloted the Abiye program with support from the World Bank Health Systems Development Project (HSDP) funds using an

Equity Fund model to cover reproductive health services. The programme had been operational since 2009. The implementation strategies for the project included upgrading and equipping of health facilities, procurement of ambulances for referral services, training of Community Health Extension Workers (called health rangers) and equipping them with tricycle ambulance and essential delivery kits. In addition, toll-free phone numbers were provided for pregnant women to call when in distress and health workers in the facilities in the rural local government areas were given monetary incentives. It was noteworthy that traditional birth attendants were not included in the program. Some increase in service use has been observed for all health facility users, not just the target population of pregnant women. In addition, a reduced number of pregnancy related mortality was observed within the implementation areas since the commencement of the Abiye Project. The State Ministry of Health (SMOH) is advocating for legislative backing to ensure sustainability of the program.

However, there are human resource shortages in the health facilities, and conflict between various cadres of health workers was observed. Like many other programs, sustainability remains a challenge. Although Traditional Birth Attendants (TBAs) are not a part of the program, however, they considering that TBAs still provide services within the communities, streamlining their role in the community also poses a challenge. Furthermore, improved capacities in data management at the health facility level is required.

In order to address the shortage of human resources for health, advocacy is targeted at increasing the uptake in Schools of Midwifery and Nursing within the State with a mandatory one year service in the Abiye program by graduating midwives and nurses. The state government should consider the development of new guidelines and protocol to encourage task shifting in order to reduce the conflict between different cadres of health workers in the state. Other related interventions that can be integrated into the program should be considered, e.g. HIV services for prevention of mother-child transmission. To ensure sustainability of the program, the government is considering other health financing mechanisms such as a community health insurance scheme.

Getting research into policy and practice: To explore options of financing Reproductive health commodities and services, the Federal Ministry of Health commissioned three studies on an Ability-to-Pay (ATP), a Willingness-to-Pay (WTP), and a supply chain costing of the contraceptive logistics management system (CLMS). The key findings from the studies were that there was value placed on modern contraceptives across the country, with altruistic willingness to pay exhibited by wealthier quintiles to support increased access to RH services by poorer groups, thereby providing a platform for risk pooling mechanisms for family planning services. This provided one of the needed evidence to include family planning services in the revised benefit package for the National Health Insurance Scheme. Equally, the studies provided evidence that informed a review of the existing cost recovery system, which charged user fees at all levels for purchase of contraceptive commodities. At the service delivery point, data revealed that the three lowest quintiles could not afford fees for family planning services, and this resulted in the removal of user charges for contraceptive services in April 2011 by the Federal Government. To ensure the costs of ensuring procurement, warehousing and distribution to the point of use were met, the CLMS costing study provided data and information that is guiding investments by government and partners. Improved funding for Reproductive Health Commodity Security (RHCS) has also been recorded as the Federal Government for the first time in 2011 provided funding for the procurement of commodities.

Challenges include securing sustainable funding from government at all levels to ensure alternative funding to cover the operational costs of distribution hitherto obtained from cost recovery user fees for family planning commodities. There is also need for operational research to determine the impact of removing cost recovery fees to avoid any unintended consequences. In addition, other factors that constitute a barrier to service access should be identified and addressed using context-specific programmatic interventions, as the removal of financial barriers alone may not result in adequate increases in service utilization levels. The integration of in-country distribution of contraceptives with existing distribution systems for other maternal, newborn and child health (MNCH) commodities is essential towards achieving universal health coverage.

3.3 MORE MONEY FOR HEALTH

What can Nigeria do to mobilize additional resources for health in order to expand access to the poor and attain universal health coverage?

In Nigeria, primary health and secondary care levels are largely underfunded for the delivery of core high impact and cost-effective interventions, with WHO Statistics (2007) reporting Nigeria as spending less than 6% of her GDP on health against 9% in Rwanda, 10.3% in Botswana and, 16% in USA. Furthermore, the Nigeria National Health Account reveals that 74% of health spending is on curative care, while the health burden continue to arise from lack of quality preventive primary health care. The key question of re-allocating more resources to the PHC level arises as a major policy issue.

In general, concerted actions at all levels are required to focus on increased domestic fund allocation and improved efficiencies in health spending through improved budgetary, appropriation and release processes, as well as alignment of funds to prioritized interventions and programmes through innovative financing mechanisms such as CCTs, PBF/ RBF, equity funds, targeted ODA, etc.

Inadequate Resource Allocation to Health Sector

Resources allocated to the health sector are inadequate in meeting the healthcare needs of the citizens. Thus the need for advocacy to Federal and State Governments by health professionals has become imperative. This can be done through broad coalitions among the stakeholders to lobby for at least 15% budgetary allocation to the health sector (to meet Abuja declaration targets), especially for services targeted at the poor and vulnerable groups. In addition, the members of the Federal and States Legislatures could use part of their constituency projects funds to cover health insurance premium for their poor constituents especially within framework of Community-based health insurance (CBHI) which is important for achieving universal coverage

Three main sources to explore in the mobilization of additional resources for health were noted as Government, semi-public and external:

Potential Government sources were noted as increased Federal, State and Local Government budgetary allocations; allocation of a percentage of VAT and other earmarked taxes; passage into law of the National Health Bill which makes provision for a PHC fund with 2% of the consolidated federal revenue and adequate funding of SPHCDAs by the state. Domestic funding through the MDG Debt Relief Gains, which is expected to be in existence until 2015, is currently a major source of government funding and needs to be streamlined to needs in the health sector using results and/or needs based allocation formula.

Semi-public funds included contributory schemes such as Social Health Insurance for both formal and informal sectors secured through advocacy and contributions of formal and informal sector workers; as well as CBHI funds obtained from individual premium payments and subsidies from government .

External sources of funding generated from donors and development partners (national and international) are noted as additional funding sources and should be explored to meet financing gaps. External sources of funding to the health sector are known to contribute varying amounts of resources depending on whether the recipient country is donor dependent or not. For the period 2003 – 2005, development partners in Nigeria contributed 4% to Total Health Expenditure (THE); while for the same period 8% was reported in Bangladesh, 14.3% in Ghana and 36.1% in Kenya.

Private sector funds, best leveraged through public-private sector partnerships. The role of the private sector and civil society in the delivery of quality MNCH services makes public-private partnerships a key area for federal and state levels to harness.

3.3.1 Improved Domestic Funding

Budgetary processes, appropriation, and release to prioritized areas by Kaduna State: Statutory allocation to the health sector constituted about 73% of revenue for the state health sector. This was achieved using the Medium Term Sector Strategy (MTSS) approach to inform evidence-based budgets linked to the State Strategic Health Development Plan, while strengthened governance structures allowed the public health sector to secure quarterly release of funds in a timely manner. The Kaduna State example provides evidence in the viability of using the MTSS to align health sector budgets to strategic plans and secure increased funding for the health sector.

Case Study of a Voucher Scheme in Jharkhand, India; used in targeting resources to the poor. The scheme was set against a background of high maternal mortality, low contraceptive prevalence rate, high unmet need for family planning, and low access to antenatal services. The Equity Framework approach was adopted for this scheme and this emphasized engaging and empowering the poor; quantifying the level of inequality in healthcare use and health status and understanding the barriers to access in order to integrate equity goals, approaches, and indicators into national policies and plans. Targeting resources and efforts to the poor also included fostering public-private partnerships in support of advocacy dialogues on equity issues.

To achieve success, key drivers included involvement of the poor to understand the barriers to accessing FP/RH services and gaining

inputs on strategies to reduce the barriers. Others included carrying out poverty analysis to quantify the inequalities in accessing health services, using evidence in organizing policy dialogues with decision makers, and mobilizing advocates to action. Key barriers to health services were identified as poverty, high illiteracy rates, socio-cultural, religious and geographic barriers.

The demand-side constraints were addressed through the establishment of a voucher scheme that enabled access to health services, while empowering the population below the poverty line to choose their own health provider. Vouchers were distributed through NGOs and tcommunity volunteers to beneficiaries, who redeemed the vouchers at accredited health facilities. Facilities were then reimbursed for services provided on presentation of the vouchers to the Voucher Management agency. In addition, mobile medical units (MMUs) were established together with NGOs to increase access to services for the under-served and remote areas.

Use of disaggregated rural and urban datasets within Africa to quantify and analyze Health Equity: There are different ways to measure poverty using wealth quintiles, relative poverty, absolute poverty, geographic residence (urban and rural), ethnicity, and gender dimensions. The Demographic and Health Surveys serve as a good source of data for such analysis, from which data can be presented in different ways. Considering the Nigerian context of husbands having many wives and children within one household, the application of wealth quintile indicators require further thought. Likewise, the use of social determinants of health beyond core health indicators to inform resource allocation should also be considered. Despite differentiations of

urban-rural poor populations, it is noted that a rural population can be wealthy but yet lack access to quality health care. In measuring poverty in Nigeria therefore, beyond using quintiles as a fifth of the population, it is recommended to also reflect poverty measures as either relative poverty *(which ranks* people within the same country or region, i.e. Group A is poorer/less poor than Group B with the limitation of not knowing by how much) or Absolute poverty (which quantifies absolute income or expenditures and compares population across the country against a standardized national poverty line such as $1/day, $2/day). A consideration of the inequality index termed gini coefficient for Nigeria at 0.49 indicating income inequality within the population should be considered in targeting resources; particularly the fact that 20% of the population is said to control 65% of the country's resources.

Long term successes in addressing health equity need to be supported by improved poverty and literacy rates, addressing physical/geographic, socio-cultural and religion barriers, to mention a few.

3.3.2 Social Health Insurance

The design and experience of the Ghana Health Insurance Scheme (GHIS) and Its Lessons for Nigeria: With 47.7% coverage of persons under 18 years and 31.8% of the informal sector, the Ghana Health Insurance Scheme is noted to be making progress. The key drivers for the GHIS were legislation on mandatory health insurance in the country in order to achieve universal health coverage, which includes provisions for pro-poor health financing funded from VAT and similar taxes. The legislation on the National Health Insurance Scheme was also amended to collect contributions from the social security agency for the formal sector. The political commitment and unitary system of governance contributed to the success of the Ghanaian Health Insurance Scheme, as the equity issues addressed through exemptions were politically motivated by the Government to score political points in fulfillment of a campaign promise to eliminate out-of-pocket expenditure for health.

