Independent Evaluation of the Effectiveness and Impact of SDG3: Healthy Lives in Nigeria

The independent SDG3 Healthy Lives evaluation is a systematic and rigorous assessment of the effectiveness and impact of SDG3 in Nigeria. Findings from this evaluation further the evidence for improving health in Nigeria and how local actors can best address systemic gaps and challenges to make progress in implementing the 2030 sustainable development agenda.

While Nigeria has made progress in reducing maternal and child mortality rates over the past 20 years, the country will most likely miss the achievement of the Sustainable Development Goals for Health (SDG3) unless strategic health policy decisions and tactical implementation are made, implemented, and monitored. At this juncture, where Nigeria and the entire sub-Saharan Africa region try to mitigate the negative effects of the COVID-19 pandemia, careful decisions are necessary to put Nigeria back on track to save lives and improve health of all Nigerians, particularly of vulnerable and marginalized groups. This policy brief presents key priority recommendations based on the latest evidence and findings from the independent SDG3 Healthy Lives evaluation in Nigeria. By design, the evaluation focused on maternal and under-five mortality as key priority issues related to SDG-. This policy brief focuses on key findings from four out of ten evaluation criteria: efficiency, effectiveness, impact, and equity.

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Health Policy Framework

The Government of Nigeria through the Federal Ministry of Health has developed a set of health policies that provide the foundation for the overall strategy for health in the country. These policies provide a strong framework for the regulation, development, and management of Nigeria's national health system. The independent evaluation took the National Strategic Health Development Plan II (NSHDP II, 2018-2022) as the anchor for a comprehensive assessment of the health policies in the country.

SHDP II Strategic Pillars

The NSHDP II is anchored on the 2016 National Health Policy with the goal to ensure health lives and promoting well-being of the Nigerian population of all ages. The plan aligns to the National Development Agenda and the Global Health Agenda including the health-related SDGs. The NSHDP II was developed through active participation of key stakeholders, including those at federal and state levels, development partners, CSOs, academia, among others. The NSHDP II was approved by the NCH and the FEC in 2018 and launched by the President of Nigeria in January of 2019.

Nigeria has a legal framework, strategic plans, and organizations that fully include the components and objectives of the SDG3 at the federal, state, and programmatic levels, including the LGA, health facility, and community. Key among them are the Basic Health Care Provision Fund (BHCPF), the National Primary Health Care Development Agency (NPHCDA), the Primary Health Care Under One Roof (PHCUOR) Initiative, Nigeria's Strategy for Immunization and PHC System Strengthening (NSIPSS, 2018-2028), Community Health Influencers, Promoters & Services (CHIPS), the National Health Act (2014), Health Sector Next Level Agenda (2019 – 2023), the National Health Sector Strategic Plan II (2018-2022) and the National Health Policy (2016).

Findings of the evaluation revealed that SDG3 targets 3.1 (maternal health) and 3.2 (child health)—the focus of the independent evaluation—are fully streamed within the NSHDP II. Specifically, these targets are part of the Strategic Pillar 2 (Increased utilization of the essential package of health care services, and within the Priority Area 4: reproductive, maternal, newborn, child, and adolescent health plus nutrition.

At the State level, the evaluation verified that in the six target states, all State Strategic Health Plans are consistent with the priority areas and goals of the NSHDP II to address SDG3 targets 3.1 and 3.2. However, they provide different levels of details on the interventions to meet those targets, and on their monitoring and evaluation plans for their implementation. Although national health programs are very well designed, the action plans at the service delivery level have important gaps. Access to health services is low in general, but in some states the situation is critical; and in those where there is access, the quality-of-service delivery is poor. There are also deficiencies in budget allocation and execution, and finally, the burden of health costs falls mainly on the family.

