



Understanding the context of health coverage in Nigeria and progress towards universal health coverage

Virtual meeting

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Opinions expressed in this report do not necessarily represent the views of all participants at the event, the Academy of Medical Sciences, or its Fellows.

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Preface

The goal of universal health coverage (UHC) is to ensure that all people have access to essential health services without enduring financial hardship, and UHC is an integral part of the Sustainable Development Goals (SDGs). Even so, half of the world's population does not have access to essential health services. Globally, 100 million people, including 11 million Africans, are pushed into poverty each year by having to pay for healthcare. In Nigeria, out-of-pocket expenditure accounts for over 70% of national spending on health.

On 2–3 September 2020, the UK Academy of Medical Sciences (AMS) and the Nigerian Academy of Science held a two-day virtual meeting to take stock of the current status of healthcare in Nigeria, progress towards UHC, and the potential role that research could play in accelerating progress. The AMS, through the Global Challenges Research Fund, funded the meeting.

The workshop programme was developed by the workshop organisers and a steering committee chaired by Professor Friday Okonofua FAS, University of Benin, Nigeria, and Professor Mike English FMedSci, KEMRI-Wellcome Trust Research Programme, UK/Kenya. This report provides a summary of the key themes to emerge at the workshop. It reflects the views expressed by participants at the workshop and does not necessarily represent the views of all participants, all members of the steering committee, the AMS or the Nigerian Academy of Science.

Executive summary

The goal of universal health coverage (UHC) is to ensure that all people have access to essential health services without enduring financial hardship. Globally, it is enshrined within Sustainable Development Goal 3 (SDG3) as an objective to be achieved by 2030.

Nigeria has committed itself to delivering UHC and has established a comprehensive national UHC policy framework. However, limited progress has been made in the implementation of this framework. Nigeria scores poorly on multiple UHC indicators, including the provision of government funding for health (amongst the lowest in the region) and the percentage of health expenditure accounted for by out-of-pocket expenses (the highest in the region). Health outcomes are correspondingly poor. Life expectancy, for example, has risen more slowly than in other African countries.

In September 2020, a virtual workshop, jointly organised by the UK Academy of Medical Sciences and Nigerian Academy of Science, sought to assess the current status of UHC in Nigeria, discuss how the UHC agenda could be advanced, and identify the potential contributions by the Nigerian and global research community that could be made towards it. Following breakout groups, plenary presentations and discussions, participants identified a range of priority issues:

- **Re-energising UHC in Nigeria:** Participants suggested that a strong national UHC policy framework already existed and did not need to be reinvented. Instead, attention should be focused on clarifying the national vision and key messages for UHC in Nigeria, and on developing an advocacy strategy that targets key national and state-level stakeholders to reinvigorate the drive towards UHC. Influential 'champions' were required to lead advocacy activities. Considering the connection between health and other development agendas, it was agreed that multi-sectoral engagement was important. It was argued that the delivery of an essential package of services to all through primary healthcare should lie at the heart of this vision. It was also suggested that UHC in Nigeria should be built upon public funding.
- **From policy to action:** Participants identified a critical need to establish greater momentum in the implementation of policy, particularly at state and local government levels. Given the scale of the task, it was suggested that a national UHC roadmap could be developed to identify sequential stepping stones on a national journey to UHC. Owned by the government of Nigeria, such a roadmap could be developed with national, state and international partners. It could outline clearly defined roles and responsibilities, and be supported by a monitoring and evaluation framework, with data on key UHC indicators, to ensure accountability and to guide corrective action at all levels.
- **Research to catalyse action:** Research was seen as having a vital role to play in generating the data to support an evidence-based approach to UHC development. As well as identifying key lessons from past research, the research community could help to establish a national research agenda, identifying key evidence gaps and unanswered questions. The contribution of research could be nurtured through the strengthening of national and international networks and multi-sectoral collaboration. To ensure buy-in and the generation of policy-relevant findings, it was considered essential that policymakers were closely engaged in the development of a research agenda and individual projects, and were informed of results.
- **Engaging stakeholders – community engagement:** Participants argued that awareness of UHC and its benefits needed to be raised among communities, to support bottom-up advocacy and social accountability. Greater public support for UHC could help to generate pressures on elected authorities and thereby build political commitment to UHC. Communities have the potential to be involved in multiple aspects of UHC, including the design of essential care packages, service delivery through community health workers, and the oversight of facilities and providers.

- **Engaging stakeholders – private sector:** The private sector makes a major contribution to health service delivery in Nigeria, however, a reliance on the private sector raises questions of equitable access and quality assurance. Nevertheless, attempts have been made to leverage the private sector to improve the quality and reach of health services. While there is potential to include private providers in publicly-funded UHC programmes, it was recognised that this would have implications for health service staff, for example raising the need for effective service procurement, as well as the oversight and regulation of private providers.
- **Leveraging COVID-19:** The COVID-19 pandemic has presented new health challenges for Nigeria and highlighted the shortcomings in primary healthcare systems and inequitable access to services. Following the lead of other countries, participants argued that COVID-19 could provide a catalyst to achieve transformative change.