Household out-of-pocket payment constituted the major financing mechanism in Ghana before the introduction of the National Health Insurance Council (NHIC). The introduction of NHIC was preceded by an extensive pilot of the Mutual model for more than 10 years, and the experience gathered from the pilots formed the basis for setting up the Ghana Health Insurance Scheme. The GHIS authorized the District Mutual Health Insurance Scheme (DMHIS), the Private Mutuals and the Private Commercial Insurance with only the DMHIS being subsidized. These policies led to the gradual death of the latter two models. Funding for the programme is secured from 2.5% of VAT, 2.5% of social security contribution, and premiums from the informal sector, which is between US$5 to $33 per person.. In a given year,

Social Health Insurance Schemes Operational in the Nigerian States: Available evidence from some of the papers presented show that various types of social health insurance schemes are being implemented in some Nigerian states to improve financial access to health services for the poor and vulnerable groups such as pregnant women and children. Though most of the schemes have been implemented as pilot projects with no legislative backing or policy framework, they have helped to improve access to essential health care for the target population. While the emergence of these schemes is commendable, existing country experiences indicate that efforts to inform design and implementation with evidence based data and information is important.

2008, it was noted that 69.5% of the funds was mobilized from VAT insurance levies, 23.2% from social security membership contributions, 5.1% from the non-exempt informal sector insurance premiums and 2.2% of investment income. In comparism with subscribers data, the largest beneficiary groups were individuals under 18years accounting for 47.7%, followed by the non-exempt formal sector group constituting 31.8% of the enrollees..

The target populations for exemptions are persons under the age of 18 years, the elderly, pensioners, pregnant women and the poor. The benefit package consists of comprehensive primary and secondary services covering ambulatory care, hospitalizations, surgery and diagnostics, with some exclusion such as acute renal failure, dialysis, ARVs and other services covered by vertical programs. Addressing emergency cases within the GHIS is done through co-payments at service delivery and waivers for exempted populations. Evidence has demonstrated that a greater proportion of the wealthiest quintile are covered under the Ghana NHIS when compared to the lowest and within the same quintile, with those having insurance cover possessing easier access to health care than the uninsured.

The Insurance scheme is managed by the National Health Insurance Council, which has two agencies. The National Health Insurance Authority responsible for revenue and expenditure (i.e. pooling and purchasing functions) to ensure available funding for the scheme. It is also charged with supervision and oversight functions which regulate the DMHIS teams that undertake registration of beneficiaries. The DMHIS are firms with financial guarantees, chaired by elected boards with dedicated management staff day-to-day operations of the scheme (promotion, recovery of dues, etc.). The National Insurance Fund manages resources from taxes and social security fund. The GHIS has a strong monitoring and evaluation component undertaken by the regulatory National Health Insurance Authority with continuous adaptations to track provider payment methods and mechanisms, quality of services, etc.

The linkages between CBHI and NHIS can be seen within the Ghanaian context which had a rapid growth of Mutual Health Organizations (MHOs) before 2004, with different models comprising of districts, trade unions, women, student, villages, etc. With the advent of NHIS established by the NHIS Act of 2003, a policy decision was made to support only District MHOs supported by NHIS, with the CBHI providing a base for growth. The Ghana experience provides Nigeria with an example of including an innovative financing mechanism through the VAT levy into a social health insurance scheme. Equity considerations should enhance the features of the insurance scheme with cross subsidies and pooling between the formal and informal sectors being explored. A strong CBHI base ensures greater coverage for a national NHIS scheme. In the situation that a country has social security contributions for the formal sector, a potential opportunity would be to explore the convergence between the Social Security Organization and the NHIS.

Potential lessons for Nigeria include securing the needed political commitment, ensuring design issues are clarified including determining the benefit package and geographic coverage, while pursuing innovative fund mobilization with equity enhancing features and strategic mobilization of rural communities.. Potential revenue sources in Nigeria could also include mobile telephone recharge card levies and strengthened microfinance policies that will increase the ability of Nigerians to pay premiums within prepayment schemes. To complement existing obligations from government, there is need for laws to strengthen the LGAs to fund

primary health care in addition to ensuring availability of human resources for health in the rural areas.

Community Based Health Insurance Scheme (CBHIS) in Kwara State: the experience of a Health Maintenance Organization (HMO) operational since 2007 was shared. With 55,807 enrollees that pay Naira 300 per annum as premium and supported with donor funding subsidy, the scheme continues to create a grassroots movements that entrenches community health insurance as a way of life in the served communities. Having established the willingness of the served communities to pre-pay for services thereby reducing financial risk, the CBHI scheme has made progress in improving delivery of quality health services.

The HMO is responsible for ensuring the quality of health care services and has responsibility to educate beneficiaries and providers about the scheme and health care issues. The benefit package covers inpatient and outpatient care, hospital care and admissions, specialist consultation, provision of prescribed drugs and pharmaceutical care, laboratory and diagnostic tests, radiology, and treatment of HIV/AIDS, malaria and Tuberculosis (TB).

Renewal rates ranged from 47% to 73%, with dropout rates resulting from migration. The increased network of providers is comprised of public and private health facilities - 10 primary care hospitals, of which 3 are private entities, and 2 secondary care/referral hospitals, of which 1 is private. Independent M&E systems were instituted to ensure quality improvements. The Kwara CBHI also faces challenges including below-target enrolment, low ability to pay token co-premiums, inadequate staffing of providers, and sub-optimal quality of service.

CBHIS provides a framework to mainstream vertical donor programs as it can be adopted to achieve universal health coverage. Key drivers highlighted include community involvement, intensive marketing activities for the schemes, and close monitoring of the CBHI. Efforts to improve the scheme include modifying the pricing for premiums to reflect disease prevalence. Also, poverty assessment studies to determine target populations and a willingness-to-pay study to inform the premium should be conducted.

Co-existence of Rwanda Health Insurance scheme, Community based health insurance and Performance based financing: The evolution of the Rwandan Health Insurance Scheme was based on the need to improve health indices and eliminate financial barriers to accessing health care services. Three basic schemes targeting the formal sector, informal sector and the military were developed, and risk pooling was planned at two levels - district and provincial - with cross subsidization from the formal sector and military programmes into the informal programme. Equally, the reasons to start CBHI in Rwanda emerged from low utilisation of health services following the 1994 genocide, as health centres faced financial losses due to unpaid bills, and there was a felt need for a social protection scheme targeting the poor and the informal sector. Pilot studies based on the mutual model were conducted for 4 years, with evidence-based reports emerging from evaluations indicating an improvement in health indices with the exception of poor uptake of ANC services and poor quality of service. This led to the development of a performance based financing (PBF) strategy at the facility to provide incentives to health workers to increase performance and improve the quality of services.

As a result of both schemes, 95% of Rwandans are enrolled and accessing care, and OPD utilization rates have increased significantly. In addition, there has been a progressive increase in ANC visits and about 78% of deliveries are assisted by skilled health workers, with family planning service utilization almost doubled between 2001 and 2004. However, the quality of services is doubtful, as they have not been measured and late ANC bookings are still observed. Success factors, especially in the policy area, were the leadership and commitment at all levels of the administration (including a "performance contract" between Présidence and District authorities). Others include making health insurance compulsory with a legislative backing; decentralization of a management structure for the CBHI down to the district level where local administrations promote CBHI; institution of strong operations research to show results of CBHI and the PBF schemes; and strong backing by donors contributing 30% of the costs of CBHI. There are concerns about the sustainability of the schemes with the high dependence on donor funding. In addition, the strong government drive means that the scheme lacks community participation and ownership.

Considering the emergence of PBF and CBHIS in Nigeria, there is potential for co-existence between CBHI and PBF, with the need for states to have a strong CBHI base at the community levels and political commitment at all levels. It is noted that in Rwanda, the political commitment, unitary system of governance and high level of social control at the local level were key drivers that contributed to the success story of the co-existence of the Rwandan Health Insurance

Adoption and Roll-out of Community-based Health Insurance: Building on the general consensus by delegates on the need to roll-out CBHIS in the states, efforts should be made by the government and development partners to provide technical and other needed support to states that show willingness and political commitment to roll-out such schemes in their domain. The federal and state governments, under the coordination of the NHIS and in collaboration with development partners, should develop a comprehensive action plan that will incorporate the different models that are applicable within the Nigerian context. And in states where CBHIS have been piloted, efforts need to be made to scale-up the schemes to cover a wider segment of the population.

Scheme, CBHI and PBF financing strategies. In addition, just as Rwanda utilized a decentralized administration in its scheme, it is recommended that Nigeria use the Local Government Administration to support CBHI.

It was noted that demand side interventions at the community level should not be made compulsory so that it is not perceived as coercive actions by government. FP services for example should be introduced/promoted as an integral part of a benefit package of maternal, newborn and child health services, so that women see the benefit of child spacing in improving maternal health outcomes and make appropriate choices for suitable methods.

Integration of CBHI in Mali's National Health Insurance Policy: The Malian government adopted a financial risk protection framework in 2009 with three pillars: a) a national health insurance system for the formal sector; b) a national "health assistance" system for the poor; and c) a nationwide CBHI system for the informal sector. Following a study tour to Rwanda, the Mali CBHI national strategy was drafted and a pilot was planned in three regions over three years. The pilot targeted 150 counties in 21 districts and the beneficiaries constituted 40 % of the target population. Premiums were co-paid by the beneficiaries and the government to ensure that equity concerns are addressed. The subsidy became necessary due to the weak contributory capacity of the population. Each county had a Health Management Organization that managed premiums and handled negotiations with the health centres. District-level CBHI networks in the 21 districts handled co-payments from

government and negotiated payment modalities with hospitals. Coordination and monitoring was effected by the Ministry of Social Welfare through its regional and district-level offices.

Key drivers are the involvement of high-level decision makers in order that support implementation of CBHI strategies developed by technical experts. Government commitment creates an enabling environment and ensures available technical assistance at national and district levels which supports individual schemes, and improves monitoring systems to manage risks and address quality of care issues. CBHI is noted as the only insurance model that can effectively reach informal/community sector in Africa increase utilisation of health services and reduce financial risks of accessing health care. When managed well, CBHI promotes good governance and creates a channel to subsidize demand for health services.