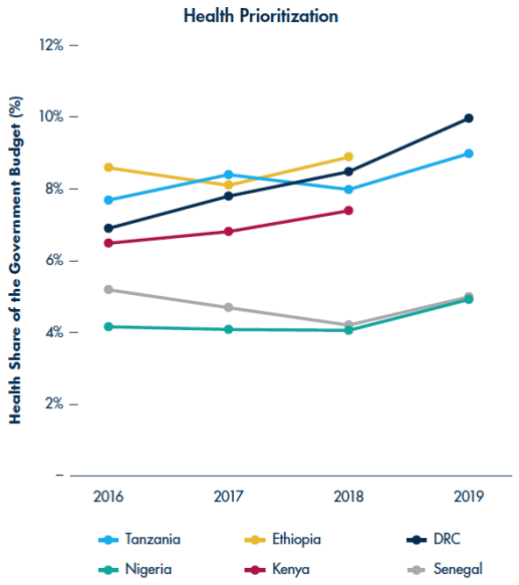
The achievement of the SDG3 targets 3.1 and 3.2 will require high-quality Primary Health Care (PHC) services delivered at scale in Nigeria. To achieve both targets, health policies and programs should be aimed at increasing access to quality services at the PHC level, especially at the implementation level, health centers, LGAs and at the community. The following policies and programmes are fundamental for Nigeria to advance towards SDG3 targets. These are key pillars for the strengthening of PHC services in Nigeria.

- Basic Health Care Provision Fund
- National Primary Health Care Development Agency
- Primary Health Care Under One Roof
- Nigeria's Strategy for Immunization and PHC System Strengthening

- Community Health Influencers, Promoters and Services
- National Health Act
- National Health Policy
- NSHDP II
- Health Sector Next Level Agenda (2019-2023)
- One Health Policy/Strategy (2018-2023)
- Private Partnership Memorandum of Understanding for Routine Immunization
- Country Compact
- National Health Management Information System Policy
- Health Insurance Under One Roof
- Medium Term National Development Plan (2021-2025)
- Nigeria Vision 20:2050

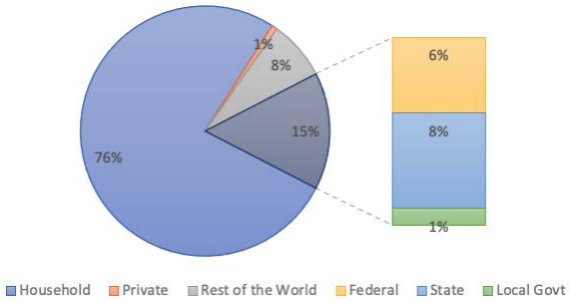
Health Financing and Efficiency

While the existing health programmes and multiple coordinating mechanisms are described in the NSHDP II and with direct links to SDG3 (targets 3.1 and 3.2), a major constraint remains the limited resources that Nigeria invests in health as shown in the graph below. Nigeria registers the lowest health share of the government budget compared to other countries in sub-Saharan Africa.



Financing for health in Nigeria come mainly from three sources: the government (Federal, State and LGA) covers 15% of health expenditures; private employers and donor organizations cover up to 9% of health costs; and the remaining 76% of health costs is covered by the family, or out-of-pocket (OOP) expenditures. Household OOP has been stagnant over the past decade, with an average of 74% between 2010-2017. OOP expenditures have a strong effect on the equality and access to health services, mainly PHC.

Sources of Health Financing in Nigeria



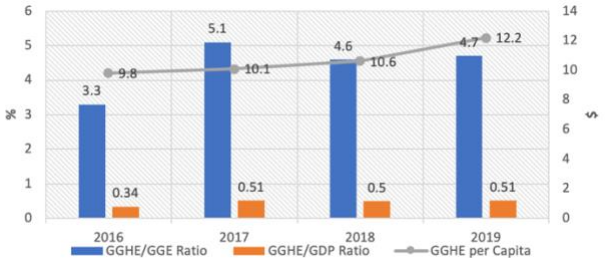
Funding for the operationalization of PHC programs at the health facility level is insufficient and, in some cases, practically non-existent. After excluding personnel costs, ***only 1% of public funds reaches the health facilities to cover the day-to-day operations***. While at budgetary level, PHC may be budgeted at significant share of health budget, in reality, much of it does not go where it should go. Given low levels of governance and accountability for fiscal performance, including budget execution and reporting of what funds are released, and how it is spent, little is ever reported to the Nigerian population and national leadership.