Despite the challenges, participants were optimistic that many of the foundations for accelerated progress towards UHC were already in place in Nigeria. What is needed is a catalyst to bring interested parties together and to generate momentum to overcome the current impasse. The Nigerian Academy of Science expressed a desire to engage with the government to identify the contributions it and the research community in Nigeria could make to the reinvigoration of the UHC agenda in the country.

Introduction

According to the World Health Organization (WHO), universal health coverage (UHC) is a means of ensuring that all people and communities can use the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, whilst also ensuring that the use of these services does not expose the user to financial hardship.¹ UHC is an integral part of the WHO Constitution agreed in 1948, which declared health a fundamental human right, and of the 'health for all' agenda set out in the Alma-Ata Declaration in 1978.² UHC is specifically referred to in Sustainable Development Goal 3 (SDG3)³ and, by ensuring the health of populations, it also makes a fundamental contribution to the achievement of other SDGs.

The concept of UHC is based on three key dimensions (Figure 1):

- **Equity:** Services should be available to all, regardless of their ability to pay.
- **Quality:** Services should be of the highest possible quality.
- **Financial protection:** Using health services should not place individuals at risk of financial hardship.

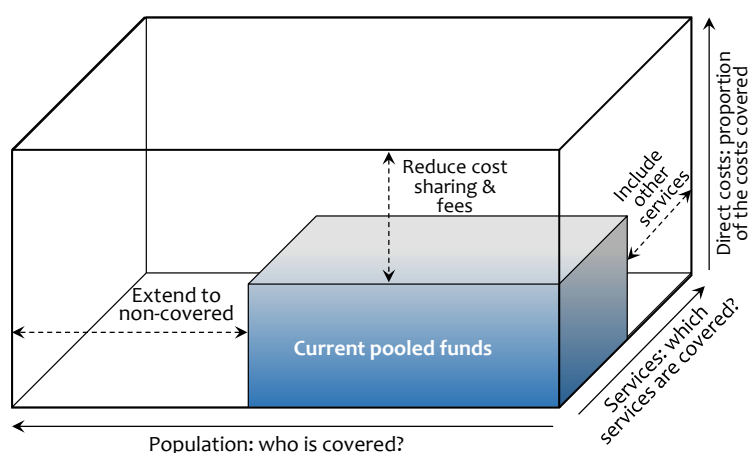


Figure 1: The three dimensions of UHC

As captured in the Alma-Ata Declaration, primary health care is the foundation of UHC.

1. WHO. *Universal health coverage (UHC)*. [https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))
2. WHO (2018). *Declaration of Alma-Ata*. Geneva: WHO. https://www.who.int/publications/almaata_declaration_en.pdf
3. United Nations. *Sustainable Development Goals. Goal 3: Ensure healthy lives and promote well-being for all at all ages*. <https://www.un.org/sustainabledevelopment/health/>

The Declaration called for urgent national and international action to strengthen primary healthcare in order to deliver 'health for all'. In 2018, the Global Conference on Primary Health Care in Astana, Kazakhstan, marked the 40th anniversary of the Alma-Ata Declaration by reaffirming the centrality of primary healthcare to UHC.⁴

There is a variety of ways in which UHC can be financed.⁵ UHC is fundamentally based on equitable access to health services, yet individuals vary greatly in their ability to pay. In resource-poor settings, a large proportion of a population may lack the ability to pay for health services, yet the effects of poverty place them at an increased risk of ill-health. Hence, market-driven, privately financed health systems are unlikely to deliver equitable access. In addition, evidence to date suggests that private voluntary insurance schemes are not effective at achieving UHC. This leaves public financing as the route most likely to deliver UHC, based on pooled resources for health that are allocated according to need.⁶ Resources can be generated by taxation, social insurance or a combination of the two.⁷

Nigeria is sub-Saharan Africa's most populous country, with an estimated population of around 200 million. Its population is projected to double to nearly 400 million by 2050. Despite some progress, health outcomes in Nigeria are poor.⁸ Life expectancy is 18 years shorter than the global average. One Nigerian child under five years dies every minute and one Nigerian woman dies in childbirth every 10 minutes. Nigeria accounts for a quarter of global cases of malaria and half of the non-communicable disease burden in sub-Saharan Africa.

In part, this reflects a weak and underfunded health system. Nigeria spends a relatively small proportion of national income on health (3.76% of GDP in 2017),⁹ and out-of-pocket expenditure on health as a proportion of total health expenditure is amongst the highest in the world (77.23% of total health expenditure).¹⁰ Many primary healthcare facilities have fallen into disrepair and public services are not well used or trusted. Most services are provided within the non-profit and for-profit private sector, including informal providers who are a source of western and traditional medicines. As well as for cost and convenience, deep-rooted cultural factors may also encourage the use of traditional medicines and providers.

A voluntary National Health Insurance Scheme exists in Nigeria, but it is not widely used, covering less than 5% of the population. Furthermore, the system does not reach into Nigeria's informal economy, which accounts for more than 60% of its total GDP.