Across all the SHI and/or CBHIS schemes, a reoccurring challenge is the inability and/or unwillingness of communities to pay certain amounts of premium, largely arising from lack of trust for government sponsored projects and competing priorities. Including provider payment mechanisms such as DRGs (Diagnostics Related Groups) as a means of controlling reimbursements could also be a challenge, as it requires a robust implementation and monitoring system. At policy levels, ensuring long term sustainability is a key challenge, considering frequent political changes at national and sub-national levels.

.3.3.3 Reproductive Health/Family Planning

To mobilize additional funding for Reproductive health services, family planning inclusive, regional and international experiences were provided.

Promoting Access to FP/RH Services in Kenya Using the Output-Based Approach: The output based approach targets services including: safe motherhood (ANC, delivery, post delivery care), family planning, and treatment for victims of gender-based violence (GBV). It targets poor women aged 15-49 within 3 districts (2 urban and 1 rural) and uses government, private, and FBO health providers. Using asset-based tools to determine poverty levels and inform targeting, OBA has a high potential to reduce neonatal and maternal mortality; while encouraging service providers to invest in services that are priority to the community. OBA encourages provision of high-quality services and competition amongst providers. Subsidized vouchers are provided to clients to allow them to receive a defined benefits package (US$19-350). The design and structure of the scheme include a Steering Committee and Advisory Board, a Voucher management agency charged with design, marketing, M&E, and reimbursement based on outputs.

The OBA system recorded high acceptance of safe motherhood vouchers and varied levels of acceptance for FP vouchers offeref for the long-term methods. There were however frequent stock-outs, unrealistic targets and lack of awareness, as well as low uptake of services for GBV victims due to socio-cultural factors and limited community involvement. The OBA achieved better performance in reaching the poor within urban areas. Cost analysis of the OBA revealed that more than 50% of expenditure made was for service delivery, 13% on management and monitoring, with 8% for operations. Other success factors include the demand-side focus, as well as using OBA as complementary to the national social health insurance. Performance incentives can therefore be a health system strengthening strategy if conceptualized well.

Challenges reported with the OBA system include weak fraud control measures to guard against

Public-Private Partnerships for Health Financing – Experiences from Sub-Saharan Africa: Existing myths about the private sector in Nigeria indicate that health is financed primarily by the public sector, while the reality is that 70% of health is funded out-of-pocket by individuals with the private health sector serving a significant proportion of the population in Nigeria. It is important to note that majority of private health sector is for-profit, representing about 20% of total health facilities. The Private health sector is comprised of informal and formal private health sector, as well as, health product manufacturers, distributors, pharmacies, chemists, patent medicine vendors, etc. Financing strategies known to advance under PPP models include health insurance, community based financing schemes, vouchers and subsidies, and tax exemptions, to mention a few. Depending on the scope, a public-private partnership (PPP) can help expand the pool of human and financial resources towards achieving universal health coverage. PPP allows the public sector to focus on areas most in need. To pursue PPP models, regulation (licensing, accreditation and certification) and contracting (leasing and management contracts, concessions, divestitures, performance-based remuneration) are key areas that need to be agreed upon.

African country examples provided some possible options for PPP:

PHC level care: In Mozambique, the MOH contracted Village Reach (a private entity) to establish an immunization support system for rural health centers in Cabo Delgado in its Nampula province.. A population of 5.2 million were served through 261 health centers led to an increase in Immunization coverage from 69% to 95%; Vaccine stockouts were reduced from 80% to 1%, with cost savings of approximately 25% for the MOH. This led to a national adoption of PPP policy.

Secondary care: In Lesotho, the MOH and Netcare collaborated on the construction & management of a 400 bed hospital and two satellite clinics. A partial risk guarantee was agreed to through a unitary payment scheme over 17 years. This resulted in effective and efficient management services within the hospital.

Specialized care: In Nigeria, a formal agreement exists between the Lagos state government and St. Nicholas Hospital (a private entity) which has led to improved kidney transplant services for public sector clients.

Maintenance: In Nigeria, VAMED and the Federal Ministry of Health have an agreement for equipping and maintenance of specialized hospital equipment in selected teaching hospitals and federal medical centers.

To harness the potential of the private health sector, strong MOH leadership, clear MOH roles and a favorable policy environment are required with a deliberate attempt to engage the private sector in a systematic manner. Considering the lack of trust between the public and private sectors, especially with government being suspicious of private sector profit motives, there is need for constant dialogue and information sharing between sectors. Also, as the private sector is diverse, heterogeneous and fragmented, government is required to play a leadership role to regulate PPP models using established and clear policy frameworks, including standards of care

diversions, false reimbursement claims, determination of eligible clients, weak institutional structures, and weak capacities to conduct initial cost analysis.

Increasing Access to Family Planning by Targeting Resources to the Poor in Peru: In 1995, the MOH was mandated to provide free FP for all men and women of reproductive age resulting in an increase in the contraceptive prevalence rate (CPR) from 20 of married women to 30% by 2003. Considering the high reliance on donor funding, the withdrawal of such funds led to an initial creation of a budget line item for FP by government. This was followed by reduced levels of government funding leading to insufficient budgets and frequent stock-outs of commodities with public sector clients going to private facilities which then became over-burdened. There were also operational barriers, lack of information and counselling services, especially among indigenous women. All these difficulties led to efforts to increase targeted resources for family planning services.

Using a pilot project in two different areas of one region, focus group discussionsand interviews were conducted with poor women and men, health care providers and local authorities. Three strategies were developed to address the barriers in accessing FP services. The CCT Program (Local Funds) identified poor women who received cash payments to encourage utilization of health services. Counselling guides were created and groups were formed to help inform indigenous women about FP in their own language, and in a culturally appropriate way. Within one year, the number of people attending these groups doubled, training of trainer sessions were provided and the training information was put on a website for everyone to access. At the regional level, Regional funds were targeted to support the development of a training course on proposal writing, which enabled regional health offices to

obtain grants. Social Insurance (National Level) covered pregnant women and children under age 5 as part of an initiative to reach the MDGs. These schemes were initially providing MCH services with no FP services; however, using data helped in making an investment case to policy makers of additional benefits in including FP services and the impact on health outcomes. The three funding channels for health care in Peru now include FP specific funding i.e. the CCT Program (Local Funds), Regional Funds and National Social Insurance.

The importance of data during advocacy for support and funds, engaging local people, targeting the poor using community committees and ensuring they receive quality care through effective M&E are some of the key drivers for the Peru system. Others are the use of combined DHS/RHS data with house visits by social workers for the social insurance scheme.

3.4 TAKING ACTION

The roles and responsibilities of all stakeholders were recognized and critical actions were proposed to be taken to expand access to the poor in Nigeria and attain Universal Health Coverage for MNCH Services. This section details commitments and recommended actions, as well as policy perspectives to guide future actions.

3.4.1 Stakeholder Commitments

Federal Ministry of Health(FMOH)
FMOH acknowledged best practices and success stories of design and implementation of health financing strategies within and outside Nigeria, which target the poor and thereby improving access to MNCH services.. Valuable lessons were learnt that would lead to innovations in Nigeria's healthcare financing policies, strategy formulation, planning, implementation, monitoring and evaluation. Greater focus would be placed on equity, effectiveness, efficiency and sustainability as the country strives to achieve universal health coverage. FMOH re-iterated Nigeria's commitment to increase funding for health, particularly for the delivery of high impact and cost effective interventions. It was noted that the Nigerian President had included the Federal Ministers of Health as part of the National Economic Team; and in line with decisions of the High Level Panel on Health Financing at the 4th Joint Annual Meeting of the African Union Ministers of Economy/Finance and Health held in March 2011, Nigeria was intensifying its efforts to strengthen delivery of key interventions such as childhood immunization, family planning, antenatal care, skilled birth attendance, emergency obstetric and newborn care as strategies to reduce mortality and morbidity in sub-Saharan Africa by 2015.

National Health Insurance Scheme (NHIS)
Recalled its inception and pilot phases arising from a political decision to provide social health insurance cover to Nigerians.. NHIS re-affirmed its committed to serve as a regulator to ensure that all actors involved in social health insurance deliver services to enrolled beneficiaries. NHIS equally committed to improving financial access by the poor to services targeted at MDGs 4 & 5. In addition to its NHIS/MDG MCH project in 12 states, NHIS informed of its efforts to commence the Community Based Health Insurance Scheme guided by lessons learnt from its pilots and informed by the CBHIS blueprint and implementation manual which reflect 3 different models. NHIS solicited buy-in from political leaders at federal, state and local government levels to support social health insurance as a strategy to reduce financial barriers to quality health care services.

National Primary Health Care Development Agency (NPHCDA)
Committed to ensure good primary health care for

all Nigerians. NPHCDA recognized that innovations and reforms are necessary to strengthening PHC services and thereby improve maternal, newborn and child health outcomes. As part of the efforts to achieve "More health for the money", NPHCDA in collaboration with the World Bank is conducting a pilot of results-based financing approach in selected LGAs in three states to incentivize health service providers at facility level to improve service delivery, while also strengthening institutional performance at LGA and state levels. With this approach, the agency seeks to demonstrate that public resources can be effectively leveraged through strategic use of Performance Based Financing and ultimately, increase utilization of high impact MNCH interventions at PHC facilities. NPHCDA is also committed to ensuring equitable access to health services and shall ensure targeting of vulnerable populations as part of its efforts to achieve universal health coverage at PHC level. NPHCDA will continue to explore additional innovative financing mechanisms targeting demand side interventions, specifically conditional cash transfers using funding from the Subsidy Reinvestment and Empowerment Programme (SURE-P) to increase access to primary health care services.

Senate and House Committees on Health

Legislators, said to be representatives of the citizenry, the poor inclusive, were pleased with the recognition of parliamentary roles within efforts to improve financial access to MNCH services for the poor. The parliamentarians noted the meeting had the potential of providing evidence and facilitating cross learning to improve health indices in the country including attainment of the MDGs in shortest possible time. The parliamentarians indicated a willingness to

further discuss improved ways of financing health services for the poor in Nigeria with a commitment to observe and participate actively in the workshop, as well as to inform future legislative functions with the knowledge and experiences gathered, especially towards ensuring that emerging policies and actions have the necessary legislative backing.