While existing health programmes have been technically designed with evidence-based, high-impact health interventions to contribute to the achievement of SDG3 targets 3.1 and 3.2, government resources for health financing are inadequate for the achievement of SDG3 targets. Out-of-pocket expenditures for health have remained stagnant at alarming high levels over the past decade (76% from the latest NHA available, 2017). Wide variations exist across the 36 states and the FCT as per the 2019 NBS expenditure report. This scenario negatively affects vulnerable groups, particularly those who live under poverty, which are more than 80 million Nigerians.

Government general health expenditure (GGHE) more than doubled over the four years under review. It increased from NGN352.5 billion in 2016 to NGN747 billion in 2019. As shown in Figure 3, the proportion of the government general expenditure (GGE) allocated to health

increased from 3.3 per cent in 2016 to 4.7 per cent in 2019. This level of contribution is largely inadequate as it falls short of the 15 per cent recommended in the 2001 Abuja Declaration. The GGHE per capita consistently fell below US$85; it peaked in 2019 at US$12.2. The GGHE to GDP ratio also consistently remained below 1 per cent against the ideal ratio of 5 per cent as suggested by global health communities.

GGHE Ratios in Nigeria

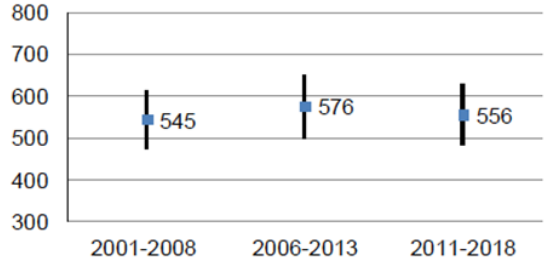


Financial resources were significantly lower than the moderate scenario for the implementation of the NSHDP II between 2016-2019. In addition, the health expenditure per capita for the same timeframe was USD$11 at federal level. Fund disbursements under the moderate scenario revealed inefficiencies across all target states and at the federal level, which translate limited reach to end users, particularly vulnerable and marginalized groups.

Effectiveness and Impact

The evidence reviewed showed that Nigeria has not achieved the NSHDP II, SDG3 targets 3.1 and 3.2 by 2020. There was a stagnant mortality ratio measured in the 2013 and 2018 Nigeria Demographic and Health Survey as shown below, in addition of the negative effects of the COVID-19 pandemic that affected the overall access to health services.

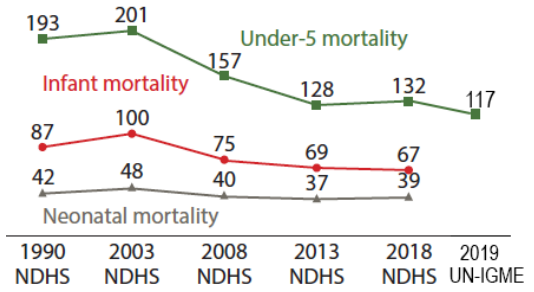
Maternal mortality ratios in Nigeria



As for childhood mortality, Nigeria has performed better, although if this trend continues, the SDG3 targets for year 2030 may not be attained.

The greatest progress has been registered in the reduction of under-five mortality rates, with a declining trend from 193 deaths per 1,000 live births (1990) down to 117 in 2019. However, infant and neonatal mortality have shown a less pronounced reduction since 1990 while showing stagnation since 2013 as show in the graph below.

Child deaths per 1,000 live births



Driving Factors of Maternal and Child Health

The independent evaluation revealed various factors that are contributing to the current juncture of maternal and child health outcomes in Nigeria. Using trend, comparison and regression analyses, the evaluation analyzed health data from six target states: two selected for their high-performance status, or above-average vital statistics; two transitional; and two low-performing states.