Nigeria has a highly devolved health system. Responsibility for health lies principally with states, who hold a great deal of political autonomy. Primary health services are organised at local government area level. Because of the devolved nature of the health system, the federal Nigerian government has limited capacity to influence state and local government activities, and centrally-led attempts to modernise and upgrade primary healthcare systems have had limited success. Some progress has been made in states where political commitment to improve health outcomes exists. Ondo State, for example, achieved remarkable progress in reducing maternal mortality through a state government-led initiative,¹¹ becoming the only Nigerian state to achieve the Millennium Development Goal for maternal mortality.

4. WHO, UNICEF (2018). *Declaration of Astana*. Geneva: WHO. <https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf>
5. Kutzin J, et al. (2017) *Developing a national health financing strategy: A reference guide*. Geneva: WHO. https://www.who.int/health_financing/documents/health-financing-strategy/en/
6. Brundtland GH (2017). *Political commitment is the key to Universal Health Coverage*. BMJ Opinion. <https://blogs.bmj.com/bmj/2017/07/10/gro-harlem-brundtland-political-commitment-is-the-key-to-universal-health-coverage/>
7. Awosusi A, Folaranmi T & Yates R (2015). *Nigeria's new government and public financing for universal health coverage*. Lancet Glob Health Sep;**3(9)**:e514-5.
8. National Population Council (NPC) and ICF (2019). *Nigeria Demographic and Health Survey 2018*. Abuja, Nigeria, and Rockville, USA: NPC and ICF. <https://www.dhsprogram.com/publications/publication-fr359-dhs-final-reports.cfm>
9. <https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=NG>
10. <https://data.worldbank.org/indicator/SH.XPD.OOPC.CH.ZS?locations=NG>
11. Ajayi AI & Akpan W (2020). *Maternal health care services utilisation in the context of 'Abiye' (safe motherhood) programme in Ondo State, Nigeria*. BMC Public Health **20(1)**:362.

At a national level, Nigeria has established a strong policy framework for UHC and health more generally. This includes the Presidential Summit Declaration on UHC in 2014, launch of the second National Strategic Health Development Plan as a UHC policy framework in 2018, and establishment of the Basic Health Care Provision Fund as a mechanism to generate additional financial resourcing for health. However, minimal progress has been made in policy implementation. Recently published data indicate that Nigeria continues to perform poorly on multiple UHC indicators.¹² Its service coverage score (38) lags behind those seen in countries such as Rwanda (59) and South Africa (60), and its incidence of catastrophic health expenditure (24.77) is far higher (Rwanda, 4.61; South Africa, 1.41). To improve these numbers, Nigeria will need to address multiple challenges (**Box 1**).

Box 1: Key health system challenges in Nigeria

- Inadequate resourcing of health
- Limited political commitment to health and primary healthcare
- Underfunding of primary healthcare and a lack of public confidence
- Lack of clarity on roles and responsibilities at different levels of the system
- Weak institutional capacity to develop implementation plans
- Human resource shortages
- Poor public financial management
- Limited absorptive capacity in the health system
- Vertical programming and silos create inefficient systems
- Lack of alignment between donors and domestic priorities
- Extensive but fragmented private sector

To explore the current status of UHC in Nigeria, the Academy of Medical Sciences (AMS) and the Nigerian Academy of Science organised a two-day virtual discussion meeting with UK and Nigerian academics, health professionals and policymakers. Breakout sessions addressed three specific issues – policy, research and multi-sectoral collaboration (summarised in **Annex 1**). A range of converging themes emerged from these discussions.

12. GBD 2019 Universal Health Coverage Collaborators (2020). *Measuring universal health coverage based on an index of effective coverage of health services in 204 countries and territories, 1990-2019: a systematic analysis for the Global Burden of Disease Study 2019*. *Lancet* **50140-6736(20)30750-9**. doi: 10.1016/S0140-6736(20)30750-9.

Re-energising UHC in Nigeria

Participants recognised that Nigeria has a strong policy framework for UHC, but that the implementation of policy directives has stalled. It was proposed that efforts were now needed to reinvigorate the drive towards UHC.

An important first step was felt to be **clarification of the national vision for UHC** in Nigeria; this would underpin advocacy activities to mobilise political commitment to UHC, and thereby catalyse the translation of strategy into action. It was suggested that existing policy documents contain all the necessary core information and that this could be repackaged in new advocacy materials.

It was felt that for **advocacy** to be **effective** influential ‘champions’ would be required who could argue the case for UHC at a high political level. Given the devolved nature of the Nigerian system, state-level political leaders were seen to be key targets of advocacy activities. It was suggested that state-level health policymakers were often unaware of the details of national UHC policy.

Participants discussed the importance of establishing a **coalition for UHC across multiple sectors**, given the interdependency between health and other aspects of development, such as education and economic development. Links between health and the wider development agenda should be emphasised, and efforts made to ensure complementarity and exploit synergies across sectors.

Importantly, UHC is not yet seen as an issue likely to influence electability, which contributes to the lack of state-level political commitment. **Mobilising public support** for UHC will therefore also be a critical element of an advocacy strategy (as mentioned later in the report). **Promoting competition between states** could also help to motivate state-level actors.