State Governments
The state representatives acknowledged the difficulties encountered by the poor in seeking health services and urged timely implementation of the National and State Strategic Health Development Plans, inclusive of the review and evaluation components. Health insurance was noted as a strategic and viable strategy for improving access to health care services. State governments committed to providing free health care services to all pregnant women and children under age 5 and enacting laws to improve Primary Health Care services, with a focus on interventions that would assist the country achieve the health MDGs. The states also committed to implement equitable health policies by ensuring health care services are affordable and available.

Development Partners for Health
Partners re-iterated commitments to provide coordinated assistance to the government and people of Nigeria at all levels, inclusive of support to the design, implementation, monitoring and evaluation of effective, efficient and equitable health financing strategies. Commendations were extended to the Nigerian government for convening the forum of policy makers, technical officers, academicians, researchers, civil society and development partners to learn from home-grown examples, as well as relevant regional and international experiences on improving financial access, a first of its kind in the country.

3.4.2 Policy Perspectives

Recognizing the critical role of policy level actors in improving financial access to MNCH for the poor in Nigeria, a policy round table was convened with the Nigerian Minister of Health, Commissioners of Health (i.e. Heads of State Ministries of Health), as well as Parliamentarians at national and state levels to discuss pertinent issues. The ensuing section highlights key perspectives expressed.

Ministerial level
Inclusion of health on the concurrent list within the scheduled constitutional review by the National Assembly: In 1999 constitution, health was not mentioned in the concurrent list and there are on-going efforts involving the President and the National Assembly in order to introduce same for consideration in the current constitutional review.

Signing of the National Health Bill into law for implementation: The National Bill which had been passed by both houses of the National Assembly was awaiting Presidential assent. It was noted that the on-going process had included facilitated meetings with relevant groups and the Federal Ministry of Finance.

Revision of the National Health Policy and its health financing policy: a review of the existing National Health Policy with its Health Financing Policy will be carried out within the context of on-going implementation of Nigeria's Economic Transformation Blueprint "Vision 20 2020" and the National Strategic Health Development Plan. As part of the way forward equity, efficiency, and sustainability will serve as key terms as Nigeria strives to achieve universal access.

Actions taken to prevent stock-outs of adequate quantities and timely availability of health commodities and supplies to ensure quality MNCH services nationwide: the significance of accurate and timely data for forecasting needs cannot be

overemphasized. Improvements in developing evidence based budgets in collaboration with the Federal Ministry of Finance and the National Assembly to ensure high impact cost effective interventions are budgeted for and funded is important. An example of the newly created budget line for Contraceptives in the FMOH budget and increased funding for routine immunization, both informed by evidence-based forecasting and costing were cited as improvements in budgeting for priority interventions.

Health Commissioners

Policies and strategies developed to ensure out-of-pocket expenditures (OOPE) for healthcare are reduced from its current high levels: Fee exemption schemes in public health facilities for pregnant women and children under 5; investments in rural hospitals to expand coverage of free maternal and child health services, scaling up of preventive services through community health workers, to mention a few would be pursued.

Achieving improved health outcomes using available resources in the health sector: All states acknowledge that the health systems, particularly PHC services needs to improve and the fact that though most states have specific PHC strategies, there are many other vertical programs that are competing for limited funds. Weak M&E systems do not provide the required data to inform targeting. The role of LGAs in funding and monitoring PHC services needs to be strengthened, with the recognition that funding for PHC staff salaries and general budgetary allocations for LGAs seem to be improving in some states. The need to harness such funds was noted as critical.

Actions taken to prevent stock-outs of adequate quantities and timely availability of health commodities and supplies to ensure quality MNCH services nationwide: Supply Chain Management System needs to improve, with clearly defined roles for the management of the procurement and distribution systems for essential drugs, supplies and contraceptive commodities. The role of Drug Revolving Fund (DRF) and NHIS also needs to be clarified within this context.

Limited State involvement in the NHIS with pooling of health risks and resources to ensure universal health coverage: a coordinated national health program can provide good health care if managed well. However, with only four states participating in the formal sector scheme, it could indicate lack of understanding on the benefits of collaborating with NHIS. The way forward would be to create further awareness, particularly the need to create large pools including trade union, civil servants, religious groups, market groups, etc.

Parliamentarians

Bridging the communication gap between senior government officials in the executive arm and the parliamentarians: considering possible underlying issues between the Executive and legislative arms of government; it is important to pursue avenues that would foster cross learning.

Parliamentary role in ensuring increased resources to primary health care through budgetary allocations and appropriations: Commitment was expressed to sustain on-going efforts in this regard.

3.4.3 Proposed Actions by All Stakeholders:

The primary action agreed to by all stakeholders was the development and dissemination of all technical and policy products emerging from the national discourse to deepen further discussions and contribute to actions on financing pro-poor strategies in the health sector. To improve efficiencies of existing funding and also mobilize additional resources, government representatives at federal, state and LGAs, as well as stakeholders agreed to undertake actions enumerated in the table below.

Levels	More Health for the Money	More Money for Health
All Levels	Strong health systems are essential for improving access and delivering services at low cost to the society; Efficiency is important in the health sector. As such all actors are to ensure value for money and equitable resource allocation between the three levels of government; Detailed costing should be undertaken as part of programme design and sources of funding (at least in the medium term) clarified before implementation commences; Better coordination of all partners is important; Reduction in corruption and increased accountability are important; There should be results based monitoring and impact evaluation of all programmes in the country; HMIS should have indicators to track expenditures at Facilities, LGAs, State and Federal level in order to inform evidence-based decision making; Resource allocation decisions should be made based on evidence; Improved budget implementation targeted at high impact and cost effective interventions; Strengthened transparency & accountability mechanisms within government institutions towards improving efficiencies in health spending; Involvement of the media in disseminating the products from the workshop was identified as critical.	Health professionals must build broad coalitions to lobby for at least 15% budgetary allocation to the health sector (meeting Abuja declaration), with a greater focus on allocation and expenditure of the $31.63 per capita for the NSHDP minimum package of care at the PHC and referral levels; Sustained advocacy for the signing of the National Health Bill into law following assent by the President; There should be a national framework to guide resource mobilization efforts. It should be inclusive of innovative channels such as earmarked taxes: (1 kobo per telephone usage second for NHIS, % of VAT) and PPP, to mention a few; Community-based health insurance is important for achieving universal coverage and should be rolled out. National and state assembly members could use part of constituency project funds to buy CBHI premium for vulnerable groups; Continued involvement of politicians in articulating means of addressing financing challenges in the health sector was underscored; Involvement of the media in disseminating the products from the workshop.

Levels	More Health for the Money	More Money for Health
Federal Level	Health should be put on the concurrent list in the on-going process for the revision of the Nigerian constitution; Adaptation processes for health programmes that have worked in other countries should include feasibility studies to determine relevance and potentials of such interventions in the Nigerian context; Results based-financing (RBF) or Performance based financing (PBF) in the health sector has potential approach in improving health service delivery and utilization rates. However, but the on-going pilots should be evaluated (relevance, cost-effectiveness, equity, efficiency, sustainability dimensions) prior to scaling-up implementation; The MSS is a good scheme and similar initiatives should be encouraged; Limited human resources capacity in Nigeria to drive reforms and activities in health financing must be addressed; The capacity of National training institutions (such as Universities) should be enhanced to develop human resources needed to drive health financing reforms and activities in the country.	Increased interaction between programme managers and national assembly members are needed; Intensified advocacy to Mr President and the Ministry of Finance for increased budgetary allocation for health, especially for interventions targeted at the poor and vulnerable groups; Possible amendment of the NHIS act was proposed to reflect emerging issues including mandatory health insurance for all Nigerians and reflections of specific revenue sources.
State Level	Adequate financial support to PHC systems, including developing efficient referral systems; All states should develop programmatic and legal frameworks for social health insurance schemes thereby reducing use of out-of-	States should make concerted efforts to identify and progressively address bottlenecks militating against the adoption of social health insurance schemes for the formal and informal sectors; In particular, support establishment

Levels	More Health for the Money	More Money for Health
	pocket spending at the point of health service use; Existing funds could be channelled to demand-side financing mechanisms such as vouchers and conditional cash transfers for essential services, including family planning, immunization, ANC, facility deliveries, etc; Establish and /or strengthen resource tracking systems for health expenditure as part of efforts to institutionalize routine expenditure tracking systems.	and implementation of CBHI; Increase resource allocation and timely release of funds to essential programmes especially maternal, newborn and child health interventions; Strengthened decentralization process for integrated MNCH service delivery at the state level is important. Mobilize and organize communities systems to support CBHI;
LGA Levels	Improve rational use and equitable allocation of funds for PHC services; Secure support to address the weak technical capacity to design, implement, monitor and evaluate health interventions.	There should be improved budgetary provisions and timely release of funds for PHC systems and services.

4.0 SUSTAINING THE MOMENTUM

Efficiency considerations in the Nigerian health system reveal that lower costs do not automatically imply good efficiency unless one could control for quality of services and health outcomes. Inefficiencies in the health sector could be due to sub-optimal use of factors of healthcare production. Allocation of public resources towards higher levels of healthcare system and towards urban areas contributes to inefficiency of the healthcare system. It is more efficient to use public resources at those points where they would have greater impact such as PHC and endemic disease control. Typified by examples of inefficiency in HIV/AIDS control and technical efficiency of hospitals, there are significant inefficiencies in public spending in Nigeria, increasing budgetary allocations for controlling diseases may not be the sole or most efficient option to increase output and reduce health burden. Also, more attention should be given to increasing efficiency of expenditure and strengthening the link between spending and outcomes which would allow Nigeria to achieve the same outcomes at lower levels of spending or achieve better outcomes at the same level of spending.

Achieving Good Health at Low Cost (GHLC) in Nigeria will emerge from a multi-sectoral focus; Coordination of different actors; Innovative approaches to health workforce generation; Innovative use of health workforce; Innovative health financing (especially in purchase of health services); Improved affordability to improve access for all socio-economic groups; Innovative ways of securing health system inputs; and Building resilience in the health system.