The leading causes of maternal deaths in Nigeria are obstetric complications, such as hemorrhage, eclampsia, sepsis, and complications due to unsafe abortions. Similarly, studies show that factors such as age, education, antenatal care, parity, domestic violence, and social autonomy (which has been established as determinants of maternal mortality) are associated with maternal deaths in Nigeria.

Missed opportunities to provide health services is an important dimension of quality of care. While the evaluation revealed improvements in antenatal care, important gaps still persist; like the administration of tetanus toxoid vaccine for pregnant women (TT2+) and the administration of intermittent preventive therapy to avoid malaria complications during pregnancy. Findings also revealed a generalized decrease in coverage between the attendance of antenatal care and birth delivery, which is more pronounced in low-performing states.

Another missed opportunity is case-finding among HIV-positive pregnant women. There is an annual estimate of 150,000 HIV-positive women in the country, but only 41,000 are receiving ARVs. This reflects the huge gap in the coverage of prevention of mother-to-child transmission of HIV (PMTCT) services, with just 10-20% of ANC sites offering PMTCT.

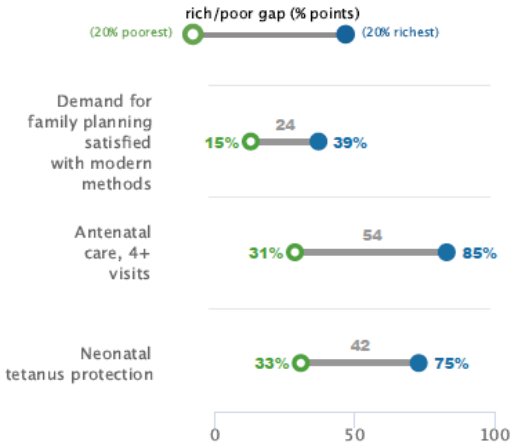
The three leading causes of childhood mortality are malaria, pneumonia, and diarrheal diseases. Lack of malaria testing was observed when an under-five child with fever seeks care outside home. Less than 50% of children with fever seek care outside home. Early care seeking is more frequent in high-performing states, showing better access to private health providers.

The main drivers for childhood mortality include place of living, mother's level of education, family income, availability of potable water, and basic sanitation. Children living in rural areas in low-performing states have higher probabilities of illnesses and life-threatening conditions, than children living in urban areas. Mothers with no education increased the odds of childhood deaths by 50% when compared to mothers with higher education in low-performing states and up to 78% in transition states. These findings reveal that lack of education among mothers is a significant predictor for childhood morbidity and mortality. Lastly, regarding water source and sanitation, more than half of households in high-performing states had improved water sources while six out of ten households in low-performing states lacked a clean water source.

Equity

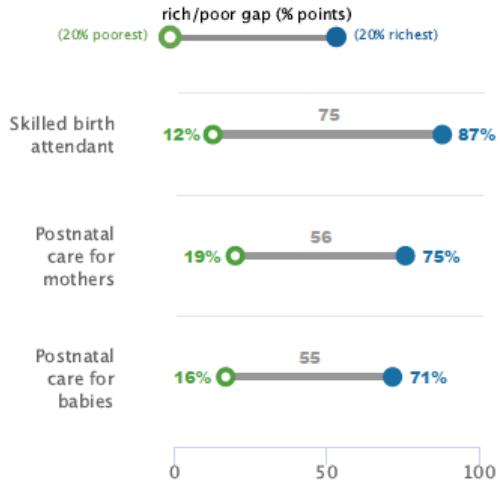
There are significant barriers to access basic health services in Nigeria. These barriers are rooted in social determinants of health, including socio-economic status, education, gender inequality, geographical location, and poor access to water, sanitation and hygiene. In addition, there are strong disparities in the utilization of health services and significant differences between the North and the South. Health data trends from the FMOH revealed inequities in maternal mortality rates across the six geopolitical zones in Nigeria, with the North-East and the North-West zones of the country reporting almost ten and six times, respectively, higher mortality rates than the South-West of the country. In addition, women from rural areas in northern Nigeria are at higher risks of maternal deaths than those from the southern part of the country. Lower access to health care services is most common in the Northern zones of the country, particularly in rural areas, among individuals with low socioeconomic status. This is due to distance to a health facility, limited means of transportation, poor staffing in health facilities, poor attitude of health providers, and lower levels of education.

