

**REPORT OF ASSESSMENT OF FREE MATERNAL HEALTH SERVICES IN
NIGERIA**

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LIST OF ABBREVIATIONS

ANC	-	Ante Natal care
ATBU	-	Abubakar Tafawa Balewa University
CHEWS	-	Community Health Extension Workers
CHOs	-	Community Health Officers
CS	-	Caesarean Section
D&E	-	Deferral and Exemption
DFID	-	Department for International Development
DRF	-	Drug Revolving Fund
DRPC	-	Development Research & Policy Centre
EMOC	-	Emergency Obstetrics care
ELSS	-	Expanded Life Saving Skills
EMS	-	Emergency Medical Service
FBOs	-	Faith-Based Organizations
FmCHP	-	Free maternal and Child Health Program
FMCP	-	Free Maternal Care Program
FMHS	-	Free Medical Health Services
FP	-	Family Planning
GDP	-	Gross Domestic Product
HERFON	-	Health Reform Foundation of Nigeria
HMB	-	Hospital Management Board
ICT	-	Information Communication Technology
IMNCH	-	Integrated Maternal, New Born and Child Health
LASUTH	-	Lagos State University Teaching Hospital
LGA	-	Local Government Area
LSS	-	Life Saving Skills
M&E	-	Monitoring & Evaluation
MDG	-	Millennium Development Goals
MHF	-	Medical Health Facility
MHS	-	Maternal Health Services
MMR	-	Maternal Mortality Rate
NANNM	-	National Association of Nigerian Nurses and Midwives
NAWOJ	-	National Association of Women Journalists
NEEDS	-	National Economic Empowerment Development Strategy
NGOs	-	Non-Governmental Organizations
NHIS	-	National Health Insurance Scheme
NMA	-	Nigerian Medical Association
NURTW	-	Nigerian Union of Road Transport Workers
OPD	-	Out Patient Department
PATH	-	Partnership for Transforming Health
PHS	-	Public Health Services
SHP	-	State Health Policy
SMOH	-	State Ministry of Health
SOGON	-	Society of Gynecologists and Obstetricians of Nigeria
TBAs	-	Traditional Birth Attendants
TT	-	Tetanus Toxoide

UNICEF - United Nations International Children's Emergency Fund
WHO - World Health Organization

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EXECUTIVE SUMMARY

Advocates of safe motherhood/maternal and child health services believe strongly that offer of free maternal and child health services is capable of increasing access of women to services and in the long run reduce maternal and neo-natal mortality. In 2001, Kano state blazed the trail with the declaration of free maternal health services to pregnant women and implementation commenced immediately. A few other states in Northern Nigeria such as Katsina, Jigawa (Deferral and Exemption Scheme), Bauchi also followed suit. The Federal Government of Nigeria also in 2006 declared free maternal health services for pregnant women in all federal health institutions in Nigeria. However, the tempo increased and gathered momentum in Northern Nigeria following the Northern State Governors Forum at its First Health Summit held in December 2007 with the theme “**Alarming death rates in the Northern States: *The time for change is now.*** The Governors at the end of The Summit declared their commitment to Free Maternal and Child Health Programs in their respective states with the aim of reducing the alarming maternal mortality ration/rate in Nigeria.

In all the states (Kano, Katsina and Kaduna) where the program has been in practice for some time, there is no known attempt to evaluate/assess the outcomes (“impact”) of the program with a view to determining accomplishments, what worked, what did not work, the challenges and lessons to inform decisions and actions for improvement in areas of policy, legislation, funding, management, infrastructure, stakeholder participation and quality.

Consequently, Health Reform Foundation of Nigeria (HERFON) with support from OXFAM designed and conducted a **research study on assessment of free maternal health services in Nigeria** in October 2008. The overall aim of this study was to review and evaluate free maternal health services practices in the country, the efficiency, effectiveness and sustainability of the practices with a view to scaling up the best practices.

The assessment method includes desk review of maternal situation in Nigeria and six Africa countries, this was followed by collection of basic data on free maternal health in the states in the country namely Kwara, Niger, Abuja, Kano Kaduna, Sokoto, Zamfara, Kebbi, Katsina, Bauchi Gombe, Lagos, Ibadan, Edo, River, Delta and Enugu. In-depth research were conducted in Kano, Kaduna and Katsina States in the North West, Bauchi and Gombe States in the North East, Lagos State in the South West, Rivers state in the South South and Enugu State in South East.

Data were collected using interviewer administered questionnaire on key informants: policy makers, health managers, health care providers, and health care consumers [clients/patients]. An observational facility checklist on personnel, infrastructure, equipment and materials in facilities was also used to collect data on the facilities. The findings revealed that the program in each state is at various levels of development and implementation (advanced, emerged, just emerging) with varying results and challenges that require specific actions.

In 62.5% of the nine states studied, the cost of ANC and delivery services have been completely eliminated. These states include Kano, Kaduna, Katsina, Gombe, Enugu and Bauchi. In the remaining states of Jigawa, Lagos and Rivers only some components of MCH are free under different schemes namely deferral and exemption in Jigawa, free antenatal care service in Lagos as a component of the Free Health Policy, while in Rivers State it operates under the free medical care program. In terms of policy and legal framework, only Enugu, Kaduna, Katsina Bauchi and Gombe States have adopted written policies for free maternal health while Kano and Jigawa States have draft policies documents awaiting legislation by State Houses of Assembly. Lagos and Rivers states have no written policy documents regarding free MHS.

The study revealed that though free maternal and child health services come under different names and arrangements in the states and efforts are being made to achieve wider coverage considering that in most states, the services are only available as State Government health facilities. In most states (with the exemption of Kano), Local Government Areas/facilities are yet to be integrated into the scheme and as such free maternal services are not available at primary health care level. In addition, it was evident that family planning is not included in the bouquet of services that is provided free in all the states perhaps with the exception of Enugu and Rivers states. In the other states, it is the responsibility of any client/patient that desire family planning to pay for such service. This is an indication that family planning is not accorded priority in most of the states as an integral part of maternal services that should be provided free.

SUMMARY OF FINDINGS

In Kaduna state, the scheme (free maternal and child health services) is guided by a policy document and a transitional operational guideline approved in 2006. Implementation started in September, 2007 in 26 State government-owned hospitals and Local government-owned 113 Primary Health Care (PHC) facilities. The involvement of the local government councils at inception of the programme makes the Free Maternal and Child Health (FMCH) programme in the state a unique one. Available records showed that about 184,783 pregnant women benefitted from the programme from inception in September, 2007 to June 2008. Specifically there has been an upsurge in the number of patients in the ANC and deliveries in centers offering this service. The health facility managers, the health care providers and the patients are happy with the introduction of free FMCH but are concerned about the inadequacy of drugs and consumables considering the unexpected surge in patients and inadequate staffing. There are concerns that, the state is unable to meet the additional demand of the program on both human and material resources and it also appeared that the programme is more costly than anticipated. Another concern was non release of funds for the program on time.

In Kano State, program is more advanced in its operations and outcomes. The program is guided by a government policy paper approved in 2001 and a guideline for its implementation, however, program implementation did not start until 2002 and is limited

to only the 33 state government owned hospitals in the state. The legal framework by the State Assembly is still pending even almost after 7 years of implementation. The state government is demonstrating commitments to ensure the success of the project through adequate financial allocation to the program, and provision of equipment and motivation of health care providers which has significantly contributed to increased use of maternal health services by women and children.

There have been tremendous positive outcomes of the program in Kano state as evident by massive increase in the number of pregnant women attending hospitals for antenatal care and delivery from within and outside Kano state including neighboring countries. This has resulted in the over-stretching of manpower and equipment in all the hospitals participating in the program. The health facility managers, the health care providers and the clients interviewed were generally happy with the programme; however, there are concerns about the overcrowding of the health facilities and occasional lack of consumables.

In Bauchi state, the free maternal and child health care services program is still at the rudimentary stage considering that implementation started after the launching in February 2008, but coverage is limited as it is yet to cover the entire state. An enabling law exists while a management structure has also been established. Though available data was incomplete, however, there was indication of consistent increase in the number of women benefiting from the scheme.

The **Jigawa State** version of the free maternal health services is referred to as the Deferral and Exemption (D&E) Scheme and it provides for health care services including emergency obstetric care, even though maternal health services are not yet free. This scheme commenced in February 2005 with support from PATH 1 (a DFID funded project). The draft policy document has been produced, but is awaiting legislation and passage by the State House of Assembly. This explains the rationale for not making the policy document including implementation strategies public.

The D&E Scheme provides a safety net for those who cannot pay hospital charges at the time of need and the services available under scheme include free emergency obstetric care regardless of ability to pay and deferral of payments for all categories of illness for those who can not pay on the spot but has the capacity to pay later. Though baseline data were not available to make comparison possible and scientific, however, pattern of attendance at clinics and utilization of services show positive outcomes of the scheme, though there are instances of inconsistency in increased usage of some services when 2006 and 2007 are compared.

In Gombe state free maternal health service scheme is relatively young and still rudimentary. It is operational only in state owned health facilities with no legislative backing and there is inadequate staffing to implement the program. It is on record that following the introduction of free MHS, government hospitals experienced an unexpected influx of patients from neighbouring states and LGAs. As a result, facilities in these

hospitals have been overstretched due to non involvement of LGAs (PHC) in the program.

In Katsina state, the free maternal services took off with a legislative backing and a 5-year strategic plan in place. All health facilities (secondary health facilities) under the direct control of Katsina State government operates free MHSs for women. No involvement of LGAs yet. The state has also demonstrated strong commitments to stakeholders' involvement in the programme. Available records showed that since the inception of the program, ANC attendance and hospital delivery before and after inception of the free scheme showed some remarkable improvement.

In Lagos state, the Free Maternal Health Services (FMHS) is yet to be backed by any written policy or legal framework, but a derivation of a public pronouncement of the Executive Governor of the State. The program is implemented in at least one state government health facility per LGA except in 3 LGAs that are presently underserved. No data was available to assist in determining the response of women to the program and utilization of services

In Enugu state, the Free Maternal Health Services is available in all the state-owned health facilities i.e. at primary, secondary, and tertiary health care levels. The state has an existing policy document and implementation guideline. There is also an implementation committee which was formed by the executive governor and reports directly to him. The services cover free health services for all pregnant women during ANC and delivery and free child health care services for all children below 5years of age. The bill has been passed by the state House of Assembly and signed into law by the Executive Governor.

In Rivers state, the free maternal health systems does not have a policy and operational framework, however, the program operates in at least one facility per LGA with the exception of 5 LGAs that do not have secondary health care facilities, The assessment also showed that no specific budget line exists for the program, but reimbursements (in the form of out of pocket expenses) are made to health facilities based on submission of reports to the State Ministry of Health

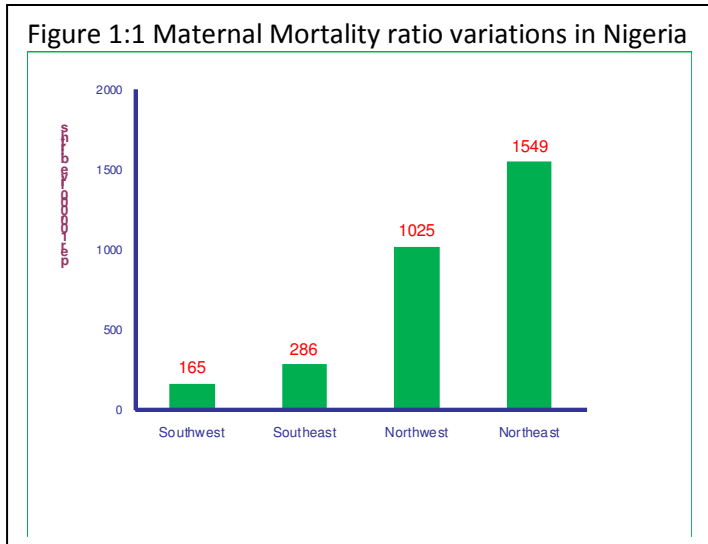
While the survey revealed that some progress has been made in all the states, it is important that across the states, a number of actions are required to bring about improvements. Based on the findings, a number of recommendations should be considered including; active involvement of LGAs in the scheme to expand coverage to rural communities, strengthening monitoring and evaluation mechanism including adequate record keeping, strengthening management structure and systems for the scheme, active mobilisation and participation of partners and stakeholders, consistent and adequate resource allocation, recruitment deployment and training health care providers and establishing participatory internal review mechanism to track progress, identify problems and re-strategizing for positive outcomes and sustainability. It is also recommended that advocacy be stepped up by all stakeholders for the inclusion of family planning in the free maternal health services in the state.