In terms of messages, it was argued that the **provision of quality primary healthcare services** should be emphasised as core to UHC. There is a risk that UHC is seen primarily as a health financing mechanism. While adequate financing is clearly important, resourcing should be driven by the requirement to deliver a package of high-quality essential health services to all populations.

In terms of **UHC financing**, the extensive private health sector was seen as a potential contributor. However, to ensure equity of access, it was argued that services should be free at the point of use, and supported through public financing. This would be consistent with the 2001 Abuja Declaration, in which countries in the region committed to allocating at least 15% of their annual budgets to improve the health sector.¹³ Public financing could come from a range of sources, including general taxation and health insurance schemes, as well as international development assistance. It was suggested social health insurance schemes should be mandatory to expand coverage.

Schemes such as the Basic Health Care Provision Fund were felt to have the potential to make a contribution to UHC financing in Nigeria if implemented effectively.¹⁴ However, it was suggested that the scale of the fund is insufficient to deliver maternal and child health services, let alone full UHC. It was felt that the National Health Insurance Scheme has limited scope for impact, particularly given the large size of the informal economy. Suggested opportunities for **raising additional revenues** included taxes on telecommunications companies or mobile phone usage and ‘sin taxes’ (e.g. on tobacco). Nigeria is also one of the world’s largest oil producers, and has extensive other natural resources, which could provide additional opportunities to raise funds for UHC through taxation. However, it was noted that there would be competition from other sectors for tax revenues. There was some reluctance to consider ‘hypothecated taxes’ – taxes raised with a specific purpose in mind.

It was also noted that the lack of resources was not the full story. The Nigerian health system also **lacks the absorptive capacity** to process greater amounts of financial support, while significant shortcomings exist in public financial management. To support calls for additional resources, it will be important to demonstrate that current funds are being used effectively.

13. African Union (2001). *Abuja declaration on HIV/AIDS, tuberculosis and other related infectious diseases*. OAU/SPS/Abuja/3 27.

14. Onwujekwe O, et al. (2018) *Examining the Financial Feasibility of Using a New Special Health Fund to Provide Universal Coverage for a Basic Maternal and Child Health Benefit Package in Nigeria*. *Front Public Health* 6:200. doi: 10.3389/fpubh.2018.00200.

From policy to action

Participants argued that overcoming the current impasse would require a greater focus on implementing existing policies related to UHC, and would be dependent on **strong engagement with policymakers at both the federal and state level**, backed up by the advocacy activities discussed earlier in the report. It is also important to involve lower-level local government structures, given their central role in delivering primary healthcare services, and sectors beyond health in order to identify potential synergies and opportunities to align activities.

Given the scale of the challenges and the current underdeveloped state of the Nigerian primary healthcare system, UHC is not a goal that can be achieved overnight. It was suggested that **developing a roadmap to UHC** might be helpful – ideally at national and state levels – to map out the stepping stones required to achieve full health coverage. Kenya, for example, initially implemented a package of UHC services in four out of 47 pilot counties.¹⁵

Owned by the government, but developed in collaboration with state, national and international partners (potentially including the Nigerian Academy of Science and other civil society organisations), this roadmap could clearly set out the key milestones to UHC, as well as the **roles and responsibilities** of all stakeholders involved in achieving them. It would need to be sufficiently flexible to allow a degree of experimentation and the generation of new evidence, and to take account of the context-specific challenges faced by different states.

To provide a mechanism for tracking progress, and to ensure accountability for achieving targets, a **monitoring and evaluation framework** would be essential to gather data on key UHC indicators. These data should be collected, analysed and used at all levels of the system, to monitor performance and to drive and evaluate corrective actions when required. A stepwise approach to the achievement of targets towards UHC would also help to motivate stakeholders.

The implementation of policy would also need to address the issue of **fragmentation**. Progress to date has generally been piecemeal, with vertical programmes established to overcome deficiencies in the current health system. As well as creating silos, vertical programmes can lead to a focus on a limited number of goals, often linked to a donor agenda, without consideration of wider impacts. Participants suggested that future efforts should be more integrated, country-led and have a stronger emphasis on strengthening health systems.

15. WHO Regional Office for Africa (2018). *Kenya rolls out Universal Health Coverage*. <https://www.afro.who.int/news/kenya-rolls-out-universal-health-coverage>

Research to catalyse action

Participants argued that the research community in Nigeria has the potential to play a key role in re-energising and guiding the implementation of UHC in Nigeria. For example, multiple initiatives have been put in place to improve primary healthcare and the health system in Nigeria, and there are opportunities to **identify the lessons learned** from these efforts to inform the development of a UHC roadmap.

Building on this synthesis, the research community could also help create a **national UHC research agenda**, identifying key gaps in knowledge and unanswered questions that need to be addressed in order to develop an evidence-based implementation plan.

As well as formative research to inform the design of UHC packages of care and delivery systems, research will also be critical to the **monitoring and evaluation of new UHC-related activities**. Implementation research¹⁶ has the potential to play a key role in understanding the factors affecting the successful introduction of new delivery systems and ways of working.¹⁷ Research is also required to understand the factors that affect the use of evidence in policymaking and how best to promote evidence-based policymaking.