Equity gaps during pre-pregnancy and pregnancy



Skilled birth attendance, which is one of the key indicators for maternal health, registers the largest gap among key health indicators in Nigeria between the richest and the poorest quintiles as shown below.

Equity gaps at birth and postnatal care



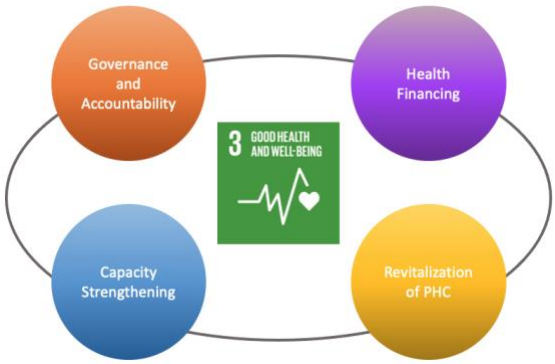
Similar equity gaps were observed for children's immunization and management of childhood diseases for pneumonia and diarrhea.

The equity gaps observed in many of key health indicators for maternal and child health demonstrate a persistent disparity of health services for women and children across the country. Income, education and location (north/south, urban/rural) are the driving contributors of equity gaps in key health indicators for women and children.

Policy recommendations

The analysis and findings form the independent evaluation provide a systematic foundation for addressing gaps and opportunities for improving the health of mothers and young children in a complex Nigerian health system. The recommendations are grouped under four interdependent thematic areas as shown in the following table.

SDG3 Recommendations by Thematic Areas



There is no single formula to address the problems of access and quality of health services in Nigeria, as there are many variations among state health systems, population conditions, and economic factors. The recommendations below can serve as a guide for Nigerian policy and decision makers to consider and to facilitate progress to attain the SDG3 targets by 2030.

Governance and Accountability

- Empower leadership for the design, implementation, monitoring, and evaluation of health programs, focusing on PHC and referral sites.

Health Financing

- Increase the allocation of resources to the overall health budget by increasing the proportion of the Government General Expenditure to at least 10% by 2025 and 12% by 2030 to fast-track the achievement of SDG3.
- Strengthen the public financial management system to address inefficiencies: maximize spending levels within budgets, focusing on increased spending at LGA and/or facility level for improving PHC services.

Revitalization of Primary Health Care

- Strengthen local and decentralized strategic planning, and associated implementation plans focusing on management skills, identification of key barriers for high program performance, and design how to overcome them in a systematic way.
- Continue the rollout of the BHCPF in all 36 states and the FCT to deliver the BMPHS to 20.6 million Nigerians by 2023 and to 40.0+ million Nigerians by 2030.

Capacity Strengthening

- Maximize systematic coordination for strengthening the capacity of State, LGA and facilities for the implementation of the BHCPF in all 36 states and the FTC using a phased approach for the roll out of the BHCPF in three aspects: technical/clinical (at facility level); management (at facility and LGA); accountability (at all levels).
- Strengthen training curricula by program area and training plans, focusing on standardized case management and quality of care, supportive supervision, and in-service training.

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This brief is based on the **Independent Evaluation of the Effectiveness and Impact of the SDG3: Healthy Lives in Nigeria.** The purpose of this brief is to facilitate the exchange of knowledge between UNICEF and its partners. The contents of the evaluation report, and consequently this brief, do not necessarily reflect the policies or views of UNICEF. For more information, please contact UNICEF Nigeria (nigeria@unicef.org).