In addition are the following general recommendations for consideration at national levels, state and LGAs proposing to introduce and implement free maternal and child health services.

- a. Baseline or rapid assessment (situation analysis) should be undertaken to provide baseline data that serve as basis for progress monitoring and comparison over a period of time
- b. The Federal Ministry of Health may consider the development and provision of appropriate policy and guidelines for free maternal services including the package, structure, resource mobilisation and allocation (budgeting for free health services), monitoring and evaluation and management structure
- c. Adequate time and resources should be committed to advocacy and community mobilisation as part of preparatory activities
- d. Legislative back up will be required prior to take off to give it legal backing and position it for funding
- e. There is the need for wider consultation, partnership and collaboration with various interest groups, the community and other stakeholders
- f. Consideration should be given to creating consultative forum on Reproductive Health and Maternal & Child Health/Safemotherhood at national and state levels
- g. The avenues of National and State Councils on Health should be used for consensus building and strategizing for effective implementation and expansion of services to rural communities
- h. HERFON should spearhead the composition of a national advocacy body to engage the Federal Government in accelerating the implementation of free maternal/maternity and child health services in Nigeria

1. INTRODUCTION

In Nigeria, maternal mortality is still a relatively common event in spite of a steady increase in the provision of maternal services in the country. Average maternal mortality ratio (MMR) figures for Nigeria are 800 to over 1,700/100,000 live births (with state/geo-political variations – Figure 1.1) and has a life time risk of 1:14-16. (compared with 1 in 2800 in developed regions).⁴ This figure makes Nigeria second to only India which however has a population eight times her own.¹ Most of the MMR figures cited for Nigeria are estimates from institutions and a major defect of these studies is that they were largely hospital-based, limiting their usefulness and applicability to cover mortality at the community level.



The ultimate causes of maternal morbidity and mortality have been well defined. In Nigeria, direct obstetric causes are responsible for majority of maternal death.² Obstetric haemorrhage, either antepartum or postpartum is often the leading cause of maternal deaths in most health care centres in Nigeria. Other leading causes of death are pre-eclampsia/eclampsia, septic abortions, puerperal sepsis, obstructed labour, uterine rupture and anaesthetic deaths. Indirect obstetric causes of maternal death include fulminating hepatitis, acute hepatic failure, severe anaemia in pregnancy, malaria, post-partum pneumonia and recently HIV&AIDS. (Fig 1.3)

However, the immediate determinants of maternal deaths may be more important in terms of prevention of morbidity and mortality. These variables include access to and utilization of antenatal, natal and postnatal services and the quality of care of these services. Although what is seen in the health facility is the pathology, it is important to understand the factors that lead to the situation where the woman eventually dies such as the three levels delays at the family, community and health facility levels.

In Nigeria, only 60% of women have received antenatal care at least once from a trained health care provider and two thirds of all Nigerian women deliver outside of health facilities and without medically skilled attendants present.^{3,4} In some parts of Asia and

¹ Shiffman J, Okonofua F. The state of political priority for Safe Motherhood in Nigeria. BJOG 2007; 114:127–133.

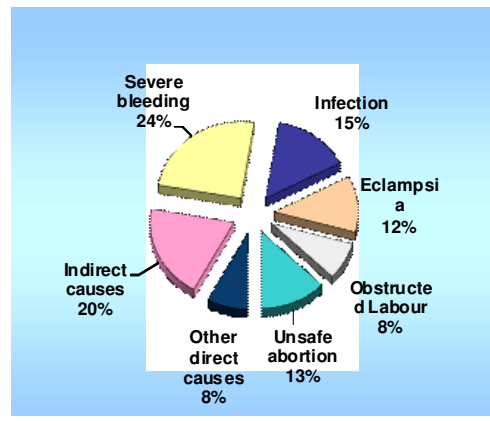
² Omigbodun AO. Reducing maternal mortality in Nigeria through the primary health care. Dokita, 1988, 18:14-16.

³ National Population Commission (Nigeria) and OR Macro. Nigeria Demographic and Health Survey 2003. Calverton, Maryland:

Africa, it has been shown that there are about only one midwife to 15,000 births.⁵ In Nigeria, 17% of women have no assistance during delivery and 26% are assisted by untrained persons;⁴ in contrast, skilled attendance is nearly universal in developed countries.

In 2000, the World Health Organization (WHO) ranked the performance of Nigeria's health care system as 187th among 191 UN member states.⁶ Despite the fact that Nigeria has the 47th highest gross domestic product (GDP) worldwide and is the world's 8th largest exporter of petroleum, she has an average maternal mortality ratio (MMR) of 800/100 000 live births. In contrast, Sri Lanka is 78th on the GDP list but has an MMR of only 92/100,000 live births.^{7,8}

Figure 1:3 Causes of Maternal Deaths in Nigeria



A 2003 study revealed that only 4.2% of public facilities met internationally accepted standards for essential obstetric care in Nigeria.⁹ The financial cost of basic maternal and newborn health services that could prevent these problems is, on average, only USD \$3 per person per year in developing countries. It is even said that the cost of maternal health services alone can be as little as USD \$2 per person,¹⁰ the total cost of saving the life of a mother or infant is approximately USD \$230. In 2004, for the first time, the Federal Government of Nigeria provided a line item allocation for reproductive health, a portion of which was directed towards maternal health. The total amount released was only around US \$800 000, hardly enough to deal with a crisis of national scope. An assessment of the Impact of User Fees on Obstetric Admissions in Zaria, Nigeria showed decreasing attendants at the hospital and an increasing mortality figure.

⁴The Safe Motherhood Initiative: Family Care International. www.safemotherhood.org, Accessed June 3, 2007.

⁶ World Health Organization. World Health Report 2000—Health Systems: Improving Performance. Geneva, Switzerland: World Health Organization, 2000.

⁷ IMF. World Economic Outlook, April 2006. World Economic and Financial Surveys. Washington, DC: International Monetary Fund, 2006.

⁸ WHO Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF and UNFPA. Geneva, Switzerland: World Health Organization, 2004.

⁹ Fatusi A., Ijadunola K. National Study on Essential Obstetric Care Facilities in Nigeria. Abuja, Nigeria: Federal Ministry of Health and UNFPA, 2003.

¹⁰ "Mother-Baby Package Costing Spreadsheet" (unpublished), World Health Organization, Geneva, 1997

The uptake of family planning in Nigeria is not encouraging, only 8 percent of currently married women are using contraceptives while about 17% of currently married women have an unmet need.⁴ In Nigeria, about 610,000 abortions are performed annually accounting for 40% of maternal deaths – approximately 50,000.¹¹ The campaign against unwanted pregnancy is on in Nigeria and its been spearheaded by Ipas who is making efforts to make the sensitive issue of safe abortion, a subject of public discussion and to improve the quality of post- abortion care in the country.¹²

Reducing maternal death, therefore, still requires more than good quality health services. Women must be empowered, and their human rights — including their rights to good quality services and information during and after pregnancy and childbirth — must be guaranteed. One manifestation of the readiness of the Nigeria government to address this situation is the growing interest over the past half decade. There is an increase of commitment to the cause by the Federal Government with the creation of the National Economic Empowerment and Development Strategy (NEEDS), an overarching national framework for social change, which explicitly lists maternal mortality reduction as an objective.³ The Nigeria Federal Ministry of Health produced a National Reproductive Health Policy in 2001 and a National Reproductive Health Strategic Framework in 2002 with specific maternal mortality reduction aims.^{13,14} It has also established a multi-sectoral National Committee on Safe Motherhood. For the first time in 2004, the Ministry secured a budget for reproductive health with specific funding for safe motherhood and launched a birth preparedness plan in 2005.

In 2006, the Federal Government of Nigeria declared free maternal health services for pregnant women in all federal health institutions in Nigeria. Following this, some state governments also made such declarations aimed at reducing maternal mortality rate. More profound was the Northern Governors Forum of December 2007 where pronouncements and statement of commitments were made to introducing and implementing free maternal health services in all the states in Northern. At the Summit, Governors of Northern States resolved to commit *a minimum allocation of 15% of their total budget to health care, in accordance with the Abuja Declaration of 2007*” and also to *“implement free health services for the vulnerable groups of the population especially women during pregnancy, childbirth and puerperal conditions) under five-year children....”*⁽¹⁴⁾ The major areas of focus for discussion at the Health Summit included (a) Health care financing, (b) health resources, (c) Health care services organization and provision and (d) Health management and coordination.

¹¹ Oye-Adeniran B, Long C, Adewole I. Advocacy for reform of the abortion law in Nigeria. *Reprod Health Matters* 2004;12:209–17 25.

¹² Ipas. Ipas Nigeria country report, 2005. www.ipas.org- Accessed July 2005.

¹³ Federal Ministry of Health. National Reproductive Health Policy and Strategy. Abuja, Nigeria: Federal Ministry of Health, 2001.

¹⁴ Federal Ministry of Health. Nigeria National Reproductive Health Strategic Framework and Plan, 2002–2006. Abuja, Nigeria: Federal Ministry of Health, 2002.

Some of the banes identified to be responsible for poor health care financing in Northern Nigeria include over dependence on federation allocation and development partners, low funding of health sector at all levels, poor governance and commitment to health especially at the local government level, lack of accountability and absence of health care financing policy and health plan. Also, lack of diversification of funding options and higher rates of poverty were identified as barriers to effective access to health care.

Some states in Northern Nigeria and a few other states in the South have introduced free maternal and child health services. Though young, the programs can be described as noble and a good start. In some of the old states such as Kano, Jigawa and Kaduna, no attempt has been made to assess the outcomes of the program. Consequently, HERFON with the support of OXFAM commissioned a national team to undertake an evaluation of the policy in nine states in the North (6) and South (3).

2. AIMS AND OBJECTIVES OF THE SURVEY

The overall aim of this study is to review and evaluate free maternal health services practices in the country, the efficiency, effectiveness and sustainability of the practices with a view to scaling up the best practices. In formulating the best fundamental practices, it is desirable for the country and states to determine the level of implementation of the services, identify its achievements, constraints, challenges and lessons learned. The states assessed were Kano, Kaduna, Jigawa, Bauchi, Lagos, Enugu, Rivers, Gombe and Katsina states based on a number of criteria including general health indices, maternal mortality ratio, existing free health services, national/geographical spread and demonstrable government commitment to the free health programs. The specific objectives are to:

1. To determine whether ANC and delivery cost have been eliminated in the States surveyed.
2. Determine the impact of free maternal health care on maternal health indicators.
3. Identify the challenges encountered in transitioning from a fee for service to free service system and how they were addressed.
4. Review the strategies employed to bring about a change in the policy and practice.
5. Determine the effectiveness and efficiency of free care and define the roles of different actors (who are blockers? Who are allies?).
6. Identify strategies for effective implementation of advocacy including the level of implementing an effective advocacy strategy and the potential influential actors that could play a role in bringing about changes in policies and practices.

3. METHODOLOGY

3.1 Scope of assessment: Geographic Sites

The assessment method includes desk review of maternal situation in Nigeria and six Africa countries, this was followed by collection of basic data on free maternal health in the states in the country namely Kwara, Niger, Abuja, Kano Kaduna, Sokoto, Zamfara, Kebbi, Katsina, Bauchi Gombe, Lagos, Ibadan, Edo, River, Delta and Enugu. In-depth

research were conducted in Kano, Kaduna and Katsina States in the North West, Bauchi and Gombe States in the North East, Lagos State in the South West, Rivers state in the South South and Enugu State in South East to ensure national spread. The assessments were conducted from August to November, 2008.

The assessment framework outlining the research plans including research objectives, target populations (including target segmentation), methodology, the composition of research teams and field activities, was developed ahead of time during a pre-survey meeting in Abuja. The survey population comprised of Policy makers/Health managers at the State/Local Government levels, Health Facilities, Healthcare providers and Healthcare recipients (clients/patients) at the three levels of care. The surveyed facilities comprised of:

- one tertiary federal health facility per state
- one secondary healthcare facility in a rural area
- one secondary healthcare facility in an urban area
- one facility at PHC level in a rural community
- one facility at PHC level in an urban community

3.2 Sample size estimation & sampling technique

The number of respondents included in the study was also predetermined and agreed on at the pre-survey meeting as follows; a minimum of five (5) facilities and five (5) healthcare providers [one each in urban & rural facilities at the State and Primary Health Care levels and one federal facility if any]. Also, three key informants/policy makers at the State level [the focal person for free Maternal Health Services in the state, the Commissioner/Permanent secretary of state ministry of health, Director General/Executive Director of the health services management board, Local Government Chairmen, Supervisory councillors for health, Director Personnel Management, Ministry of Health/Primary Health Care coordinators].