Participants also noted the **potential of new technologies**, particularly digital technologies, to enhance the quality of services and interactions with the public and patients. There is significant scope for innovation but also a need for careful evaluation, including consideration of factors such as cost-effectiveness and scalability.

These activities could be facilitated by **enhanced networking and collaboration** across the Nigerian health research community, as well as through engagement with other research sectors. There is the potential to bring multiple disciplines together, including social science researchers and health economists. A range of national and international sources of funding could be identified to support these activities, leveraging global interest in UHC, particularly if links are made with the sustainable development agenda. Global partners have identified the need to accelerate efforts to achieve SDG goals and to coordinate activities, as outlined in WHO's Global Action Plan.¹⁸

Participants also noted the importance of **engaging policymakers early** in the development of a research agenda and in individual projects. This can help to ensure that research addresses the questions that matter to decision-makers and generates evidence that can be used by policymakers; it also increases ownership of the results by policymakers.

In 2020, the African region was certified as having eradicated wild poliovirus – a landmark achievement. The Global Polio Eradication Initiative (GPEI) has supported multiple initiatives in Nigeria, the last country in the region with a documented case of wild poliovirus. As GPEI funding ramps down in the coming years, it was argued that the Government of Nigeria needs to take on responsibility for funding essential polio assets to maintain polio-free status, as well as to sustain other critical activities that have been supported by GPEI resourcing.

Participants argued that there is an opportunity to use the human resources, expertise and technology that were mobilised to combat polio to strengthen primary healthcare systems and improve public health. These opportunities range from the use of novel geographic information system (GIS) technologies to map communities and plan service delivery, the development of strategies to address the needs of mobile and displaced populations, particularly in conflict-affected areas, and community-based surveillance and service delivery.

16. Ridde V, Pérez D & Robert E (2020). *Using implementation science theories and frameworks in global health*. *BMJ Glob Health* **5(4)**:e002269.

17. Uneke CJ, et al. (2016). *An assessment of maternal, newborn and child health implementation studies in Nigeria: implications for evidence informed policymaking and practice*. *Health Promot Perspect* **6(3)**:119-27. doi: 10.15171/hpp.2016.20.

18. WHO. Stronger Collaboration, Better Health: Global Action Plan for Healthy Lives and Well-being for All. <https://www.who.int/initiatives/sdg3-global-action-plan>

Engaging stakeholders – community engagement

To date, there is little evidence that UHC has captured the imagination of the Nigerian population. Indeed, health in general appears not to be a particularly political issue, and in the absence of a strong groundswell of public support, there are few pressures on politicians to address public health issues. In part, this may reflect the high usage of private services, particularly in urban centres such as Lagos, resulting in healthcare provision not necessarily being seen as a public function. In addition, marginalised communities, for example in remote rural or impoverished urban areas, have limited opportunities to make their voices heard.

Participants suggested that **community engagement** was required to highlight the benefits of UHC, the universal right to health, and to government commitments to improve healthcare provision. As well as building demand for primary healthcare services, greater public awareness and knowledge could help to generate bottom-up pressures to increase political commitment to and prioritisation of primary healthcare.

Such mechanisms could also contribute to **greater social accountability**. Attempts are being made to involve local community groups in the governance of primary healthcare facilities to improve service quality. It was also suggested that individuals involved in the Community Health Influencers, Promoters and Services (CHIPS) Programme, recently launched to strengthen community-based health in rural areas, could play a key role in raising public awareness of UHC. These and other efforts can ensure that facilities provide quality and convenient people-centred health services that meet their needs.

Engaging stakeholders – private sector

The private sector currently delivers the bulk of primary healthcare services in Nigeria, particularly in urban centres. Given this significant presence in the healthcare sector, it is difficult to imagine that the private sector will not make some contribution to UHC. Furthermore, the entrepreneurial spirit in Nigeria is a national strength that could be mobilised to address healthcare challenges. There are examples of projects that have involved engagement with the private sector, for example to help restore inoperative public health facilities and to improve coordination and quality of care.

However, participants also noted a number of challenges associated with the involvement of the private sector in healthcare. These include the potential impact of out-of-pocket expenses and the lack of any motivation among private providers to consider equitable access to services.

On the other hand, the private sector could be a mechanism to deliver publicly funded health services (as illustrated by the well-respected French healthcare system). This would require developing the expertise of public health officials in the **procurement of services** rather than in practical health service delivery, and would also depend on **effective governance systems** for monitoring and regulating private sector activities.

Participants also noted that traditional approaches to healthcare and informal providers were popular in Nigeria, particularly in rural areas. Discussion would be needed on whether and how these approaches could be integrated into Nigerian UHC systems.

Leveraging COVID-19

COVID-19 has presented Nigeria with an additional health challenge on top of an already high disease burden and frequent outbreaks of emerging and re-emerging infections. Globally, COVID-19 has highlighted the critical links between health security and economic prosperity, with the COVID-19 pandemic dealing a devastating financial blow to the Nigerian and world economy. Nigeria's economy contracted by 6.1% year-on-year in the second quarter of 2020.