4.1 LESSON LEARNT

With the successful conduct of the first national health financing workshop in Nigeria, key lessons learnt include:

Commitment to Health Financing
The overwhelming interest in issues relating to health financing generated among the stakeholders is unprecedented. Delegates actively participated in all the workshop sessions and there is a level of improved understanding of the various health financing strategies which were critically examined to identify their merits and demerits. Countries have a variety of strategies to adapt from to suit national contexts and complement on-going efforts to address health financing challenges. These include vouchers, conditional cash transfers, basket funds, and equity funds, RBF/PBF, CBHI, etc.

Case Studies from Nigeria
Though CBHIS schemes have yet to be implemented to scale in Nigeria unlike some other developing countries, case studies from some of the states in Nigeria provided key lessons that can be used to improve design and implementation in other states.. The workshop provided an opportunity for stakeholders to have an overview of the laudable health financing strategy implementation ongoing in the country.

International Participation
The workshop was greatly enriched by the active participation of delegates from other developing countries in Africa (Ghana, Kenya, Mali, Senegal, Rwanda, and Ethiopia), Asia and South America, who shared case studies from an international perspective. Their participation was facilitated by development partners that provided the needed support. This was noted as commendable.

Participation by top Government Officials and Parliamentarians
The active participation in the workshop sessions by senior government officials and legislators from the federal and state levels is an indication of the increasing interest of public sector officials in health financing in Nigeria. This positive interest can be leveraged to advance the health financing agenda and movement towards universal health coverage in Nigeria.

Added Value from the external technical facilitation
The use of external technical facilitators from AfHEA, comprising of experts from Nigeria and other African countries) as well as the mix of rapporteurs from HPP, NPHCDA and NHIS added value to the entire process. The objectivity, diversity of skills and expertise demonstrated by AfHEA and HPP impacted positively on the technical content and outcome of the workshop, as well as documentation of the proceedings. The contribution by AfHEA as technical facilitators demonstrated that there is capacity within Africa to provide the technical support and leadership needed for the planning and implementation of health financing strategies.

Workshop Coordination and Outsourcing of workshop management
The establishment of a central planning committee (CPC) led by government and comprising of all collaborating partner was a key success factor that informed the planning and implementation of the activity. Equally, the engagement of professional workshop management services – innate, arts and media (iam), contributed to the successful hosting of the workshop.

4.2 RESEARCH FOR HEALTH

The potential role of health system research in generating evidence that informs results-oriented policies and strategies was noted in efforts to improve financial access to MNCH services for the poor. Guided by available research information emerging from the workshop proceedings and discussions, emerging research gaps in Nigeria would be targeted at political, programmatic and community level dimensions. Specifically, they include:

Scaling up financing mechanisms through design and improved targeting of eligible populations;
Strategies to improve routine tracking of health care expenditures at federal, state, LGA and health facility levels;

Utilization of out-of-pocket expenditures through pre-payment mechanisms;

Robust impact evaluations and cost benefit analysis of health financing strategy implementation and impact to inform decision making processes.

4.3 WAY FORWARD

To ensure the national workshop transcends a "talk shop", e series of next steps were identified to improve financial access to MNCH services by the poor, inclusive of SRH interventions. They include:

a. **A set of policy briefs** comprising of policy relevant issues informed by evidence and including immediate, medium, and long-term actionable steps. The briefs will be used to engage policy makers in the country towards improving policy formulation, policy statements and revision of existing health financing policies;

b. **Actionable ideas** identified for responsible parties by the participating entities to improve financing mechanisms, processes, allocation and utilization of financial resources. A summary is presented in section 3.4.3 of this report with details in Annex III;

c. **A resource-kit** comprising of a technical documentation of best practices on sustainable health financing policies for the poor for use by government and non-state actors. The resource-kit will detail elements that are critical for the development, implementation, monitoring and evaluation of financing policies and mechanisms that improve access to health services. It will be informed by the knowledge, evidence and key issues emerging from the workshop (presentations and analytical work). the technical report serves as a first step in this regard, while specific manuals and/or handbooks would emerge to inform future design, implementation, monitoring and design processes;

d. **A website-based** knowledge learning platform/hub (www.healthfinancenigeria.org) is available for federal, state and LGA level actors, as well as CSOs, private sector, development partners and all other stakeholders in Nigeria. The website will enable all stakeholder access information and discuss issues related to improving financial access to the poor. The knowledge learning platform will have institutional linkages that provides technical expertise, as may be required post-workshop to guide specific design, implementation, documentation, monitoring and evaluation of the financing strategies.

ANNEXES

i. Concept note

ii. Workshop Agenda

iii. Detailed actionable ideas by geopolitical zone

iv. List of CPC membership

ANNEX I: CONCEPT NOTE

Background

1. Despite being 2% of the world's population, Nigeria accounts for 10% of global maternal mortality and together with 5 other countries bears 50% of the global child mortality burden. Out-of-pocket expenditure on health is high at about 70% and it accounts for high incidence of catastrophic health expenditure in Nigeria. With almost half the population living below a dollar a day, high expenditure on health needs increases the vulnerability of the poor to slip further into poverty; with the impact on the poorest households, likely to be more severe. Poverty analysis indicates differentials across the geopolitical zones in the country, with attendant linkages to health indicators in the zones. Adopting equitable health financing strategies that are sensitive to the needs of the poor, in the country, is therefore critical. This will be one of the steps towards achieving universal health coverage, especially using appropriate financial risk protection mechanisms in Nigeria.

2. The Nigerian government is firmly committed to fast tracking progress towards the MDGs and other national development challenges. It has developed a National Strategic Health Development Plan with federal and state component plans, as well as signed the Health Country Compact on mutual accountability for measurable results with development partners. The Health Plans acknowledge the need for health financing policies, strategies and mechanisms that are equitable and reflect commitments to increase the proportion of Nigerians in the bottom 2 quintiles that are covered by any risk-pooling mechanisms from present levels to 30% by 2015. This is in addition to reducing the percentage of Out-of pocket expenditure for health from its current level to less than 50% by 2015. The strategies to achieve these need to be further articulated with results-oriented implementation plans at all levels and by all actors within and outside the health sector.

3. Current efforts by the government to address health financing challenges include efforts to improve multi-year budgetary processes linked to strategic results; and the recently passed National Health Bill by both chambers of the National Assembly, which ring-fences resources from the consolidated fund of the federal level account. This fund will be targeted at scaling up primary health care services and extending National Health insurance to all Nigerians. The bill also clarifies statutory roles of all tiers of government in the health sector. The National Health Insurance Scheme, in partnership with the Office of the Senior Special Assistant to the President on MDGs is implementing a maternal and child health fee exemption project targeting pregnant women and children under five years with primary health care services in twelve states. Several states have equally launched free maternal and child health schemes with varied levels of coverage and benefit packages; while some community-type financing schemes and/or equity funds exist in some states.

4 In recognition of the aforementioned, as well as the governance context, national health system and size of the country; the need to ensure continued commitment of federal, states and LGs to improve financial access to health services by Nigerians is considered critical, while promoting buy-in of the private sector and CSOs. Therefore, providing sustained and long term technical assistance; creating platforms for cross learning amongst states and between national entities and regional/developing country initiatives are a few of the agreed collaborative areas between the Nigerian government and its development partners.

5. Further to the above, the Nigerian government has continued to engage in various national and international consultations to garner experiences and best practices to improve financial access for the poor in the country. These have included study tours and visits to Ghana, Kenya, India, Rwanda; participation of a delegation at the Harmonization for Health in Africa (HHA) Regional workshop on Financial access for the poor conducted for West and Central African countries in November 2010; as well as national and zonal consultations on Primary Health Care financing held in 2011, to mention a few.

6. A step down workshop for Nigerian actors on Financial access for the poor was agreed to by government and collaborating HHA/IHP+ partners as follow-up to on-going efforts in the country. This is pertinent as each country agreed to establish a knowledge learning network "community of practice" for improving health financing, especially for the poorest households. Government being – The Federal Ministry of Health, National Health Insurance Scheme (NHIS) and National Primary Health Care Development Agency (NPHCDA); while the workshop collaborating partners (in alphabetical order) are – Canadian International Development Agency (CIDA), Department of International Development (DfID), Health Policy Project (HPP), Management Sciences for Health (MSH), Partnership for Transforming Health Systems (PATHS 2), United Nations Population Fund (UNFPA), United Nations Children Fund (UNICEF), United States Agency for International Development (USAID), World Bank (WB) and World Health Organization (WHO).

6. The workshop is therefore being designed to not only strengthen the knowledge base of federal and state governments, as well as the private sector on health care financing for the poor, but also to identify key interventions and draw lessons learnt and best practices from national, regional and developing country perspectives to inform future programming in the country. It is hoped that these will contribute to on-going efforts to achieve the pro-poor indicators in the National and State Health Plans.

Objectives of the Workshop

8. The objectives of the workshop are as follows:
   i. Facilitate inter-state sharing of experiences on health financing policies and strategies to improve financial access to health services for the poor and individuals without health insurance;
   ii. Share knowledge, evidence and best practices from health financing mechanisms or options that target the poor from other African and developing countries; which have implications for Nigerian states;
   iii. Document lessons learned and best practices (focusing on the "how") shared during the workshop on improving

financial access to the poor; while developing realistic and actionable technical recommendations to policy makers and programme managers in the public sector, private sector, CSOs and development partners (also related to the 'how'); and

iv. Initiate an inter-state learning platform that promotes knowledge sharing on implementation of health financing policies and mechanisms; which will be linked to institutional technical support.

Expected Outputs

9. There will be four main outputs from the workshop.
   i. **A set of policy briefs** comprising of policy relevant issues that are informed by evidence and will including immediate, medium, and long term actionable steps. The briefs will be used to **engage policy makers** in the country towards improving policy formulation, policy statements and revision of existing health financing policies and mechanisms.
   ii. **Actionable ideas** identified for responsible parties by the participating entities to improve financing mechanisms, processes, allocation and utilization of financial resources.
   iii. **A resource-kit** comprising of a technical documentation of best practices on sustainable health financing policies for the poor for use by government and non-state actors. The resource-kit will detail elements that are critical for the development, implementation, monitoring and evaluation of financing policies and mechanisms that improve access to health services. It will be informed by the knowledge, evidence and key issues emerging from the workshop (presentations and analytical work).
   iv. **A website-based** knowledge learning platform/hub of federal, state and LGA level actors, CSOs, private sector, development partners and all other stakeholders involved within the health sector in Nigeria working on health financing issues will be established. The knowledge learning platform will have institutional linkages that will provide technical expertise, as may be required post-workshop to guide design, implementation, documentation, monitoring and evaluation of the financing mechanisms.