Also interviewed were Health Managers [Head of Health Facility, Head of maternity, Head of pharmacy, Head of nursing department, Head of community health department, Head of Medical Department, in charge of Primary Health Care facility], Service Providers [Doctors, Nurses, Community Health Officers/Community Health Extension Workers, Laboratory scientists/technicians, Pharmacists/technicians, Clinical assistants, Medical records officers/assistants] at Federal, State and Local Government levels. One patient/client accessing Antenatal/postnatal Care, laboratory services, or delivery services in the study facilities were also interviewed.

3.3 Data collection: Instrument & Methods

This assessment relied on a combination of quantitative and qualitative methods. The tools used include interviewer-administered questionnaires, key informant interview

guide and facility checklists. Specifically; Face to face interview using an interviewer administered questionnaire on key informants (policy makers, health managers, health care providers, and health care consumers [clients/patients] were conducted in addition to undertaking facility assessment focusing on personnel, infrastructure, equipment and materials in the study facilities. The tools were developed, reviewed and discussed and finalized at a pre-survey meeting held preparatory to the survey. The instruments were later pre-tested during a pilot study before the fieldwork. Research assistants were also trained on the methodology for data collection in each state before the commencement of the fieldwork. The purpose of the training was to ensure mutual understanding of the research issues, concepts and protocols and to enhance the capability of state-level research assistants to administer the instruments.

Table I: Numbering Tools administered in the sampled states

Target groups	Kano	Enugu	Kaduna	Jigawa	Bauchi	Gombe	Katsina	Lagos	Rivers	Total
Policy makers	2	3	3	3	3	3	3	3	2	25
Health providers	5	5	5	5	5	5	5	5	3	43
Patients	5	5	5	5	5	5	5	7	4	46
Health facility	2	5	2	5	5	5	5	5	4	38

4. SURVEY RESULTS

The results of the survey are presented on state basis to bring about greater appreciation of status and progress made, or being made or not made in the implementation of free maternal and child health services as adopted in each state surveyed.

Secondly, the presentation was in accordance to the survey objectives (i) to determine whether ANC and delivery cost have been eliminated in the States surveyed (ii) determine the impact of free maternal health care on maternal health indicators (iii) Identify the challenges encountered in transitioning from a fee for service to free service system and how they were addressed (iv) Review the strategies employed to bring about a change in the policy and practice (v) Determine the effectiveness and efficiency of free care and define the roles of different actors (who are blockers? Who are allies?) and (vi) Identify strategies for effective implementation of advocacy including the level of implementing an effective advocacy strategy and the potential influential actors that could play a role in bringing about changes in policies and practices.

A major challenge during the survey was lack of or inadequate information/data on a number of issues in some states. This largely explains the variations in the presentations since some states (Kano and Jigawa) have information on all the objectives while information could not be obtained in a number of areas in states like Rivers, Bauchi, Kaduna, Lagos, Enugu, Gombe and Katsina.

STATE SPECIFIC RESULTS

- **BAUCHI**
- **KADUNA**
- **KANO**
- **JIGAWA**
- **LAGOS**
- **RIVERS**
- **GOMBE**
- **KATSINA**
- **ENUGU**

BAUCHI STATE

1. ELIMINATION OF ANTENATAL AND DELIVERY COST FOR WOMEN

a. Policy, legal framework

In Bauchi State, the House of Assembly has passed the bill into Law in order to give legal backing to the provision of free maternity services and medical and nutrition services for under 5 children in the State in 2007. The Law is known as Bauchi State Maternity and Under five children medical and nutrition services Law 2007 and have provisions for a wide range of services in all government hospitals and clinics in the state and conditions for access. The legislation also makes provision for sanctioning health workers that default in performing his/her obligations to patients. However, a review of the policy reveals some inherent weaknesses such as not being explicit about resource allocation, non definition of role and involvement of the community, lack of clearly defined organisational and managerial framework and lack of guidelines for procurement. Prior to the adoption of the free health program for women and under five and nutrition services, an estimated cost of N26 ,469,250 per month was arrived at which provide basis for monthly release by the State Government.

b. Scope of Services

The survey revealed that the free maternal health services policy makes provision for a package comprising of free card, consultations, laboratory investigations including urine and haemoglobin tests, immunization, HIV screening, drugs, postnatal check up, treatment for any form of miscarriage, emergency Caesarean section, and nutritious food and dietary advice. It also has a nutrition component including provision of nutrition to any clinically malnourished child (as determined by a clinician) with a coupon to collect specified measures of rice and beans from the state store. The committee in charge of the scheme has produced a customised bag for the purpose of distribution of food stuff to beneficiaries directly.

c. Procurement and supplies

Procurement under the program is through bulk purchase of drugs which is handled by the Pharmacy through locally registered pharmaceutical companies and local purchase orders are issued for discounted prices. These are drugs distributed monthly to the health facilities involved in the program. So far, supply of drugs and consumables in most hospitals has been steady and it was revealed that shortly before the survey, the state government released money for the purchase of drugs to deworm Under five children in the state. However, a few of the staff collected the items meant for the free maternal and child health services and refused to disburse them.

2. ELIMINATION OF FREE MHS ON MATERNAL HEALTH INDICATORS

a. Service utilization

The program commenced on 6th February 2008 and this assessment was conducted in August 2008. It is also difficult to make valid conclusions regarding the effect of the program since no baseline data exists. At baseline, the maternal health indicators quoted were for the entire north east zone as there were no state specific figures. However, there is no doubt that the program has recorded some positive outcomes on the utilization of services as well as on health care providers in the state.

The data available shows that there has been increased attendance at antenatal clinics, hospital deliveries and postnatal clinics following the introduction of the free maternal health services in the state. However, the monitoring and evaluation system in the state is weak that it is unable to put measures in place for data collection before and after introduction of the free maternal health services. If adequate have been available, it could have provided objective evidence of these increases. Nevertheless, in the maternity unit of the Specialist Hospital Bauchi, the table below shows the trend in attendance.

	Before Implementation of Free MHS			After Implementation
	2005	2006	2007	<i>JAN TO JUNE 2008</i>
ANC attendance	19,456	17,517	16,136	12,232
Postnatal visits	486	625	2,411	1,442

From the above, it is evident that the program is recording significant outcomes. Though available data was for half of the year when the program started, it shows that utilisation within a six month period was significantly close to the figures recorded in the previous year (2007). There is every indication that with awareness, the end of the year figure will be more than double of what it was in the first half of the year (2008). On the other hand, though there has been changes in the number of patients for post natal visit, however, the figure is quite low generally as expectation is high considering that at least about 30% of patients that attend ANC will qualify for post natal services,

Similarly, in Kafin Madaki General Hospital the pattern of deliveries as indicated in the table below shows the same trend

2005	2006	2007	Jan to Jul 2008
201	240	197	152

This gives a projected percentage increase in antenatal attendance and postnatal visits of 52% and 20.0% respectively against 2007 figures.

b. Health Managers and providers

From the health providers’ perspective, the survey established that they were initially sceptical about the free maternal health care service programme considering it as a political gimmick, but, this opinion later changed having witnessed actions that

demonstrated government seriousness and commitment. As frontline workers, they witnessed unnecessary maternal deaths as a result of inability of the patients or their relatives to pay for treatment and surgery prior to the free scheme. Having established the commitment of government, the health facility managers in the state supported the program, though they were apprehensive about attendant increased workload on them without commensurate provision for incentives that will boost staff morale. Though this was a genuine concern, however, it was revealed that these have been addressed through timely promotion, prompt payment of emoluments, staff vehicle and housing loans and recruitment of additional staff to decrease the burden. For private health care providers, they perceived the free maternal health services programme as a competition with a tendency to divert patients from their private clinic to government hospitals.

3. CHALLENGES WITH TRANSITIONING FROM FEE PAYING TO FREE SERVICES

A number of challenges have been associated with the implementation of the program. One is the increase in the number of pregnant women attending hospital for antenatal care and delivery from within and outside Bauchi state thereby overstressing available financial, human and resources. Two, due to the bureaucracy involved in securing the release of funds, delays in memo approval and due process, occasional delays were encountered in release of fund, however with the intervention of the Executive Governor allocations are now made to the Committee on quarterly basis instead of the initial monthly arrangement. Three, some hospital workers receive the drugs and food stuff and refused to dispense them, rather the items are kept in stores for prolong periods, risking pilferages.

4. STRATEGIES FOR CHANGE IN THE POLICY AND PRACTICE FOR FMHS

The high maternal mortality ratio for the north eastern geopolitical zone (Bauchi inclusive) has been highlighted in national surveys conducted by Macro International in collaboration with the National Bureau of Statistics and the United Nation Children Fund (UNICEF). Deliberations at northern governors meetings also brought the issue of maternal mortality to the front burner. Different professional groups including SOGON (Society of Obstetrics and Gynaecology of Nigeria) carried out surveys and made presentations on the high maternal mortality ratio to the Executive Governor and the First Lady.

Other local NGOs such as (dRPC) conducted desk reviews and advocacy regarding maternal health policy and services in the state. These antecedents coupled with the change in government in the state set the tone for people oriented free health program in the state. The state government has gone further by sending 23 female students to be trained as Obstetricians and Gynaecologists in Egypt. In addition, the state has obtained approval for converting the State Specialist Hospital into a Teaching Hospital to train

medical students at the newly approved College of Medicine, Abubakar Tafawa Balewa University (ATBU) Bauchi.

5. EFFECTIVENESS AND EFFICIENCY OF FREE CARE

The three hospitals namely Specialist Hospital, Bauchi, Kafin Madaki General Hospital and Primary Health Centre, Liman Katagun involved in the program and they are at different levels of capability in terms of infrastructure to deliver free health services

a. Infrastructure.

The **Specialist Hospital, Bauchi** provides 24 hour services to patients from urban centre mainly and receives referrals from rural areas. The infrastructure and road network is good and there is constant electricity and water supplies. However, clinical waste management was poor. The radio and telephone services in this hospital are inadequate. The staff are knowledgeable about the free maternal health services and their roles and responsibilities. New staffs are given orientation to the workings of the hospital and the program. The free maternal and child health services provided at this hospital include; Antenatal care, Delivery care, postnatal care, antimalarial treatment, caesarean section, HIV&AIDS screening for pregnant women and laboratory screening. However, Family planning is not included in the package

Clinic days and hours are insufficient for the patient flow despite the seemingly logical organization and flow of patients. Guidelines for free MHS services are available while it is also adequately staffed with different category of health professionals.

The patient waiting area is inadequate; some patients end up sitting on the floor or standing for prolonged periods. There were adequate IEC materials in the antenatal and postnatal clinics. The hospital utilizes a confidential paper based registration system. Patients are triaged based on the severity of their condition. The record system is yet to be computerised and the monitoring and evaluation system needs to be beefed up. Patient examination rooms are inadequate, although the ones available provide visual but not auditory privacy. The centre was recently renovated and new extensions provided, however, there were no sufficient functional adult and infant weighing scales. Paediatric sphygmomanometer cuffs were also lacking and staffs of the centre observe universal precautions. The facilities and equipment requires minimal improvements to reach the minimum requirements.

Kafin Madaki General Hospital also provides 24 hours service. This hospital did not have a functional back-up generator, but adequate water supply was obtained from a hand pump. This centre had no blood transfusion services and drugs were in short supply. Surprisingly, despite the free maternal health services programme, there is low turnout of patients suggesting the need for public enlightenment and community mobilization. The centre though a secondary health care facility but does not have the minimum requirements for a secondary health centre. Providers confirmed that remuneration is regular and prompt while training is provided for staff by state government and

international partners and NGOs. However, the workers informed that there were no additional incentives for extra work occasioned by the free maternal health services and there is no reward or recognition for outstanding performance. The centre did not have a functional ambulance which means that patients' relatives arrange their transportation whenever they are referred elsewhere.

b. Monitoring and evaluation

The record system is yet to be computerised and the monitoring and evaluation system was found to be weak which may partly explain inadequate data collection and record keeping.

c. Gaps in the understanding of beneficiaries

Health providers complained that some mothers come to deliver without bringing clothes and baby wears with the assumption that the government is providing these items free as part of the free maternal health services. They also complained of increased workload with the introduction of the free maternal health services in the state.

d. Beneficiaries satisfaction

Beneficiaries expressed satisfaction with the program and services provided at the centres involved. Their satisfaction was confirmed through experience sharing by two beneficiaries at the Specialist Hospital, Bauchi and Kafin Madaki General Hospital. One of them expressed appreciation to the government for the scheme, but suggested that the state government should ensure adequate supply of drugs. Another patient acknowledged the benefits of the program and expressed satisfaction with the services received and conduct of the health personnel and also commended reduction in time spent in the hospital (from entry to exit). However, she could not confirm the participation of the community in the program.