Although the middle of a pandemic might seem an inopportune time to initiate reform, it can also be sufficiently disruptive to catalyse major change. China's experience during the SARS-CoV-1 outbreak shone light on the inadequacy of its primary healthcare system and triggered major new investments; public sector expenditure on healthcare in China increased almost 14-fold between the SARS outbreak in 2003 and 2018.¹⁹

Another example of reform at a time of crisis was following the Asian financial crisis in the early 2000s, when Thailand committed itself to UHC and financial protection, and by 2015 98.5% of its population was covered by health insurance schemes. It is now seen as a model for how low- and middle-income countries can achieve UHC.²⁰ Its GDP at the time it launched its UHC initiative is comparable to Nigeria's current GDP. Notably, its primary healthcare infrastructure has contributed to a highly effective response to COVID-19 in Thailand.

In South Africa, the country in the region most affected by COVID-19, President Cyril Ramaphosa has led active efforts to control the pandemic. High levels of inequality, which extend to inequities in access to healthcare, are a particular challenge in South Africa. The government has developed a National Health Insurance (NHI) Bill to enhance access to services, and implementation of the bill would provide a major boost to primary healthcare services for the disadvantaged.²¹ President Ramaphosa has argued that the COVID-19 pandemic has both highlighted the need for the NHI mechanism and will shape its implementation.²²

19. Sita P (2020). *What has China's public healthcare system learned from the twin coronavirus outbreaks of Sars and Covid-19?* South China Morning Post. 14 March. <https://www.scmp.com/business/china-business/article/3075095/what-has-chinas-public-healthcare-system-learned-twin>
20. Tangcharoensathien V, et al. (2019). *The Political Economy of UHC Reform in Thailand: Lessons for Low- and Middle-Income Countries*. Health Syst Reform **5**(3):195-208. doi: 10.1080/23288604.2019.1630595.
21. Reid S (2020). *Coronavirus pandemic holds lessons for South Africa's universal health care plans*. The Conversation. 17 May. <https://theconversation.com/coronavirus-pandemic-holds-lessons-for-south-africas-universal-health-care-plans-137443>
22. Hunter Q (2020). *South Africa: Ramaphosa Says Govt's COVID-19 Response Is Preparing Country for NHI*. All Africa. 1 June. <https://allafrica.com/stories/202006010161.html>

Conclusions

The SDGs include a commitment to deliver UHC, yet progress is currently insufficient to ensure that key SDG goals will be met by 2030. Furthermore, despite some progress, wide disparities in health outcomes and service provision persist within Nigeria.²³ Nigeria's 2018 Demographic and Health Survey identified major variations in, for example, infant and child mortality and maternal healthcare across the country.

Nigeria has established a coherent policy platform for achieving UHC. However, policy implementation is proving a sticking point, and efforts are needed to catalyse action to accelerate progress towards UHC. This will depend on strong political commitment by federal government but, critically, also at the state and local government levels. Coalitions of key state, national and international stakeholders are required, across sectors, to map out a future direction of travel and key milestones on the journey to UHC. People-centred healthcare systems delivering UHC have been identified as crucial to future health and prosperity in sub-Saharan Africa, and are an achievable goal with sufficient political commitment.²⁴

COVID-19 has added a further challenge to the Nigerian health system. It has also emphasised the fundamental importance of a strong primary healthcare system to absorb new shocks and to provide the foundation for an effective response to new health threats.

The research community has the potential to make a critical contribution to the achievement of UHC. As WHO has noted, each country in the region is likely to navigate its own route to UHC, given their unique histories and contexts. National health research systems will play a vital role in generating the evidence to support the necessary re-engineering of national health systems during this journey.²⁵ In 2015, countries in the region signed up to a national health research strengthening strategy²⁶ and a 'barometer' has been developed in order to track progress.²⁷

Consistent with this idea, the Nigerian Academy of Science is committed to working with the Government and other national and international stakeholders, to identify how the extensive intellectual capital available within the country and via international networks can be mobilised to support an acceleration of UHC in Nigeria.

23. Bill and Melinda Gates Foundation (2019). Goalkeepers Report 2019. Available at: <https://www.gatesfoundation.org/goalkeepers/report/2019-report/>

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Annex 1: Summaries of breakout groups

Policy

How can a vision for UHC in Nigeria be supported, and what strategies are required to operationalise this?