Participation

10. The workshop's audience will include technical experts involved in health financing policy and strategy formulation and implementation, as well as political leaders (as their buy-in is important, given the significant role played by government leadership on health financing). Each state will be represented by a delegation of health commissioners, programme managers overseeing health financing and health service delivery at the state ministries of health and Local Government, in addition, to representatives from finance ministries. Other key government ministries, departments and agencies, with Private sector and CSO representation will be included. International, regional and national participation from development partner agencies that will serve a s technical resource persons are also being targeted.

11. Federal level participation will include the Federal Ministry of Health, National Health Insurance Scheme, National Primary Health Care Development Agency, Federal Ministry of Finance, Budget Office of the Federation, National Planning Commission and Office of the Senior Special Assistant on MDGs.A maximum of a five (5) member core State

delegation will include the Directors of PRS and PHC from the State Ministry of Health; Director PHC from the State Ministry of Local Government/its equivalent; representatives of the State PHCDA (where in existence); and the Director Budget from State Ministries of Finance. In addition, representatives from selected State and LGAs would be invited from State Parliaments, Local Government authorities/ALGON and traditional/religious leaders. Targeted NGOs working in the area of health financing will be targeted and include PATHS 2, PPRIN, MSH, HEFRON, with all development partners providing assistance to the Nigerian health sector.

Format and structure of the Workshop

12. The workshop will be organized in plenary and concurrent sessions for the technical work areas, with a high level event for the opening or closing ceremonies in order to engage with policy makers. The technical sessions will comprise of a first plenary session to set the stage for the workshop and will focus on objectives, overview of the agenda and 'rules' for the learning event. Lead presentations and general feedback will also be taken in plenary, while clustered presentations alongside sub-themes of health financing mechanisms targeting the poor would be delivered in concurrent sessions. Interactive discussions will feature all through the workshop to allow for group learning and articulation of key strategies to improve financing. Key technical and policy recommendations from the sessions will be presented at the closing plenary.

Technical Content

13. Pre-selected topics guided by the under-listed principles will be presented and discussed during the plenary and concurrent sessions:
    i. Nigeria-specific initiatives and attempts at improving financial access for the poor to Maternal, Newborn and Child Health (MNCH) services, including Sexual Reproductive Health (SRH);
    ii. Analytical pieces of work and discrete studies carried out at the country level that focus on MNCH services, including SRH;
    iii. Considering the timing of conference; presentations will strive to build on existing knowledge and evidence to improve implementation and/or inform new options;
    iv. Showcase regional and international experiences on financing MNCH, including SRH services that are relevant to Nigeria and Sub-Saharan Africa;
    v. Feature areas that will get political traction and buy-in; i.e building on what government can deliver in the immediate, short, medium and long-term; and
    vi. Each area of work will highlight lessons learned, best practices and limitations, as may be applicable, particularly the key change drivers (technical and policy level actions)

14. In addition, all technical content of the workshop will be organized to answer 4 main questions that target financing of Maternal, Newborn and Child Health (MNCH), including SRH services as articulated in the Nigeria National Health Plan (the NSHDP) namely:

    Current Status: *What is the current status of universal coverage and financial access for the poor*—particularly for women and children—in Nigeria today when compared to selected countries in Africa?

    More Health for the Money: *What can Nigeria do to use existing domestic and external funds more efficiently to achieve better health?* How can Nigeria improve pooling of funds for

financing health services to ensure financial risk protection with greater emphasis on the poor? What purchasing mechanisms can Nigerian states use to ensure increased equity and efficiency in the purchase of more MNCH services including sexual reproductive health? Relevant discussions may include effective OOPE utilization and risk pooling mechanisms such as SHI, CBHIS, and exemption schemes.

More Money for Health: *What can Nigeria do to mobilize additional resources for health in order to attain universal coverage and expand access to the poor?* To answer this question, speakers will address issues related to domestic funding allocation and spending – i.e. the budgeting, appropriation and release; alignment to prioritized interventions and programmes; additional domestic funding (MDG Debt Relief gains, Health bill). Discussion of innovative financing mechanisms (CCTs, PBF/ RBF, equity funds, targeted ODA, private sector involvement, etc) will also help to answer this question.

Taking Action: What actions needs to be taken by government actors and its stakeholders to improve efficiencies of existing funding and also mobilize additional resources in order to attain universal coverage and expand access for the poor for health? What are the potential roles of Health system research in generating evidence that will inform results-oriented policies and strategies for improving financial access to MNCH services for the poor? This will include political, programmatic and community level actions.

15. Federal and State actors, private sector bodies (practitioners and Health Maintenance Organizations), Researchers (national, regional and international), NGOs and Development partner agencies constitute the team of presenters. They will share their experience on implementing health financing policies to improve access to services for the poor. The emphasis will be in the 'how'. Annex I gives a tentative Agenda for discussion purposes which lays down the structure of the conference. It is based on Annex II, which is a list of possible speakers and topics. It should be noted that this is an evolving list and could significantly change. A team of technical officers with expertise in health financing will work to finalize the Agenda and technical content of oral presentations.

Technical Assistance for the workshop

16. Technical assistance will be sought from within the collaborating partner agencies (as listed in section 6 above), in addition to the African Health Economics Association and its Nigerian Chapter – the Nigerian Health Economic Association - towards fostering institutional partnerships that will sustain TA to the states post-conference. Detailed terms of reference for the TA for the pre-conference activities will include selection and review of technical presentations, agenda formulation, development of guidelines for presenters and moderators, as well as anchoring preparation of conference documentation, including serving as technical resource persons/rapporteurs.

Timing

17. The confirmed dates for the workshop are 1st to 3rd November 2011. The rationale for the proposed timing is to ensure that the government actors in attendance would have enough time to either revise on-going strategies and/or conceptualize context specific strategies that would improve access for the poor for 2012 fiscal year. The timely inclusion of interventions/strategies in 2012 annual operational plans and budgets would therefore be facilitated by the conduct of the workshop as proposed.

ANNEX II: DETAILED WORKSHOP AGENDA

WORKSHOP DETAILED AGENDA			
Day 1	**Tuesday 1st November 2011**		
8.00-9.00	Registration & Networking		
	Opening Ceremony (Plenary room)		
	National Anthem		
	Opening prayers		
	Welcome address by the Commissioner of Health, Cross River State		
9.00-10.30	Remarks by the Executive Secretary, National Health Insurance Scheme		
	Remarks by the Executive Director, National Primary Health Care Development Agency		
	Goodwill messages by the cochairs of the Development Partners Group on Health in Nigeria		
	Remarks by the Honourable Minister of Health		
	Keynote Address by His Excellency, the Executive Governor, Cross River State		
	Vote of thanks by the Chairman, Workshop Central Planning Committee		
10.30-11.00	**Tea/Coffee break & networking**		
11.00-11.45	Opening Technical Presentation (Plenary room)		
	Nigerian challenges within a global context: Pro-Poor Universal Access and Health financing options - an overview		
	By Dr Chris Atim, World Bank		
11.45-13.00	**Plenary Session 1: "Q1"**		
	Technical Overview of the Current Status of Universal Coverage and Financial Access for the Poor - Nigeria's health financing policy		
	FMOH, Dr Tolu Fakeye		
13.00-14.00	**Lunch Break**		
Current Status "Q1" - Concurrent sessions			
	Plenary room	**Concurrent session 1**	**Concurrent session 2**
14.00-15.30	Policy analysis (1)	Policy analysis (2)	Analyzing the financing gap
	Nigeria's NSHDP-equity analysis with comparisms with Mali health system analysis *David Gwatkin, Results for Development*	National Health Bill provisions-an equity perspective *NHIS Hope Uweja & NPHCDA Dr Abdulalhi*	Costing and budgeting tools at the decentralized level – State of the Art *Rudolph Chandler, HPP*
	Bottleneck Analysis of the Lagos State Health System towards Development of an Investment Case for Health *Sara Beysolow-Nyanti - Chief, UNICEF Lagos Field office*	PHC financing – findings from stakeholder consultations *NPHCDA Lekan Olubajo*	Kenya- National Health Account Institutionalization. *Munguti Nzoya, Health System 2020*

15.30-16.00	**Tea/Coffee Break & networking**		
16.00-17.30	**Team Exercises 1:** Delegations meet among themselves to do an exercise regarding their state. In addition, the states articulate how they propose to address Q4, following the experience sharing and cross-fertilization of ideas with other states, regional and international participants.		
Day 2	**Wednesday 2 November 2011**		
8.30-8.45	Recap of the previous day (Plenary room)		
8.45-9.30	**Plenary Session 2: "Q2: More Health for the Money"**		
	Technical Overview - What can Nigeria do to get more health for the money (improve efficiency)?		
	Obinna Onwujekwe, AfHEA/NiHEA		
More Health for the Money "Q2" - Concurrent sessions			
	Plenary room	**Concurrent session 1**	**Concurrent session 2**
9.30-11.00	Innovative financing mechanisms	Exemption schemes	RH/FP session
	Performance-based financing: preliminary analytical work, institutional arrangements & potentials of equity funds within PBF *NPHCDA, PBF States, World Bank*	MDG/NHIS MCH Scheme–a country experience *NHIS/MDG Hope Uweja and Hamza Aliyu*	Ondo State (Abiye), equity funds for FP services *Ayo Adinlewa, Abiye Project Coordinator, Ondo State*
	Equity funds – Kebbi state experience in community based financing targeting the poor and vulnerable groups for MNCH services *Director, Primary Health Care, Kebbi State*	Free MNCH implementation bottlenecks, assessments and impact evaluation studies in Jigawa State. *Director, Planning Research and Statistics, Jigawa State*	Getting Research into Policy and Practice (GRIPP)–three-piece research (Ability to Pay; Willingness to Pay for contraceptives and costing of CLMS) and its implications to policy and programming *Bosede Adeniran FMOH, UNFPA, USAID,*
	Zamfara State basket funding system for PHC services with a focus on MNCH services *Yusuf A, Musa, Director Primary Health Care, Zamfara State*		
11.00-11.30	**Tea/Coffee Break & networking**		
11.30-13.00	**Team Exercises 2:** Delegations meet among themselves to do an exercise to summarize what they have learned about innovative financing, exemption schemes and the RF/FP issues, that may be applicable to states' context. In addition, the federal and state actors articulate how they propose to address Q4, following the experience sharing and cross-fertilization of ideas with other states, regional and international participants.		
13.00-14.00	**Lunch Break**		
14.00-14.45	**Plenary Session 3: "Q3: More Money for Health" (Plenary room)**		
	Technical Overview- What can Nigeria do to mobilize additional resources for health in order to expand access to the poor and attain universal coverage?		
	Hyacinth Ichoku, AfHEA/NiHEA		