6. STRATEGIES FOR EFFECTIVE IMPLEMENTATION OF ADVOCACY FOR CHANGES IN POLICIES AND PRACTICES

In Bauchi State, local and International NGOs, Professional associations in the health sector, women groups, political and religious leaders are potent advocates for free maternal health care services. Advocacy targets include the Executive Governor, First Lady, members of the State Executive Council, Speaker and members of the State House of Assembly.

7. RECOMMENDATIONS

The positive achievements of free MHS in Bauchi State should be sustained and improved upon. It is recommended that;

- a. A specific percentage of the state health budget should be set aside for the free maternal health services programme rather than arbitrary allocations. This should be indicated in an amended bill. Advocacy will be required for the achievement of 15% mark of total budget to health that the Governors committed themselves to at the Northern Governors' forum while efforts should also be stepped up for involvement and participation of LGAs for expanded coverage
- b. Wide community and stakeholder involvement in the implementation and evaluation of the free maternal health services in the state will be required to facilitate and strengthen community participation
- c. The existing NHIS in the state provides an opportunity for partnership to ensure sustainability of the free maternal health services in the state
- d. The weak Monitoring and Evaluation system for free maternal health services needs to be strengthened in order to provide feedback to stakeholders and government about the impact of the free maternal health services. It will also provide evidence for improved funding
- e. Clinical waste management at the Specialist Hospital Bauchi should be outsourced for better management and cleanliness of the hospital premises. In addition is the urgent need for infrastructural upgrade.
- f. Intensive sensitization and mobilisation of community members and all critical stakeholders including the private health care providers
- g. The policy on free maternal health services needs to be reviewed to concretely address issues such as resource allocation, defined roles for community members, defined organisational and management framework and guidelines for procurement
- h. Advocacy and meaningful engagement will be required to expand bouquet of services to include family planning.
- i. Effective monitoring of the program to ensure that all supplies are acknowledged managed and provided to patients as necessary. Health personnel should also be adequately sensitized and engaged to forestall any sabotage on their part.

KADUNA STATE

1. ELIMINATION OF ANTENATAL AND DELIVERY COST FOR WOMEN

a. Policy and legal framework

The Government policy on FMHS was approved in 2007 and implementation commenced in the same year. A detailed Transitional Operational Guidelines for Free Treatment of Pregnant Women and Children Under five was produced to guide the operations of the scheme. In the state, free medical services to pregnant women and children Under five are offered at both State government owned hospitals (26) and Local government owned Primary Health Care (PHC) facilities (113). The coverage include antenatal care, treatment of severe anaemia including malaria in pregnancy, normal delivery, post natal care and treatment of complications during pregnancy up to 6 weeks after delivery for pregnant women and malaria, acute respiratory infections, diarrhoea, measles, worm infestation, meningitis and HIV for children under five

2. IMPACT OF FREE MHS ON MATERNAL HEALTH INDICATORS

In Kaduna State the free MHS program is less than a year old, however, there has been increase in ANC attendance and deliveries in government owned facilities involved. The total number of pregnant women who benefitted from the programme from inception in September, 2007 to June 2008 was 184,783 women including OPD – 117, 611, ANC – 54,738 while Deliveries – 12,434. However, due to non availability of data for the same period the previous year, no comparison could be made to assist in determining performance and progress

3. CHALLENGES IN TRANSITING FROM FEE PAYING TO FREE SERVICES

There has been an upsurge in the number of patients attending ANC and deliveries in centres offering free maternal health services which had resulted in increase in demand for both human and material resources. This has no doubt increased the cost of the programme. In addressing this, the Government is increasing the number of trainees in all cadres of healthcare provision and increase budgetary allocation by the government. The state is also considering improving the salaries of health workers to be at par with the Federal government health workers. The state has also resumed training of nurses and midwives which was suspended. There has been renovations and upgrading of all state and local government hospitals and PHC centers in phases starting with one health facility in each of the 255 political wards in 2007, two health facilities in 2008 and additional facilities proposed for 2009.

4. STRATEGIES FOR CHANGE IN THE POLICY AND PRACTICE FOR FMHS

As part of the efforts to reduce poor health indices and accelerate the achievement of the Millennium Development Goals in Kaduna state, the immediate past administration

inaugurated the committee on the provision of free health services to pregnant women and children under 5 years of age in 2006 under the chairmanship of the Permanent Secretary, Kaduna State Ministry of Health. The committee was charged with the responsibility of making realistic and implementable recommendations to Government to facilitate the take-off of the programme. Following submission of the report of the committee, the State Executive Council approved the policy of provision of free medical services to pregnant women and children under five in the State government hospitals and the Local government Primary Health Care (PHC) facilities in 2007.

5. STRATEGIES FOR EFFECTIVE IMPLEMENTATION OF ADVOCACY

The survey revealed that level of community awareness is low in the state with spiraling effect on level of community involvement and participation. The low level of awareness and involvement often resulted in friction between patients and health providers.

6. RECOMMENDATIONS

- 1 There should be more community involvement to improve awareness among the community leaders and the general population. This will reduce the friction between the patients and health providers. There is also the need to include in the committees other stakeholders like the women journalists, qualified obstetricians and also representative of the Nigerian nurses and midwives association.
- 2 A specific budget up to the 15% of total state budget agreed on at the Governors' forum should be allocated to this programme and both the local government and state governments should ensure timely release of allocation to avoid disruption of services.
- 3 The programme should have necessary legislative backing to ensure sustainability.
- 4 There is need to introduce some form of incentives to the health care workers and motivate them by recognizing and rewarding excellence.
- 5 There is an urgent need to strengthen monitoring and evaluation in the whole health sector. Training and retraining of the health records staff will ensure they know the importance of good record-keeping.
- 6 Family planning should be included in the package to increase access to those who require it.
- 7 Data collection and management systems should be established, made functional and maintained

KANO STATE

1 ELIMINATION OF ANTENATAL AND DELIVERY COST FOR WOMEN

a. Policy and legal framework

Kano State is the pioneer State in free MHS to pregnant women, but only available in State Government owned hospitals. A government policy paper (draft bill) was adopted in 2001 and is currently in the State House of Assembly for consideration and passage into law. This effort is backed by many international NGOs who are advocating and engaging the state house of assembly for passage of the bill. There is also a guideline for the implementation of the programme at various levels. There is a budgetary allocation in favour of free maternity services. At the beginning of each quarter, at least 75% of the due allocation is released at once to ensure smooth running of the programme.

b. Implementation strategies for free maternal services

The program has been running successfully in thirty three (33) State Government owned hospitals, but not yet extended to the local government owned facilities. The State Government has directed the 44 LGAs to commence similar program in their respective facilities. The package include free registration, medical consultation, routine ANC drugs, normal delivery and consumables, post delivery drugs (analgesics and antibiotics), caesarian section, post operative drugs and dressing, post abortion services, drugs for treatment of miscarriages, laboratory investigations, HIV screening, treatment of eclampsia, treatment for VVF and paediatric emergency drugs at Murtaa Muhamed Specialists Hospital.

2. IMPACT OF FREE MHS ON MATERNAL HEALTH INDICATORS

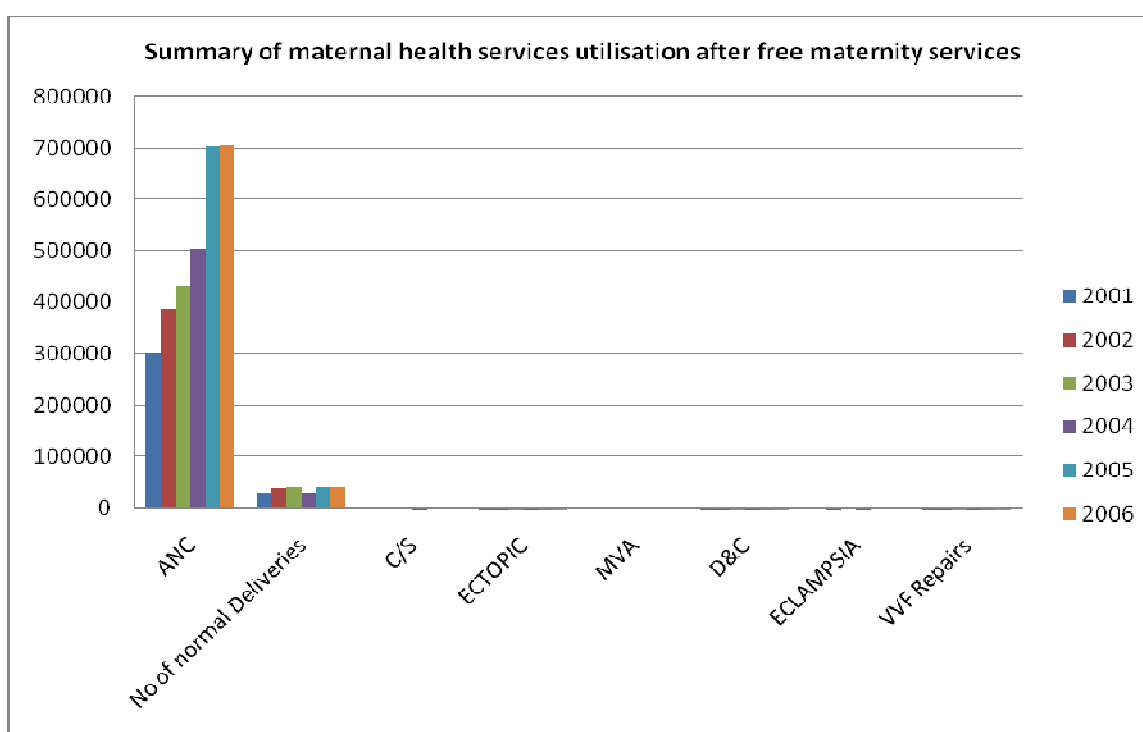
There has been tremendous positive effect of free maternity services in Kano. Although prior to the advent of the programme there was dearth of data, the trend show considerable improvement in the use of maternal services with attendant effect on state of maternal care and health in Kano State. This data is summarized below:

Summary of Maternal health services Utilization in Kano state after the commencement of free maternity services.

S/N	YE AR	ANC	NOMAL DELIVER IES	C/S	ECT OPIC	MV A	D&C	ECLAM PTIC	NO OF VVF REPAIR S
1	2001	303, 649	29,704	1, 286	79	2, 893	300	1,351	357
2	2002	387, 436	38,940	1, 507	310	2, 554	1, 405	1,300	378

3	2003	432,917	40,261	1,543	514	2,153	1,117	1,819	422
4	2004	503,649	28,573	1,327	392	2,032	984	1,106	576
5	2005	702,720	39,926	1,875	562	3,112	1,312	2,184	829
6	2006	705,468	42,127	1,409	158	3,397	1,137	1,783	486

The data in the table above is presented graphically below



The data above show a consistent increase in the number of ANC cases since 2001 when the program started while similar trend is recorded under normal deliveries within the same period. The number of patients/clients for post abortion services (using MVA) has also been on the increase.

3. CHALLENGES ENCOUNTERED IN TRANSITING FROM A FEE FOR SERVICE TO FREE SERVICE

In Kano State, there has been a massive increase in the number of pregnant women attending hospital for antenatal care and delivery from within and outside Kano state and even neighbouring countries. This has made the budget to be increasing gradually by the day due to the sharp increase. This is part of the reasons why allocations are made quarterly. The government responded to this by releasing the finances as at when due.

The effect of upsurge in the number of clients/patients was the over stretching of manpower and equipment in all the hospitals offering free maternity services. The government is also recruiting new staff and training others. The most applaudable action is the increase in the salary of the staff to make it competitive with health workers at federal health institutions. The government also has introduced all types of relevant trainings to build the capacity of health staff across all cadres. This singular act is a strong motivation for the staff and capable of propelling them to work harder.