Policy direction exists (reflected in the NSHDP2, NHP, NHAAct²⁸) – but awareness, accountability and implementation is weak

Strategies

Stakeholder engagement strategy

- Clearly define the key stakeholders and bring them on board for conversations
- The vision needs to be shared by all stakeholders

Accountability at political level

- Electability is not currently linked to performance or to UHC
- Political will for UHC needs to be strengthened; emphasis on catalysing competition

Communication strategy

- A clear communication plan
- To all key stakeholders – the leaders and the led
- Influential UHC champions are needed to drive advocacy at top level

National minimum standards; subnational specifics

- Tracked, adapted, implemented and incentivised regionally

Where, if any, are there current efforts in these areas, and are there any successes or learnings? Current efforts, successes and learnings

UHC-related initiatives at national and state levels

- Evidence of success linked with political leadership
- Stakeholder engagement has been limited
- Stakeholder including citizen education is poor
- Stakeholder alignment with the agenda
- Bring policymakers to these kind of meetings for true multi-stakeholder approach

NSHDP2 developed

- But political leadership needs to understand the subject matter
- Some commissioners do not know what is in NSHDP2
- Country leadership is needed: partners should not be the core drivers of agenda

28. National Strategic Health Development Plan 2, National Health Policy, National Health Act

Basic Health Care Provision Fund in place

- Fund is not sufficient; questions surround its governance

National Health Insurance Scheme in place

- Not mandatory (concerns here), not comprehensive enough, and still not perceived to be accountable

Political leadership needs to understand the subject matter

- Redirect and refocus leaders with clear stepped approach
- Connect agenda to accountability/electability
- Policies are being driven by technocrats (should be the other way around); UHC policies will only be owned and be backed by political will with demand from political leaders for the policies

Private sector involvement

- Private sector can be powerful beyond service provision
- Brings additional resources, strategies and tools

Should NHIS be compulsory?

- If yes, who pays for and how?

What are the barriers and challenges to supporting successful implementation?

- Poor appetite for system building and leveraging opportunities such as COVID-19 pandemic to build systems or advance UHC
- Vertical approach to issues – needs to be a holistic and integrated approach
- Fragmented approach currently with co-ordination taking place based on different approaches and varied levels
- Current finance system for health
- Not all commissioners and national-level bureaucrats are aware of detail of SSHDP²⁹/NSHDP2, nor ready to own or operationalise it
- Organisations in the health and related sectors are not yet oriented towards UHC and systems building

Are there possible mechanisms to address identified challenges and barriers, and achieve UHC goals?

- Clarity and awareness of existing policy
- UHC firmly embedded into NSHDP2
- Engaging the private sector as a key stakeholder group
- Implementing policies that are already clear in NSHDP2 and SSHDP2
- Financing through a telco/mobile levy, earmarked taxes
- Ensure models for UHC are contextualised
- UHC needs to include community health service strengthening and not focus solely on finance and clinical/medical components
- Stop seeing UHC as healthcare financing – it is about equity, inclusion, accessibility, accountability and sustainability

29. State Strategic Health Development Plan

- Community ownership of UHC
- Have a clear strategy for informal sector (it is a diverse group)
- Separate regulators from providers
- Learn from strategies such as polio and COVID-19
- Build resilience into the health system to ensure robustness

Where are the key priorities for action going forwards?

- Strengthen the health system as a basis for UHC
- Learn from other countries and their response to COVID-19 to inform potential strategies for UHC – helps to politicise it
- Address hunger and poverty at the same time: UHC is not a standalone issue – it is interrelated and integral to many other things
- Raise awareness of UHC at grassroots level and catalyse interest among political leaders
- Improve strategic purchasing functions – spending is not currently well managed

Mechanisms and priorities for action – Additional points

- Improve the political and technical interface
- Strengthen procurement practices
- Clarify who are the key stakeholders*
- Allow for varied premiums for health insurance to ensure universal access
- Use this meeting as a basis to catalyse creation of a plan

* Key stakeholders

- Politicians
- Legislators
- Executives
- Private sector (provision, funding, advocacy)
- Procurement
- Citizens – this is key as we cannot make policies for people we do not speak with or engage with
- Communities
- Clinicians
- Public health
- Academia

Research

How can a vision for UHC in Nigeria be supported, and what strategies are required to operationalise this?

A vision for UHC that prioritises equitable, high-quality coverage

1. Political leadership and governance – UHC needs to become top priority on the political agenda

- Consider actions and solutions at national AND state levels
- National accountability for delivery; benchmarking of states
- State accountability for implementation and performance
- Drive leaders to increase importance of health
- Mobilise community to exert political pressure
- Make use of ‘champions’ to drive implementation

2. Assessment of the PHC system – PHC as the ‘bedrock’

- Re-visit structures and systems for health delivery within states – what is working? How and why, or why not?
- Use research to understand what ‘quality’ PHCs can provide. What works? What could be improved? Gaps?
- Financing and funding flow – right investment in the right areas. Accountability system for fund allocation.
- Review National Health Insurance Scheme (NHIS) – plus: what financial risk protection exists for the poorest?
- Perhaps need for prioritisation. Sequencing of reforms: the term “progressive UHC” often used – it is difficult to expand on all three dimensions simultaneously.

3. Community involvement – increase demand and accountability

- Community voice will facilitate progress towards UHC; change can be quicker when citizens are provided with the adequate information regarding their rights (re-examine current top down approaches).
- Research needed to represent and highlight community voice.
- Design research responses that are fit for purpose to address needs of communities. Design research communications with community identified as a key audience.
- Engage in research that optimises ability of the Community Health Influencers, Promoters and Services (CHIPS) initiative to effectively promote the UHC agenda.

What are the barriers and challenges to supporting successful implementation in this manner?