More Money for Health "Q3" - Concurrent sessions			
	Plenary room	**Concurrent session 1**	**Concurrent session 2**
14.45-16.15	Domestic funding processes	Social Health Insurance	RH/FP session
	Improved domestic funding – budgetary processes, appropriation and release to prioritized areas *Director, Planning Research and Statistics, Kaduna State*	The design and experience of the Ghana Health Insurance Scheme and its lessons for Nigeria *Chris Atim*	Promoting Access to FP/RH Services in Kenya using the Output-Based Approach (OBA) *Dr. PIUS SHEM OWINO, HPP*
	Targeting Resources to the Poor: A case study of Implementing a Voucher Scheme in Jharkhand, India *Dr. Rajna Mishra, HPP/India*	Community based health insurance scheme – Lagos State experience, Director, Planning Research and Statistics, Lagos State, *Abt/CFI, Benson Obonyo,*	Increasing access to Family Planning by targeting resources to the poor: Mobilizing Public Resources in Peru Dr. *Cynthia Green, HPP*
	Quantifying and Analyzing Health Equity - disaggregation of rural and urban datasets – African Examples *Brian Briscombe, HPP*		
16.15-16.30	**Tea/Coffee Break & networking**		
16.30-18.00	**Team Exercises 3:** Delegations meet among themselves to do an exercise on what they have learned about domestic funding, social health insurance and RH/FP issues. In addition, the federal and state actors articulate how they propose to address Q4, following the experience sharing and cross-fertilization of ideas with other states, regional and international participants.		
Day 3	**Thursday 3 November 2011**		
8.30-9.30	Recap of the previous day (Plenary room)		
	Additional concurrent sessions		
	Plenary room	**Concurrent session 1**	**Concurrent session 2**
9.30-10.30	Innovative financing mechanisms	Private sector involvement	SHI & Policy analysis
	Coexistence of PBF and CBHIS experiences in the African Region – Rwanda experience *Dr. James Humuza. Government of Rwanda, MSH*	Public -Private partnerships (PPP) for health financing – experience and practical lessons from Sub-Saharan Africa. Joseph Addo-Yobo, SHOPS	Is free care really free & equitable? The case of Liberia - Challenges and Learned *Benedict Harris Liberia MOHSW HS 2020*
	Ethiopia- Users Fee Retention at HF levellshrat Z Husain, Senior Health Adviser, USAID	Community based health insurance schemes - Kwara; Hygeia-Dr Olapeju Adenusi	Mali: Integration of CBHI in the National Health Insurance Policy *Cheikh Mbengue, HS 20/20*
10.30-11.00	**Tea/Coffee Break - networking**		
11.00-12.00	**Team Exercises 4:** Delegations meet among themselves to summurize actionable ideas, including lessons learnt in additional concurrent sessions		

12.00-13.00	**Plenary Session 4: "Q4: Taking Action" (Plenary room)**
	Technical Overview- What actions are proposed to be taken in order to expand access to the poor in Nigeria and attain universal health coverage for MNCH services? *Federal and State level groups*
13.00-14.00	Lunch Break
14.00-15.00	**Plenary Session 5: Presentation of key conference issues/actionable points. (Plenary room)**
	Issues emerging from the range of workshop presentations and discussions presented by AfHEA.
15.00-16.00	**Policy level roundtable:**
	Policy related questions emerging from delegates posed to Ministers, Parliamentarians, Governors, ALGON, etc.
16.00-17.00	**Closing ceremony**
	Remarks by Executive Secretary National Health Insurance Scheme
	Remarks by Executive Director National Primary Health Care Development Agency
	Closing Remarks by the Honourable Minister of Health
	Vote of thanks by the Chairman, Workshop Central Planning Committee
	Closing prayers
	National Anthem
17.00-17.30	**Tea/Coffee Break - networking**

ANNEX III: DETAILED ACTIONABLE IDEAS BY ALL ACTORS

All levels

Political will from the government (Federal, state and LGA) and the legislature is critical;
Ensure community participation and ownership with the involvement of major stakeholders in all design and implementation stages as was the case of Ethiopia;
Institution of exemption schemes for the vulnerable groups with financial support from both the government and private sector (philanthropic foundations and charities);
Need for government to provide subsidies for the vulnerable groups to access health care services, and set-up selection criteria to determine those to be exempted;
Incorporate PPP model into the design of community-based insurance schemes;
NHIS to support states to roll-out pilot CBHIS and provide adequate regulatory oversight functions during the scale-up phase;
Ensure adequate number of health facilities and equitable spread of workforce to cover the under-served populations;
Health facilities should be run and managed by trained hospital managers and not by clinicians to ensure efficient use of resources (e.g. Ethiopian experience);
Co-existence of CBHI and PBF schemes could ensure complementarity and synergy in the use of resources;
Need for baseline studies/needs assessment before schemes are designed and implemented to ensure they are evidence-based;
Establish a framework for the administration and management of CBHI schemes to ensure accountability and prevent corruption in the usage of resources;
Regular quality checks through monitoring and supportive supervision by regulatory authorities to ensure that clients receive high quality of care at the health facilities;
Conflict resolution mechanisms to be put in place to reduce attrition and disputes that may stall the programs;
Volunteerism to be encouraged in order to mobilize additional human resources to run the programs (e.g. the Indian model).

NORTH CENTRAL ZONE

1. **Voucher Schemes in India**
   The commitment and faithfulness of the trustees (ushers/drivers) of the program is worthy of note, and very critical for its success;
   The envisaged problems include how to institute a reward system for volunteers, mitigate against fraudulent practices, improve monitoring and evaluation systems;
   Solutions proposed include: Reward system - to leverage on existing community-based structures to reward volunteers; Fraud- can be checked through community policing, and incorporating security features in the vouchers to enhance their authenticity and eliminate duplications; Political will and commitment to be sustained through community awareness and sensitization of the stakeholders, to hold government accountable; Religious and cultural biases to be addressed through continuous behavior change information and education; and Monitoring and Evaluation to be sustained through capacity building and logistics support.

2. **Health Financing Options**
   The Kwara State CBHI schemes were commended especially with the involvement of the three tiers of government in the design and implementation in the pilot communities.
   Challenges identified include sustained political will to secure predictable funding for the schemes in the long term to ensure

sustainability; consideration of equity issues in the determination of premiums to be paid and eligible client selection criteria; geographical mapping of communities along socioeconomic status, religion, professional backgrounds etc; generation of quality baseline data to be used for costing and budgeting of the project before the initial take-off; and community ownership can only be guaranteed only if the government adopts a bottom-up approach;

Specific state perspectives and views included:

Benue State: Financing of health services so far has only been based on the state government's budgets, hence there's need to address the issues around the non-adoption of NHIS in the state, and also ensure buy-in by the labour unions and formal sector workers.

Kogi State: The use of loans to fund health services would not be sustainable in the long run.

Nasarawa: Non-existence of a legal framework poses a major challenge in sustaining health programs due to poor budget provision to implement them. Other challenges noted included limited awareness creation, lack of capacity and poor attitude of health workers.

FCT Abuja: Training on budgeting and costing need to be done in a simplified manner to break-down the technical details in a way that health workers and administrators can understand, and be able to use to design and implement programs.

Kwara State: The Ambursa Equity Fund (Kebbi State) model can be replicated in the state but with some modifications. Part of equity fund can be given as seed capital to communities to pilot CBHIS with the collaboration of community-based associations and market women organizations, while Committee/Forum of Elders can be used to provide leadership.

SOUTH WEST ZONE

1. **Results-Based Financing**

RBF schemes should be based on results achievement and performance for a minimal set of key indicators; for which data verification would be done by external agents and auditors;

RBF can be adopted in the states within the zone by incorporating the principles into the existing HMIS/M&E systems, but would require capacity building and infrastructural support to strengthen the system;

Strong M&E framework would help to ensure data quality, and to ensure the program objectives and targets are properly tracked to measure impact;

Facility selection should be based on merit using data on the nature, scope and quality of service provided by the facilities;

Inter-state collaboration in selecting LGAs can help to strengthen the scheme;

The states and federal government need to reach agreements on how the loans used for RBF schemes will be repaid, while the States and LGAs need to formulate policies to initiate RBF schemes;

Community involvement is critical for the successful implementation of RBF

2. **Equity Funds & Basket Funding Schemes**

Equity funds are community-based initiatives supported by government, private sector and philanthropic individuals, while Basket Funding is a funding mechanism of collectively pooling funds with clearly defines utilization targets. Both are supported by relevant stakeholders including development partners, states and LGAs;

Equity funds can be implemented at the

community level, while Basket funds are applicable at the state and LGA levels;
Actions needed for their implementation include advocacy and sensitization of policy makers, the community members, socio-cultural and religious gatekeepers, etc;
Challenges that may affect their implementation include financial sustainability and weak financial management systems;
Measures to address some of the challenges would include the provision of financial support from donor agencies to under-funded priority areas in the states' health strategic plans, and strengthening of Ward Development Communities and Facility Management Committees to ensure proper financial management and other oversight functions.