4. STRATEGIES FOR CHANGE IN POLICY AND PRACTICE OF FREE MATERNAL HEALTH

In 2001, following the realization of the pathetic situation of maternal health services in Kano State, the state Government responded by constituting a very strong committee made up of health professionals, community leaders and other stakeholders which recommended provision of free maternal services to reduce preventable maternal deaths in the state. Following consultations and approval by the State Executive Council, the programme commenced in 2002 with the setting up of the Free Antenatal Committee with the following responsibilities

- 1 Provision of efficient and qualitative free antenatal services in all State Government Owned Hospitals
- 2 Procurement of drugs and consumables for the take – off of the programme; and distributing the items based on the statistics of the hospital as at that time.
- 3 Proper monitoring and evaluation of the programme to ensure effective and proper utilization of the items
- 4 Proper public enlightenment campaigns to ensure good attendance to public hospitals; among others.

This committee is now headed by the Director General of the Hospital Management Board with other members being experienced obstetricians, midwives, pharmacists, qualified accountant, a public relations officer and an administrative officer. This committee meets monthly.

5. RECOMMENDATIONS

- a. There is need for the State Government to engage the Local Government Councils to embrace and introduce this programme in their various health facilities to reduce the burden on the State Government. This will also increase coverage and access of services to people at the grassroots level who will ordinarily not have access to state facilities.
- b. There is the need for effective coordination and partnership amongst Local, State and Federal Governments to run this programme; supported by the willing NGO's to achieve the desired goal of reducing maternal mortality and morbidity in the whole country and even beyond.

- c. There should be improvement in community and stakeholder involvement in the implementation and evaluation of the free maternal health services in the state.
- d. There should be massive employment of staff at a rate faster than what is currently obtained because the current manpower strength particularly in the maternity units is grossly over stretched especially with the commissioning of new hospitals.
- e. Health personnel are unable to respond and cope with the needs of patients as a result of overstretched facilities and inadequate equipment. There is therefore the urgent need for infrastructural upgrade through the acquisition of new of modern equipment and replacement of obsolete ones.
- f. Stakeholders should be mobilized to advocate and engage the Executive and legislative arms of government to accelerate the provision of appropriate legal framework by passing the free maternity care bill into law. This advocacy and engagement should also make strong justification for the inclusion of family planning services in the package
- g. The weak Monitoring and Evaluation system for free maternal health services needs be strengthened. This will support the generation of data for the provision of feedback to stakeholders and government about the impact of the free maternal health services. There is a need to employ more trained record staff and re-train the ones in the system in record keeping and data management.
- h. There is need to expand the committee to bring on board representatives of communities, traditional institution, journalists and all other stake holders.
- i. There is also a need to establish and implement a performance based reward system for outstanding health personnel.

JIGAWA STATE

1 ELIMINATION OF ANTENATAL AND DELIVERY COST FOR WOMEN

a. Policy and legal framework

The Jigawa State version of the free maternal health services is referred to as the Deferral and Exemption (D&E) Scheme. This scheme commenced in February 2005 with support from PATH 1 (a DFID funded project). The draft policy document has been produced, but awaiting legislation and passage into law by the State House of Assembly. This explains the rationale for not making the policy document including implementation strategic plan public.

b. Implementation strategies for free maternal health care services

The D&E Scheme provides a safety net for those who cannot pay hospital charges (out-of-pocket) at the time of procuring the services available under the scheme including free emergency obstetric care regardless of ability to pay and deferral for all categories of illnesses for those who can not pay on the spot but has the capacity to pay later. For the latter group, such patients are provided with the services. They are then interviewed by a designated medical social worker who assesses the authenticity of the claims; obtain the patients contact details, particularly, village/town of abode and her Mai Unguwa/Dagachi or Hakimi. The patient is then given a moratorium of between 3weeks and 3 months depending on the patient's income within which to pay up. In the event of a default, the social worker is provided with logistics support to trace the patient to her village or town and available information confirmed that recovery rate has been high.

In addition to deferral, the scheme makes provision for free services regardless of ability to pay for a category of services and individuals including antenatal and post natal services, free treatment for boarding students of public secondary schools, inmates of prisons and reformatory and rehabilitation centres, farmer and Fulani conflict victims and victims of collapsed building, snake/dog bites, meningitis, fall from height and epidemics.

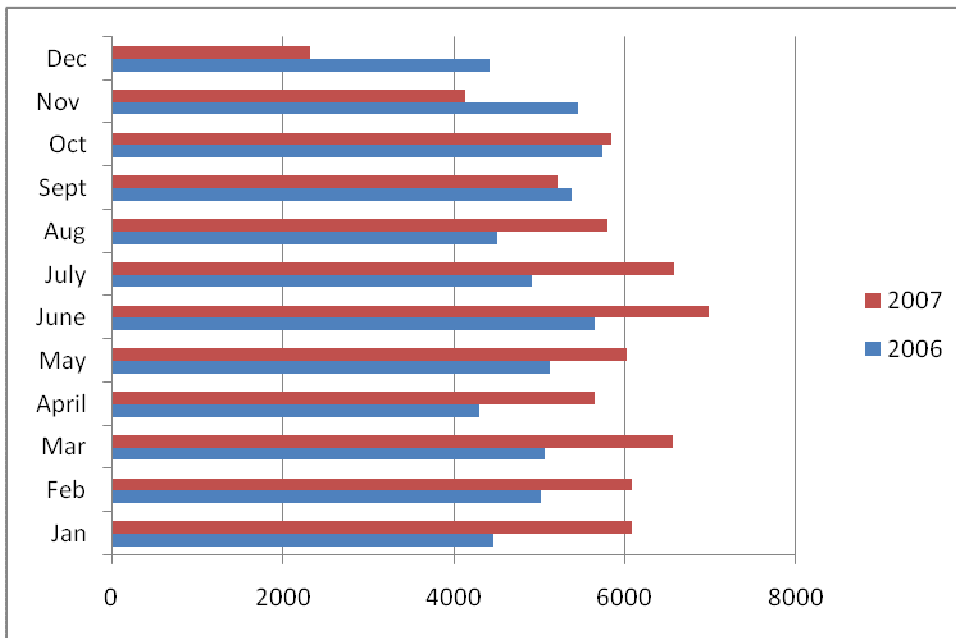
The scheme is financed by the state government and drugs are provided to the facilities through existing links with the Drug Revolving Fund (DRF). Supply of drugs under this arrangement is from Jigawa state medical supply company. A mark up of 15% is made on the cost price of these drugs. Five percent of total profit of DRF is remitted to Ministry of Health, while the remaining 95% remains in the health facility to be added to the DRF capitalization.

2. IMPACT OF FREE MHS ON MATERNAL HEALTH INDICATORS

Baseline data on maternal mortality and service utilization before the commencement of the Deferral and Exemption Scheme (February 2005) were not accessible, making it impossible to assess the impact of the D&E system on maternal health indicators.

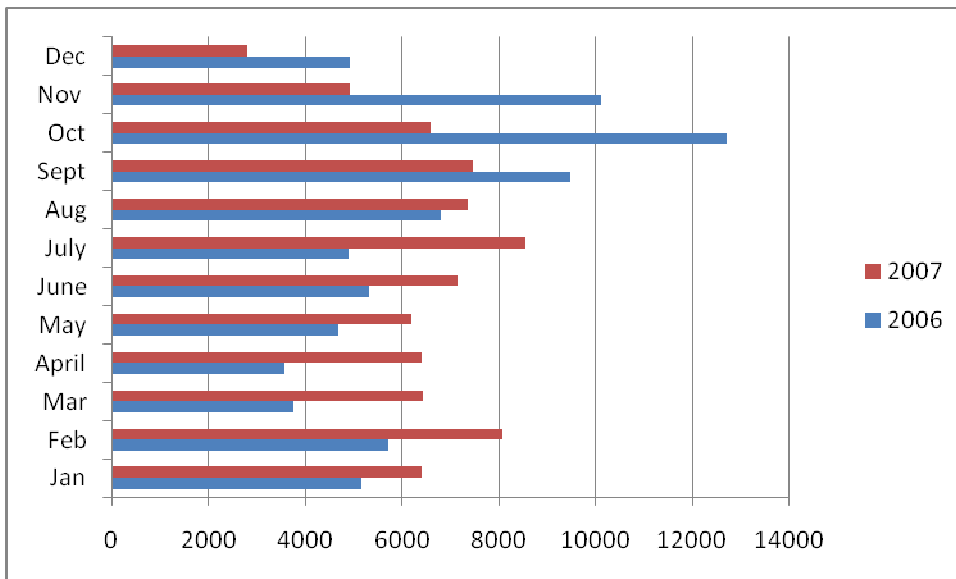
However, the pattern of utilization of antenatal, delivery and postnatal care services show consistent increase in the state during 2006 and 2007 as shown in the charts below;

a. ANTENATAL CARE ATTENDANCE- FIRST VISIT (2006 and 2007)



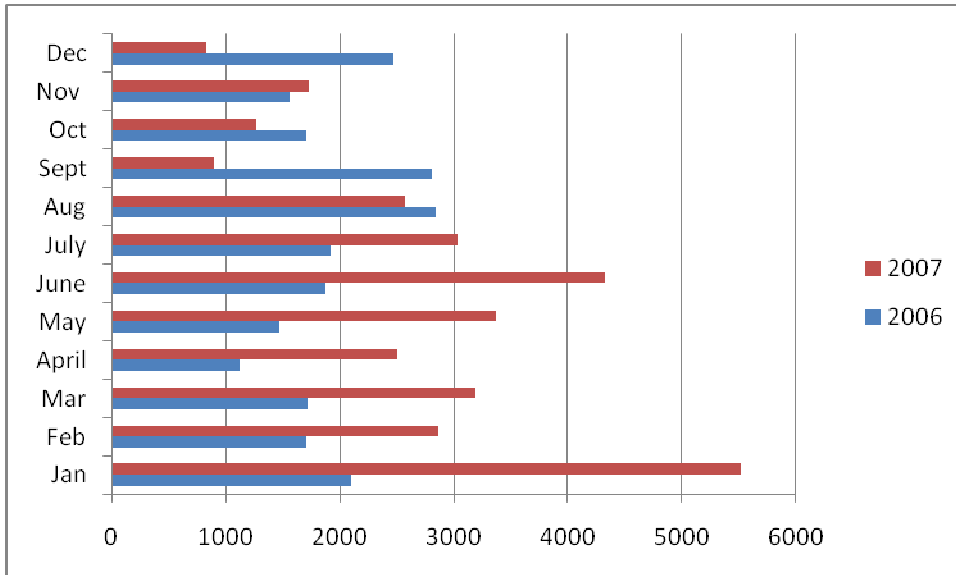
The above shows that there has been a consistent increase on antenatal care (First visit) attendance in Jigawa state in 2007 over 2006. This is a direct outcome of the introduction of the scheme

b. ANTENATAL FOLLOW UP VISIT



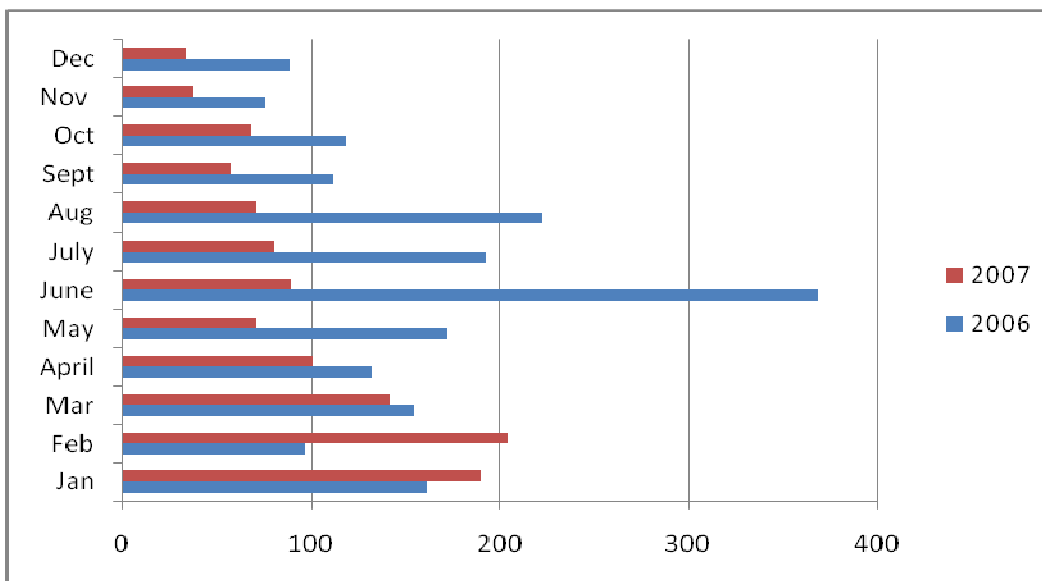
The above also shows a similar trend in the number of women for follow up on antenatal visit in 2006 and 2007