Research not always designed with research uptake in mind

- Map and involve stakeholders at the outset; plan research activities through to effective communication; target different audiences with appropriate messages/products.

Research not always allocated sufficient domestic funding

- Research needs to have country ownership but most is externally funded; externally driven limits research uptake. Need to prioritise investment in research in Nigeria; lack of investment limits effective 'communities of practice'.

The topic of 'health' is fragmented

- Relatively loose link between 'health' and 'economic development' in the discourse; many vertical health programmes; weaknesses across the health system.

Where are the key priorities for action going forwards?

Key priorities – topics

- Prioritise research that aims to optimise the PHC system and the health system building blocks that underpin high-quality care.
- Understand the end user to identify challenges and formulate the solutions; conceptualise and prioritise the concept of 'health'.
- Develop research agenda on efficiencies in health financing.
- Research strategies for more effective resource targeting to poorest.
- Investigate mechanisms for improving current financial risk protection.

Key priorities – cross-cutting

- Facilitate collaboration and coordination between universities/research institutes; maximise capabilities; different types of evidence generated across different regions are needed to fill evidence gaps for UHC.
- Push beyond descriptive research – focus on evidence-based solutions.
- Learn from other countries and their response to COVID-19 to inform potential strategies for UHC – helps to politicise it.
- Purposively develop research agenda that takes account of state-driven action.

Multisectoral collaboration

How can a vision for UHC in Nigeria be supported, and what strategies are required to operationalise this?

Strategies

- **Political engagement.** Engage the government at the highest levels to raise awareness of the need for UHC, ensure sustainable funding and encourage communication between the federal government and the states and non-state actors.
- **Development of a policy framework to strengthen collaboration** between all key stakeholders and sectors, including government, non-state actors, PHC, community and insurance providers.
- **Gather data.** Data can be used to gain insights and drive implementation.

Where, if any, are there current efforts in these areas, and are there any successes or learnings?

Current efforts, successes and learnings

- There was success with polio when granular data were shared with states who then had the insights to address issues (in a competitive manner). Data on maternity services could be shared in a similar way.
- CHIPS – maternity services could be taken to people in their own home.
- Funding availability in the primary care setting has been shown to increase access to medications.
- An NHIS MGD programme has been implemented in about 14 states with success but was not sustained. Same mechanism could be taken up but focus on UHC.

Current efforts, strategies, and learnings – Additional points

Current efforts, strategies, and learnings – Additional points

- Delta state improved care use when it co-ordinated tactics to improve UHC using public-private partnerships, ensuring people had both insurance and access to facilities.
- Kwara state had success with PHC services through building capacity of governance structures at community level. The intervention of insurance held workers to account.
- In one locality traditional birth attendants have been financially incentivised (200 naira per mother) to encourage maternity and post-natal care into the PHC to overcome the lack of mothers using PHC facilities.
- Broad takeaway – states may need to experiment with UHC but learning should be shared so successful approaches can be replicated.

What are the barriers and challenges to supporting successful implementation in this manner?

Barriers and challenges

- Fragmented approach
 - The lack of senior government engagement and a UHC champion.
 - There is a lack of clarity as to where the responsibility of NHIS falls, and weak collaboration with SHIS.
 - Insurances providers' KPIs focus on profiles rather than lives saved, not just profit.

- Challenge of how to make vertical/specific programmes work to support UHC – often accountability mechanisms for vertical programmes focus entirely on their own KPIs
- Funding is proportional to specific workstreams and programmes. Budget needs to be redirected through a central, sustainable UHC platform.
- Communication
 - Low-level awareness of UHC in the community, especially among the poor
 - Lack of clarity of current strategies, KPIs and communications.

Barriers and challenges – Additional points

- Funding
 - NHIS is not working to ensure a good use of funding.
 - Complexity and integrity issues with budget management.
 - Resources are focused on individual programmes and not a holistic approach.
- Access
 - Access is variable within and between states – so there must be flexibility in implementation to adapt to context
 - Lack of resources.
 - Time and money involved with travel to health facilities, PHC is more than just building the facilities.
 - Poor demand creation and community involvement
- Perception
 - Feels overwhelming to work to achieve UHC even at state level, let alone federal level.
 - A sense of a lack of achievement.

Are there possible mechanisms to address identified challenges and barriers, and achieve UHC goals?

Mechanisms

- UHC agenda at fora (Governors, NASS, NCH & SCH)
- Gathering data to highlight gaps in delivery, including geographic gaps, to encourage implementation.
- Engaging all stakeholders from senior government officials through to consumers to sustainably fund and develop services that are right for the locality and ensure users access them.
- A champion such as the Nigerian Academy of Science with support from organisations like the Academy of Medical Sciences and local foundations bring together important professional, CSOs/consumer or community groups to jointly advocate and hold to account.

Where are the key priorities for action going forwards?

Key priorities

- Focus on states to drive UHC
- Build alliance with private sector on UHC
- Leverage the experience of COVID-19
- Enlist a champion who can:
 - Re-engage stakeholders at all levels on the need for UHC.
 - Co-ordinate activities between stakeholders.
 - Ensure sustainable funding.
- Gather data to bring insight and action to UHC.

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