3. **Improved Domestic Funding for Health Care Services**
   Domestic funding can be improved at the state and LGAs by focusing efforts and design strategies to mobilize proportions of Internally Generated Revenue (IGR);
   The efficient use of available resources can be enhanced through the use of Medium Term Expenditure Framework (MTEF) and Medium Term Sector Strategy (MTSS) in the planning and allocation of resources to priority areas in the health sector;
   Most of the states in the zone depend on IGR to augment statutory allocation from the federation account, while Lagos state has initiated processes for the adoption of MTSS and MTEF in budgeting and resource allocation;
   To improve states' resource base and efficient use of resources, through IGR and MTSS respectively, there is need for capacity building of the public sector workforce, as well of provision of technical support to programme managers and the needed political will to drive the process;
   Measures needed to address some of the challenges would include advocacy to the Ministries of Finance, Economic Planning and Budgeting, regular monitoring of budget performance (released funds), and formulation of policies on the adoption and implementation of MTSS

4. **Targeting Resources to Meet the Needs of the Poor:**
   Use of Voucher Schemes for the provision of free services targeting the poor and vulnerable groups was noted;
   Voucher management schemes are not currently in use in the South-west states, however, fee exemption schemes for health interventions are operational in the states especially for MCH services;
   To implement voucher schemes, adequate budgeting and funds needs to be allocated for such projects, with effective and efficient design, implementation and monitoring;
   Challenges to be considered include inadequate financial backing by the states, lack of transparency and accountability in the allocation and use of the resources, and poor commitment of the relevant stakeholders;
   To address these problems, recommended measures include increased fund allocations, setting up a monitoring systems, ensuring commitment and full participation of stakeholders, as well as, the need for government to enact appropriate legislation to provide legal backing to policies on free healthcare..

SOUTH SOUTH ZONE

Public Private Partnership/ Community-Based Health Insurance Scheme
Focused on PPP/CBHI schemes from Ethiopia, Liberia, Kwara and Lagos States:

Lagos CBHIS: Monthly premium ranged from

N1200-N1500. A corrective measure to guard against defaulters was put in place such that payment of backlog were completed before clients could resume access to services under the scheme;

Kwara CBHIS: HMOs accessed donor funds utilized for running the scheme in 2 communities and families paid N300 as yearly premium. Scaling up state government's counterpart funding allowed for a decrease in donor funding and ensures a progressive move towatds sustainability;

Ethiopia: Healthcare financing was linked with the health sector reform aimed at efficient resource management with strong community participation. The use of management professional services for the scheme rather than health workers was noted as a success factor. Development partners provided support in the area of logistics, maintenance of facilities and drugs supply;

Liberia: The high out-of-pocket (OOP) expenditure resulted from the financial crisis linked to the protracted civil war and as such had nationwide implications that required urgent actions;

OOPE was noted as the means for payment of health services within the zone. The NHIS only covered federal civil servants working in the various states, while the CBHIS and other schemes targeting the informal sector were recently emerging;

The major challenges and obstacles to the implementation of CBHIS in the zone were identified as lack of commitment from Government and healthcare providers, inadequate human resources for health and weak M & E systems. Others included lack of data for evidence-based advocacy and policy formulation; PPP in health care financing and community-based insurance scheme within the zone was encouraged;

To implement PPP/CBHIS in the states, there was need for legislation to provide the legal framework for operationalization and to encourage participation of indigenous NGOs;

A system of accountability and transparency needs to be put in place with strong political backing and commitment from the government.

SOUTH EAST ZONE

1. **More Health for Money:**

The issues noted were as follows:

There's need to get value for the money invested in the health sector;

Resources should be allocated to areas of greater impact;

Health facilities need to be strengthened for improved efficiency;

Inadequate and untimely release of budgeted funds for health are major challenges

To improve efficiency, budgeted funds need to be released promptly;

States are to pay counterpart funding for donor-supported activities; and

Policy makers need to show commitment to strengthening the health care delivery systems in the zone.

2. **Performance-Based Financing (PBF) by NPHCDA**

Currently supported by donors posing sustainability challenges;

Adequate legislation also needed to ensure sustainability;

PBF schemes are not yet operational in the zone; however it was noted as a good idea that could be explored;

The anticipated high cost of monitoring was noted

3. **Equity Funds: Ambursa CBHIS in Kebbi State**

Already a common practice in the south-east as many existing health facilities were built through community effort and handed over to the government for management;

Effective data management systems to support implementation was critical.

4 **Zamfara Basket Funding for PHC Services**
A common basket of fund jointly financed by the State, LGAs, and donor agencies to strengthen PHC services. Though this is a commendable practice, however it is not yet operational in the south east zone.

5. **More Money for Health:**
Government budgetary provisions for health are still far less than the stipulated 15% of Budget based on the Abuja Declaration, and the situation is worse in the states;
Health professionals need to demand for increased funding for health services;
The National Health Bill needs to be signed into law to ensure increased funding of PHCs across the country;
There's need for improved efficiency in the delivery of health services.

6. **Domestic Funding Processes**
The improvement of budgetary processes, appropriation and release of budgeted funds to areas of priority was noted to be improved through the MTSS process;
A next step of developing annual operational plans derived from the States Strategic Health Development Plans (SSHDP) was also noted.

7. **Community-Based Health Insurance Scheme: Lagos State Experience**
A pilot project involving three communities in the state;
A PPP partnership between the Lagos state government and private sector to provide health services to the people;
Involvement of the NHIS as a regulatory body seems not to be obvious in the scheme;
Currently, there's no government or HMO-supported CBHIS in the south east, but some communities are operating CBHIS informally;
Enugu state has passed the Health Insurance Bill while states like Abia and Ebonyi are in the process of enacting a legislation;
To implement the scheme in the south east, the support of the government, private individuals and donor agencies would be needed to provide the subsidies;
The CBHIS schemes need to be replicated in more areas.

NORTH WEST ZONE

Focused on the roles and responsibilities of entities:

1. ***Government – federal, state & LGA***
Required to seek alternatives options to finance health care in the zone;
Public-Private partnership in public facilities should be explored;
Contracting out specialized services was noted;
Advocacy to policy makers and mobilizing community members was important to entrench sustainability and ownership;
Health care management needs to be improved at all levels.

2. ***Community***
Need to secure willingness of community members to contribute to insurance schemes.

NORTH CENTRAL ZONE

Also focused on the roles and responsibilities of entities:

1. ***Government – federal, state & LGA***
India's voucher system through the ASHA's project was noted as a potential strategy. It is possible to replicate in the zone but must take into consideration potential challenges experienced with the reward system, fraud control, religious and cultural biases;
Explore attaching security features to

vouchers;
Financial sustainability is key for CBHIS;
Addressing equity concerns in premium setting, identification of eligible population (i.e vulnerable and poor groups) is key;
Costing and budgeting to inform government decision making processes were required;
Strong collaboration with education sector, religious and traditional institutions would assist in addressing religious and cultural biases that limit access to quality MNCH services;
Adopting a bottom up approach will facilitate buy in and ownership of all financing strategies, thereby providing opportunities to achieve sustainability;
Adopting a phased approach in the implementation of any financing strategy is important such that documented best practices, lessons learned and challenges would be applied to review strategies for improved performance;
Results-based financing was noted as a potential for states in the zone.. The evaluation of the pilot phase was expected to yield additional information to guide further decisions.

2. ***Community***
   Leverage existing systems in villages to reward volunteer actions, while using community policing methods to address fraudulent practices; Strong community awareness and sensitization is required.

NORTH EAST ZONE

Equally focused on the roles and responsibilities of entities:

1. ***Government – federal, state & LGA***
   To achieve more health for the money, efficiency and equity issues cannot be overemphasized;
   A need to expand the MDG/NHIS MCH exemption scheme to additional states and LGAs;
   The ASHA experience is noteworthy and could inform decision making in the zone;
   Retention of user fees similar to that of Ethiopia could be adapted in the zone;
   Adamawa state pilot of the PBF will explore the practicalities of the Ethiopia model. Documentation of the process would inform other states. The Adamawa state community governing board is made up of politicians, community representatives of women, health providers at service delivery level trained in financial management;
   Lack of state counterpart funding will lead to lack of sustainability;
   Poor budget implementation at state and LGA levels, especially with Executive influence on budget is a key challenge that needs to be addressed;
   States agreed to further explore the Kebbi equity-type funds and Zambara's basket funding system as potential financing strategies;
   Advocacy was required to support signing of National Health bill into law;
   Improved health sector coordination at all levels is key;
   Need to explore generating revenues from GSM and social networking companies to fund health interventions.

2. ***Community***
   Cultural barriers limit women's access to health services, requiring BCC interventions;
   Policy to train equal percentage of men and women to be posted in communities will augur well for community participation.
   Community participation and ownership in support of insurance should be encouraged.

ANNEX IV: LIST OF CENTRAL PLANNING COMMITTEE MEMBERSHIP

SN		ORGANIZATION
1	Hope Uweaja - Chairman	NHIS
2	Hamza Aliyu	NHIS
3	Idia Anibilowo	NHIS
4	Nda Nuhu - Secretary	NHIS
5	Christopher Okoh	NHIS
6	Lekan Olubajo	NPHCDA
7	Adeniyi Ekisola	NPHCDA
8	Irene Ijoma	FMOH
9	Ebere Anyachukwu	DfID
10	Nkata Chuku	FHI
11	Zubaida Abubakar	FHI
12	Brian Briscombe	HPP
13	Aliyu Aminu Ahmed	HPP
14	Anthonia Utulu	HPP
15	Funmi Esan	MSH
16	Emeka Nwachukwu	MSH
17	Benson Obonyo	PATHS 2
18	Paul Angbazo	PATHS 2
19	Chinwe Ogbonna	UNFPA
20	Shalini Bahuguna	UNICEF
21	Maryam Abdu	UNICEF
22	Joseph Monehin	USAID
23	Husain, Ishrat	USAID
24	Dinesh Nair	World Bank
25	Chris Atim	World Bank/AfHEA
26	Ogochukwu Chukwujekwu	WHO
27	Obinna Onwujekwe	AfHEA Technical Facilitator
28	Hyacinth Ichoku	AfHEA Technical Facilitator
29	Eugenia Amporfu	AfHEA Technical Facilitator
30	Felix Obi	AfHEA Technical Facilitator


UNFPA

World Health
Organization

Canadian International Development Agency

unicef

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from the Department for
International Development

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