c. ANTENATAL ATTENDANCE – TETANUS TOXOID/2ND BOOSTER DOSE



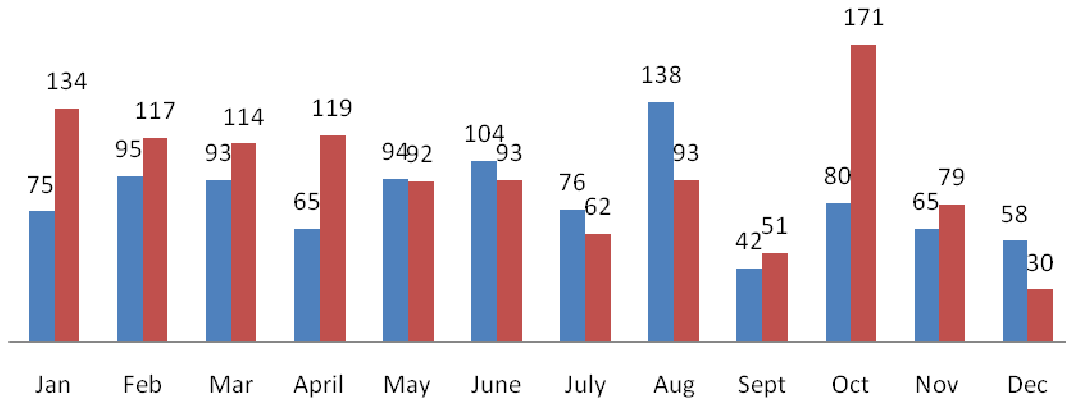
The above shows that there has been increase in the use of tetanus toxoid/booster dose to pregnant women in 2007 over 2006 in the state except the decline that is noticeable from March 2007. This might be due to the fact that the data available in 2007 were incomplete.

d. HOSPITAL DELIVERY AND CAESAREAN SECTION (2006 AND 2007)

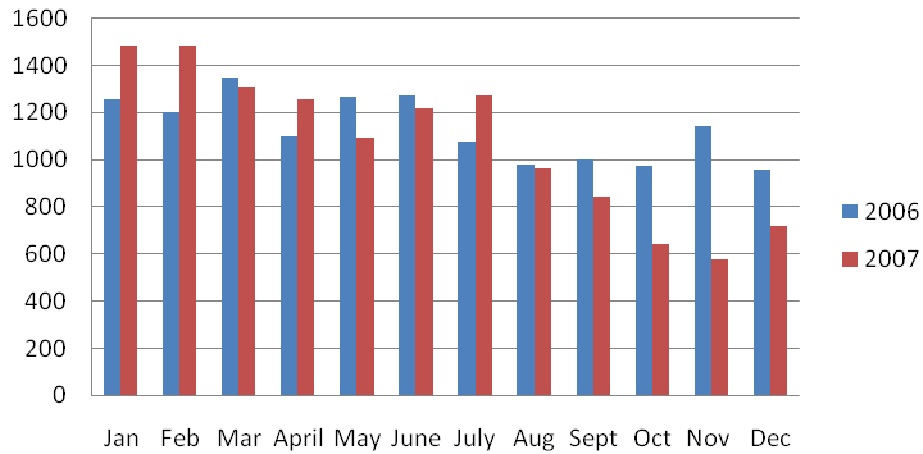


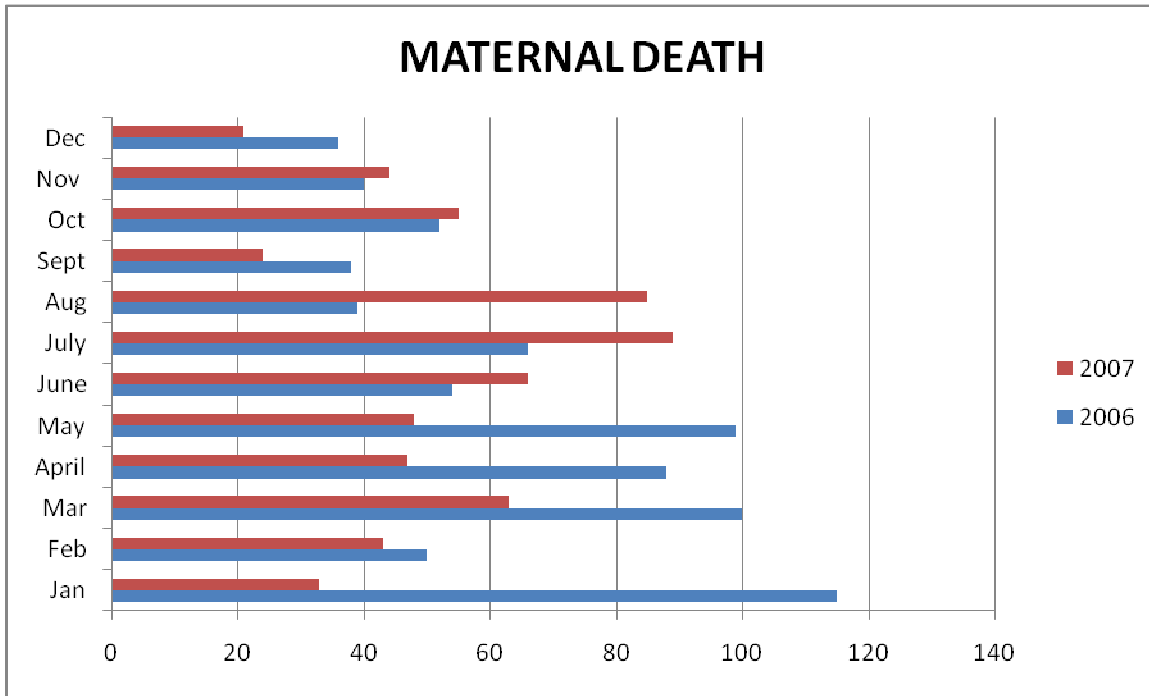
DELIVERY - CAESAREAN SECTION

■ 2006 ■ 2007

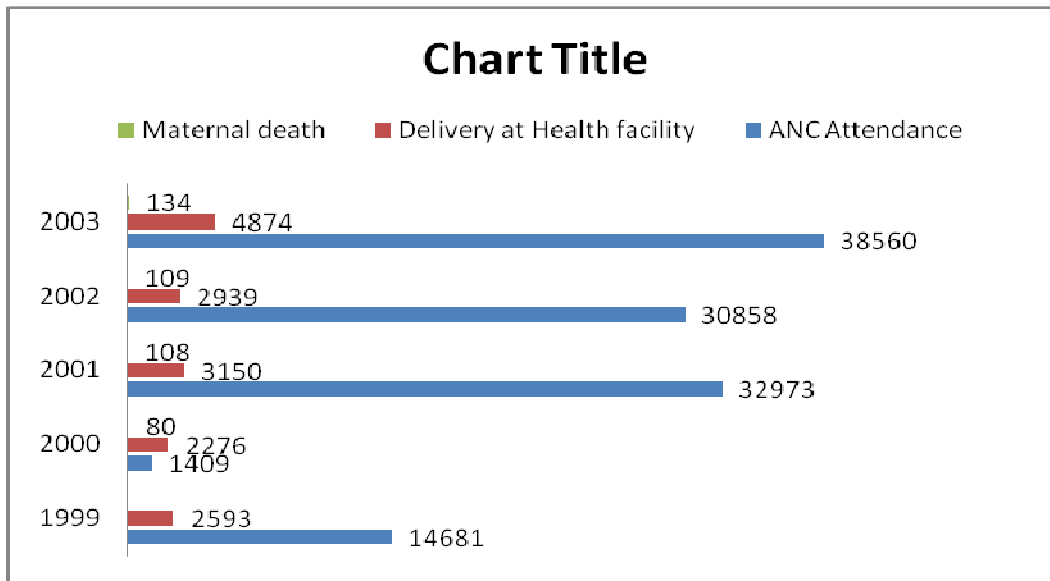


DELIVERY - NORMAL





Following the implementation of free MHS health workers have noticed an influx of patients from neighbouring State and LGA facilities. Also facilities are overstretched in the State as shown in the chart below.



3. STRATEGIES TO CHANGE POLICY AND PRACTICES FOR FREE MATERNAL SERVICES

The high maternal mortality ratio for the North West geopolitical zone (Jigawa inclusive) has been highlighted in national surveys. The state has also benefited from the PATH 1 project which assisted the state in improving its health system, setting up the Gunduma health system and training the health care providers in the state. Deliberations at northern governors meetings also brought the issue of maternal mortality to the front burner. Different professional groups including SOGON (Society of

Obstetrics and Gynaecology of Nigeria) carried out surveys and made presentations on the high maternal mortality ratio to the executive governor and the state first lady. Other local NGOs also conducted advocacy focusing on maternal health policy and services in the state.

4. EFFECTIVENESS AND EFFICIENCY OF FREE CARE

The General Hospital Dutse, one of the facilities for the scheme provides 24 hour service and had consistent power supply supplemented by a functional generator. It receives clients mainly from urban Dutse and referrals from other towns and villages in the state. This centre operates the deferral and exemption scheme through which it provides the following services free of charge; anti-malarial for pregnant women, caesarean section, HIV&AIDS screening, Syndromic management of STIs, Antepartum haemorrhage/Postpartum haemorrhage and abortion complications. However, patients pay for family planning commodities and other services not covered under the list.

General Hospital Birnin Kudu operates 24 hour service and provides the full complements of services similar to General Hospital, Dutse. The hospital had a functional standby generator and adequate water supply. However, the waste disposal system was inadequate thereby posing a risk to providers and patients alike. There exist protocols for management of the different categories of patient and well labelled sections in the hospital despite the fact that it was not originally constructed to be a hospital. It was a converted local government secretariat-an indication of good political will from the LG chairman. The staffs consist of a mix of personnel across cadres and are generally aware of the workings of the deferral and exemption system. The equipment and supplies in this hospital did not meet minimum standards, but were kept clean neat and tidy.

The team interacted with three clients to share their experience with services at the various centres where these services are provided. Their feedback suggested that apart from free consultation, they paid for all the other services. This finding contradicts information obtained that maternal services are free in all state government owned facility

5. STRATEGIES FOR EFFECTIVE IMPLEMENTATION OF ADVOCACY

In Jigawa State, Local and International NGOs, Professional Associations in the health sector, women groups, political and religious leaders are potent advocates for free maternal health services and they have overtime stepped up consultations and advocacy to relevant key stakeholders (Executive Governor, First Lady, the Executive Council, Speaker and members of the State House of Assembly.

6. RECOMMENDATIONS

- a. HERFON and other partners should conduct advocacy visits to the Jigawa State Governor and House of Assembly to accelerate the passing of the Free Maternal health service bill and its signing into law and expansion of scope of services to include family planning.
- b. The Law should be reviewed to specify the percentage of state health budget to be allocated for free maternal health services
- c. The community members and other key stakeholders (NMA, NANNM, NAWOJ, International partners etc) should be engaged in the formulation, implementation and evaluation of the free maternal health services in the state

- d. There should be a clear implementation framework for free MHS in the state and a monitoring system be established and maintained to ensure compliance as patients still pay for services in some facilities such as in General Hospital, Birnin Kudu. The system should also have a well designed data collection and utilization arrangement
- e. Jigawa state government should partner with the NHIS to access the MDG funds for free maternal health services coverage in a sustainable manner

LAGOS STATE

1. ELIMINATION OF ANTENATAL AND DELIVERY COST FR WOMEN

a. Policy and legal framework

The implementation of the Lagos State Free Maternal Health Service (FMHS) is not backed by any written policy document, but essentially by pronouncements made by the State Governor and reported in the media. Similarly, there is no legislation in support of the program.

b. Implementation strategies for free maternal health care services

At least one state government health facility per LGA offers maternal health services except in 3 LGAs which are presently underserved. There is no specific sub-head/vote of charge in the state budget for FMHS, although expenditure for same is incurred within the budgetary provision of the State Free Health Scheme (SFHS). It was established that over 75% of the budgeted cost for the FMHS is usually released, however, reimbursement for expenditure made by the health facilities is not effected as-at-when-due i.e. not timely (partly because of the high level of documentation involved) and is also not 100%. This has led to patients being charged nominal fees for some of the services in order to ensure sustainability such that working and maintenance of maternal services is not significantly affected by this 'loss of revenue'. Guidelines for procurement for the service is unwritten even as procurement is both central (SMOH level e.g. drugs and consumables) and decentralized (facility level). Procurement methods applied at both levels include selective bidding and direct purchase.

2. CHALLENGES IN TRANSITIONING FROM FEE FOR SERVICE TO FREE SERVICES.

From the perspective of both policy makers and healthcare providers, problems encountered offering FMHS in Lagos State include, delayed and inadequate reimbursement by SMOH of expenses incurred on implementing the FMHS by the health facilities, inadequate space for the volume of patients, inadequate number of staff relative to high patient load (which is further compounded by the no-rejection-of-patient policy of the state government) and very high demand for services at the maternal health services referral centers of LASUTH Ikeja and Lagos Island Maternity Hopsital. Others are lack of dedicated ambulance in many state facilities as reliance on the prescribed pooled ambulances of the state ambulance service (LASAMBUS) has not kept pace with need, inadequate infrastructure, equipment and utilities characterized by poor power and water supply, leaking roofs, cracked walls, poor ventilation, inadequate and obsolete equipment, etc. In addition are irregular supply of drugs and consumables e.g. gloves, detergent, soap, laboratory reagents, etc, referral of many unbooked patients in critical conditions from private hospitals, TBAs and FBOs (a situation further compounded by the no-rejection-of-patient policy of the state government) and poor medial records keeping making retrieval of data needed difficult.

3. RECOMMENDATIONS

From the foregoing, the following recommendations, among many others, are made (not necessarily in terms of importance):

- a. There is the urgent need for the State House of Assembly to pass the necessary legislation to give legal backing to the program.

- b. Infrastructural upgrading/equipping of existing health facilities to include provision of backup power, adequate water distribution, nationally acceptable minimum package of equipment for each service area especially the critical areas of labour/delivery room, theater, blood bank, neonatal ward, etc. Also communications should be provided at SMOH, HMB and health facility levels with same integrated into a radio network linkage accessible to the State Emergency Medical Service.
- c. Integration of free child and newborn services into the FMHS even under the Integrated Maternal, Newborn and Child Health (IMNCH) strategy, even as approved at the 51st National Council on Health Meeting which held in Lagos in November 2007.
- d. Creation of a specific budget line for FMHS backed by adequate budgetary provision and prompt release.
- e. Development of clear guidelines for procurement of FMHS goods with approval thresholds stated.
- f. Establishment of a defined structure with clear line of communications with the SMOH, HMB, health facility managers and Ministry of Local Government including a specific committee on FMHS comprising relevant health professional and other stakeholders.
- g. Mobilisation and motivation of local governments' political leadership to embrace and introduce FMHS with appropriate structures and guidelines within the limit of services offered at the PHC level.
- h. The State Health Policy, currently being developed, should contain the suggested components of the FMHS as part of the minimum package for the State Health Insurance Scheme and strategies put in place to ensure government's payment of premium for indigent citizens. Such would lead to targeted subsidies as against the present scheme that still does not benefit many pregnant mothers.

RIVERS STATE

1. ELIMINATION OF ANTENATAL AND DELIVERY COST FOR WOMEN

a. Policy and legal framework

In Rivers State free maternal health systems operates without a written policy document, but through a pronouncement by the State Governor.

b. Implementation strategies for free maternal health services

There is at least one facility per LGA that offers FMHS, though 5 LGAs are underserved as they do not have secondary health care facilities. There is no specific budget line for FMHS, although provision is made through the Free Medical Care programme. Budget released is over 75% as 100% of claims forwarded by the health care facilities to the SMOH which are approved in line with the guidelines are reimbursed. Procurement is at two levels (SMOH e.g. Drugs and consumable) and decentralized (facility level). Procurement methods applied at both levels include selective bidding and direct purchase.

Rivers state does not have a special committee for FMHS, however, there is a monitoring committee in place for the entire free medical care programme. In addition, there is no clear cut organogram for FMHS even as implementation of the FMHS is subsumed under FMCP. The state does not have a strategic health plan, though work on the State Health Policy (SHP) is being finalized. A component of the evolving SHP is the State Health Insurance Scheme of which Maternal Health Service is part of the minimum package. For the proposed state insurance health scheme, strategies are being put in place to ensure that the premium for indigent citizens is paid by the state government (free maternal plus other services).

The state has an M & E system for free medical care programme which also covers the FMHS and it includes a desk office, a plan, flow of information and reporting format, availability of logistics and ICT. Supervisory visits are conducted on a quarterly basis. Indicators captured are essentially restricted to number of operative deliveries which is the main focus of the Rivers State FMHS programme. However, this data could not be sighted. Findings from M & E are reviewed with policy makers/stakeholders and health care providers quarterly.

2. CHALLENGES IN TRANSITIONING FROM FEE FOR SERVICE TO FREE SERVICES

The survey revealed a number of challenges facing the Free Maternal Health Services in the state and they include; inadequate manpower and acute shortage of obstetricians and Anesthetists, infrastructural and equipment facilities are inadequate and in deplorable condition and obsolete. For example crates of drinks are used to form examination couch, no room for privacy during consultation and counseling, women stand for long period in crowded room due to inadequate seats. Others include large patient traffic with attendant long waiting time, workers overstretched without commensurate compensation, inadequate and irregular supplies of consumables and drugs and late arrival of complicated cases from TBAs , FBOs etc with its attendant high mortality due to poor referral system and other factors

3. IMPACT OF FREE MHS ON MATERNAL HEALTH INDICATORS

The survey revealed that clients' attendance during ANC was more than 6 times pre-service era, though the data were not made available to the team. Deliveries were generally attended to by skilled health workers i.e. nurses/midwives for normal delivery and doctors for operative deliveries. At the PHC levels, efforts of the nurses/midwives were complemented by community health workers e.g. CHEWS and CHOs in the case normal deliveries.

4. EFFECTIVENESS AND EFFICIENCY OF FREE CARE

The minimum package for free MHS in Rivers State, covers virtually all components such as basic ANC services, malaria prophylaxis/ treatment, basic lab tests, blood transfusion services, HIV&AIDS screening, provision of PMTCT services, family planning, hospital delivery (including operative delivery), post natal care etc. However, only operative delivery (CS), Intermittent Preventive Treatment (IPT) i.e. under the Roll Back Malaria programme of the state, management of teenage pregnancy referred from Adolescent Project (TAP) to the FMCP, certified wives of clergy men and destitute /abandoned patients constitute services offered free. Other services such as ANC, basic lab tests, normal delivery, blood transfusion, cards and registration, ultra sound are to be paid for by clients/patients. Although health providers claim that drugs, lab investigations, detergents, disinfectants and antiseptics are adequately available for free for FMHS, virtually all patients interviewed claimed they still bring Jik, razor, bucket, soap, wrapper, Dettol, pad, towel and slippers costing approximately N4,000 to the hospital.

In all health facilities, ANC clinic, family planning room, labour/delivery room and lying-in ward are clearly demarcated.

Secondary health facilities are equipped with dedicated ambulance service in the form of a motor vehicle. Emergency medical Services (EMS) are also available in designated areas of the state to, among others, transport patients from the riverine/rural areas. There is no transport loan scheme or deferral of emergency transport fee; neither is there any collaboration with any of the professional transport associations e.g. NURTW, to transport women to clinics.

Maternal Health facilities were found to be convenient to reach in the state . The perception of patients who had operative delivery supported the notion of maternal health services as being free while the reverse is the case with those who had normal delivery. The team could not establish community involvement in the conceptualisation, planning and management of the programme.

5. RECOMMENDATIONS

- a. The program will require an effective monitoring and evaluation system to support timely collection and management of data, to ensure standard in implementation, identify and respond to challenges, efficient utilization of resources and ensure that quality services are provided.
- b. Staffing requirements should be determined to inform recruitment and deployment of additional health personnel including ensuring equitable distribution of manpower. In addition, incentives in all forms should be packaged and provided to health personnel to motivate them in giving their best to the scheme

- c. The facilities will require infrastructural upgrade to reposition them for effective response and provision of quality service. This will also include expansion of facilities for adequate space for patients when at the facilities to receive services
- d. The referral systems should be adequately strengthened which should include active involvement and mobilisation of TBAs, Faith Based Organisations/facilities and private health care providers
- e. The state and LGAs needs to commence the process of engagement to facilitate the integration of LGAs into the scheme for expanded coverage especially at the grassroots
- f. Community involvement and participation need be strengthened and should include appointing representatives of the community to the management committee while effective partnership should be established with community structures such as NURTW and other relevant professional associations
- g. The implementation of the scheme need be appraised to remove all distortions and streamline its management including expanding and re-defining services that are free.

KATSINA STATE

1 ELIMINATION OF ANTENATAL AND DELIVERY COST FR WOMEN

a. Policy and legal framework

The State's FMHS started in the year 2000 with legislative backing of the State House of Assembly.

b. Implementation strategies for free maternal health services

The state has put in place a 5 year strategic plan to guide and facilitate the implementation and management of health care delivery. It is also commendable that there exists a LGA development committee to facilitate the participation of community in the implementation of the free health services indicates the State's commitment to stakeholder's involvement.

All health facilities (secondary health facilities) under the direct control of Katsina State government operates free MHSs. There were eleven secondary health facilities and all were functional. Examples of facilities offering free services include: comprehensive Health Centre, Charanchi, Family Support clinic, katsina, General Hospital Katsina, and the General Hospital, Rimi. Minimum maternal health services available in the state include basic AN services, malaria prophylaxis, malaria treatment, health education, T.T immunization basic lab test, hospital deliveries, blood transfusion HIV/screening and FP. There services are free with exertion of USS, PMTCT, client paid N200 for ultrasound and 120for lab test and 750 for blood bag and HIV screening.

In order to motivate staff, the survey revealed that the staff are well remunerated while some of them have been rewarded with sponsorship for Hajj Operations.

The survey also revealed that procurement of supplies for the free MHSs scheme is by centralized purchase through the MOH by open competitive bidding while the state has also put in place measures for ensuring budget allocation for the FMHS scheme but there was no projected costing of the scheme to guide informed allocation of resources sufficient for the implementation of the scheme.

2. IMPACT OF FREE MHS ON MATERNAL HEALTH INDICATORS

A comparison of ANC attendance and hospital delivery before and after inception of the free scheme showed some remarkable improvement since the onset of the free scheme.

3. CHALLENGES IN TRANSITIONING FROM A FEE FOR SERVICE TO FREE SERVICES

The research team could not establish that there was a projected cost of the program to guide resource allocation to the scheme

4. EFFECTIVENESS AND EFFICIENCY OF FREE CARE (QUALITY OF SERVICES AND PATIENT SATISFACTION)

In Katsina State, patients attending a local government facility pay for basic ANC services, malaria treatment and prophylaxis, ultrasound scan, basic lab tests, delivery, blood transfusion services and

card/registration. They also pay for delivery services, gloves/supplies, investigations, drugs and do buy razors, pad, soap, dettol, wrapper, towel and slippers when coming for delivery. Patients generally consider it convenient to reach nearest MHF even though majority of the respondents consider MHS to be free; some do not consider it free as they have to pay for drip set and extra gloves. All the patients interviewed were generally satisfied with available type of services personnel and time spent in health facilities. Those interviewed at PHC facilities also expressed satisfaction with available type of service-personnel and time spent in health facilities, however, patients recommended improved supply of free drugs and improvement of general services such as repairs of equipment.

With over 125 medical doctors on ground, 41 on leave without pay, and 11 on study course and other cadres of health personnel including 855 Nurses/Midwives, 101 Pharmacists/pharmacy technicians, 107 medical record officers, 25 X-ray staff, 7 Nutritionists, 3 physiotherapists, 1 optician, 4 medical laboratory scientists and 6 medical records on training, the human resource development for health in the State is fairly good and quite promising. This will in the future contribute to improved quality of services. The survey also revealed that electricity supply is not consistent but back-up generator and sufficient fuel is available. Water supply is generally inadequate in most of the facilities. In addition, service protocol for FMHS is followed and waiting area for service provision is adequate while equipment is fairly adequate.

The General hospitals generally have adequate furnishings in the patients' examination rooms except for inadequate examination couches, examination light and screens around examination couches. Sinks generally lack running water due to poor pressure of available water source.

5. RECOMMENDATIONS

- a. The State's policy document on free MHS should be made widely available among health care providers and hospital administrators for greater awareness and working knowledge to facilitate the successful implementation of the scheme's strategies.
- b. Need to strengthen existing facilities, personnel & supplies in the scheme at all levels of care, with greater attention to the PHC level.
- c. Need to review the viability of the current free scheme and evolution of more sustainable approaches, financing and management system including stakeholder involvement and participation.
- d. The medical records [Health Information Management System] needs be properly put in place where they are non-existent or strengthened to ensure accessibility of currently available but un-organised body of health/medical data.
- e. Intensive advocacy and engagement with policy and law makers and various interest groups will be required to facilitate expansion of services to include family planning
- f. An effective and operational monitoring and evaluation system will be required to provide the required support to implementation including data collection and utilisation, ensuring standard, improved quality of services, increasing access by removing all barriers and effective utilisation of resources

- g. There is the need for state and LGA engagement to streamline and fashion out an approach that facilitate the participation of LGAs in the implementation of free maternal health care services for adequate coverage of rural communities
- h. The LGA development committee should be provided technical assistance to increase their knowledge of the operations and their roles and responsibilities of the scheme, Such roles should include facility management, monitoring of services and personnel, security of facility, facilitating movement of patients when referred to a higher level of care and participating in reviewing program implementation.

GOMBE STATE

1 ELIMINATION OF ANTENATAL AND DELIVERY COST FOR WOMEN

a. Policy and legal framework

The State has formulated a policy on free MHS with provisions for organizational framework and managerial process, however, there has been no legislative backing for the scheme, though this has not affected the implementation significantly. The state has also established clear guidelines for procurements for free MHS, which is by centralized purchase through the MOH open competitive bidding.

b. Implementation strategies for free maternal health services

The free maternal health services scheme is relatively young and still at infancy in the state. The scheme is operational only at state government (secondary) health facilities as patients attending LGA facilities still pay for services. The scheme's implementation system and sustainability is still fragile and unstable in the absence of required legislation and adequate resource allocation and projected budgetary costing. There exists a budget line (sub head/vote) for free MHS and it is on record that the percentage budget cost for the free MHS usually released for implementation is less than 75%. A Management Committee/Team exists to manage the implementation of the scheme with members made up of an experienced midwife, Pharmacist, qualified accountant, an administrative officer and theatre Nurse, however, there are no Obstetrician and Public health Physician, representatives of community and women groups, medical records officers and the media on the management committee. The composition of free MHS committee is considered in complete without the inclusion of representatives of these critical/strategic constituencies. The committee meets at least 3 times in a year.

The survey revealed that staff members demonstrated indepth knowledge and understanding of the program, services, roles and responsibilities. It was also established that there is a State Desk Officer for free maternal Health Services, however it could not be confirmed if health workers involved in the program have been given the required orientation/training. The state carries out monthly supervisory visit and a good M&E system is also in place.

2. IMPACT OF FREE MHS ON MATERNAL HEALTH INDICATORS

Following the introduction of free MHS, government hospitals experienced an influx of patients from neighbouring states and LGAs. As a result, facilities in these hospitals have been overstretched because none of the PHC offers FMHS. There were eleven secondary health facilities and all were functional. A comparison of ANC attendance and hospital delivery before and after inception of the free scheme showed some remarkable improvement since the onset of the free scheme.

3. CHALLENGES IN TRANSITIONING FROM A FEE FOR SERVICE TO FREE SERVICES

The survey found that drugs, laboratory investigations, detergents, disinfectants and antiseptics were generally not adequately available in the facilities. HCPs expressed views that they are usually embarrassed by patients' complaints and dissatisfaction whenever drugs and supplies are out of stock. In addition, infrastructural facilities were either non existent or inadequate. For instance, electricity

supply was not consistent in the study facilities and back up generator and portable water was generally not available in LGA facilities. Similarly, health personnel were in short supply as only prescribing clinicians, mostly CHEWs and record clerks were the available personnel in the health facilities. The survey also showed that patients' registration materials/record system was deficient in addition to poorly equipped and furnished patient's examination rooms while standard precautions were not followed by the providers.

4. EFFECTIVENESS AND EFFICIENCY OF FREE CARE (QUALITY OF SERVICES AND PATIENT SATISFACTION)

It was revealed that, patients pay for malaria treatment, ultrasound scan, basic laboratory test and blood transfusion, but not for basic ANC services, malaria prophylaxis, TT, hospital delivery, HIV screening, PMTCT, FP, card registration and consultation. The clients also pay for investigation and blood bag during delivery, they were usually ask to bring razor blade, pad, soap, detol, wrapper, towel and slippers at delivery.

5. RECOMMENDATIONS

- a. There is the need to facilitate the development of a concrete government policy document on the scheme. The document should be made widely available among health care providers for increased understanding and successful implementation of the strategies. Stakeholders should take up the challenge of engaging and advocating for appropriate legislative backing for the scheme
- b. The involvement of representatives of community members and groups on the management committee would motivate and facilitate the adoption and participation of the scheme at the LG level.
- c. Need to strengthen existing facilities, personnel and supplies for effective services delivery.
- d. Extension of the free scheme to the grass-root communities through the PHC structures at the LG level.
- e. The budgetary release system needs be improved upon for greater effectiveness to avoid constant 'out of stock' syndrome of drugs and supplies.
- f. Need to review the viability of the current free scheme and exploration of more sustainable financing system for the free MHS scheme.
- g. The free scheme should be extended to the grass-root, rural and remote communities that are mostly in need, but still lack access to basic MHS due to cost and distance of the existing free services operating only in state owned health facilities.
- h. The medical records [Health Information Management] System need be properly put in place where they are non-existent to ensure access to more organised body of health/medical data.

- i. Alternative approaches such as networking and partnership with the 'NURTW' has to be worked out to overcome the difficulty of emergency transportation especially from rural to urban referral facilities.

ENUGU STATE

1 ELIMINATION OF ANTENATAL AND DELIVERY COST FOR WOMEN

a. Policy and legal framework

In Enugu state, the government has not only introduced free maternal services but has made it compulsory to the extent that collection of fees in whatever guise attracts dismissal from the services of the state government. The scheme stands out because the free health services does not only cover the health services for mothers during and delivery, but also covers free health services for the baby up to five years.

The administration approved a well-articulated but expansive policy for the delivery of free maternal and child health services to the entire residents of the State. It is the Governments roadmap for accelerated reduction of high maternal and child mortality rates in the State. It provides a framework for increasing investment in maternal and child health at institutional and programme levels. It also provides a window of opportunities for development partners that may wish to redirect their intervention in a manner that would support improvement in maternal and child health in Enugu State.

These services are implemented in all the Primary, Secondary and Tertiary Health Facilities in the state which are being funded by the state government.

b. Implementation strategies for free maternal services

The Policy articulated a package of strategies for the implementation of the scheme including advocacy and resource mobilization, human resources development and management, behaviour change communication, institutional strengthening, strengthening of the referral system, community mobilization, coordination and building partnerships, monitoring and evaluation and operations Research. At the initial stage of the scheme, only one health facility per LGA was involved. The rationale was to use the approach of a pilot initiative, learn from the process before scaling it up to a state wide scheme

According to some health care providers interviewed, most of the components of FMH services are provided (free of charge) in the various health facilities, however, there is a Fixed Fee Ticket of N50 and N20 for children, paid prior to receiving services. It was confirmed that there is adequate provision for all the items required for service delivery, although health providers complained of pressure of work as a result of increase in the number of clients.

2. IMPACT OF FREE MHS ON MATERNAL HEALTH INDICATORS

Available records have shown that ANC attendance and deliveries in Enugu State are grossly under-reported. This is largely because the private health facilities (primary and secondary) and the tertiary health facilities do not report their data as part of the State HMIS. However, out of the 163,729 estimated pregnant women in 2006, only 11,414 were reported to have attended public health facilities during their period of pregnancy. This represents about 7% of the estimated pregnant women in the State. Besides, out of estimated total deliveries of 130,983 in 2006, only about 4,927 were reported to have occurred in public health facilities. This represents about 4%. Besides, data on under-5 mortality

are rarely collected, except through surveys, which are costly to undertake. The data presented above is an indication of underutilization of services despite the fact that it is free in the state.

3. CHALLENGES ENCOUNTERED IN TRANSITING FROM A FEE FOR SERVICE TO FREE SERVICE

As should be expected of any new initiative, the scheme was confronted by a number of challenges including inadequate sensitisation and mobilisation of beneficiaries, paucity of personnel occasioned by ageing workforce in the public health sector and attrition due to poor remuneration, disproportionate distribution of available workforce and inadequate tools and equipment,

4. STRATEGIES FOR CHANGE IN POLICY AND PRACTICE OF FREE MATERNAL HEALTH

The free MCH care services in Enugu State is a demonstration of government commitment not only to maternal and child mortality reduction, but also to the attainment of the MDGs in the State. It is in realization of the importance of this program that the government set up a multisectoral committee which has provided a framework for translating the policy to plans. The plan extensively covered drug procurement and management, modalities for handling reimbursement, determining staffing requirements, employment and redistribution of existing staff/health professionals (Doctors, Pharmacists and Nurses) and support staff, training of health personnel in IMCI, LSS, MLSS, ELSS, EOC, infrastructural development and provision of required equipment, establishment and management of referral cases and program monitoring and program financing.

5. EFFECTIVENESS AND EFFICIENCY OF FREE CARE (QUALITY OF SERVICES AND PATIENT SATISFACTION)

According to some health care providers interviewed, most of the components of FMH services are provided (free of charge) in the various health facilities, however, there is a Fixed Fee Ticket of N50 and N20 for children, paid prior to receiving services. It was confirmed that there is adequate provision for all the items required for service delivery, although health providers complained of pressure of work as a result of increase in the number of clients. At primary health facility level, the survey revealed mixed findings. It was evident that there was problem of power and water supply at the facility level while high level personnel such as Doctors were not on ground, save CHOs and CHEWs. In addition, equipment were available, but not adequate. At the secondary and tertiary health facility level, manpower, infrastructure, clinic setting, supplies and space were adequate, but power and water supply was a major challenge.

Patients interviewed confirmed being beneficiaries of the scheme and expressed satisfaction with the services received and praised the government for the program. However, they mentioned that they still pay N50 and N20 respectively for FFT.

6. RECOMMENDATIONS

In view of the foregoing, the following were made as our conclusions and recommendations;

- a. For effective management of drugs, it is advisable that the free maternity and child health program be separated from the drug revolving fund

- b. Manpower requirements (across cadre and specialization and in right number) for the program should be determined to guide specific actions in ensuring adequate personnel including redistribution of existing staff and recruitment of additional personnel. Consideration might be given to using health personnel sourced from the NYSC scheme
- c. The state will also benefit from sensitization, mobilisation and involvement of private health care providers to complement the free maternal health services scheme
- d. The Planned Preventive Maintenance Officers, in each of the 7 DHBs, should be involved in the rehabilitation and equipping of the facilities as much as possible as part of the sustainability measures.
- e. Adequate security measures should be put in place, including but not limited to employment of security men, to ensure the safety of in-patients, staff, medical equipment and residents in government hospitals and health centres.
- f. Government should put mechanism in place to ensure steady supply of PMS or AGO for the Power Generating sets at the district hospitals to provide back up and make the facilities more enabling for surgical services and most especially caesarean sections.
- g. Government should consider setting up a Free MCH Management Committee with clear roles and responsibilities including but not limited to overseeing the running of the programme, particularly monitoring and reporting monthly as appropriate.
- h. Referral system should be adequately strengthened including provision of ambulance services in case of emergency. The state should mobilize LGA to be part of this arrangement.
- i. The state should establish an effective monitoring mechanism including data collection, reporting and utilisation on continuous basis to identify challenges and take corrective measures as appropriate. The current MESS visits and other monitoring arrangements need to be stepped up, particularly for the free MCH services and progress report be produced and presented at agreed intervals.
- j. Government should ensure monthly reimbursement of expenses arising from implementation of the programme and adequate budgetary provision for the programme in the State annual budget.