# HEALTH SECTOR REFORMS: IMPLICATIONS FOR REPRODUCTIVE HEALTH IN NIGERIA

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**Abstract**

Health sector reforms emerged as a major focus in the 1990s covering a wide range of structural and institutional changes. The components of a fundamental health sector reform includes: decentralization of power and resources; improving function of national health ministries; improving the performance of civil service (and managers); broadening health financing mechanism; introducing managed competition; guaranteeing access, redressing equity and pro-poor orientation; as well as broadening ownership and impact. Nigeria's overall health system performance was ranked 187$^{th}$ among the 191 Member States by the WHO in 2000. The issue of financing and user fees has implications for reproductive health services uptake. Where maternal services are rendered free there was an increase in service uptake where the quality of the services that are being provided are guaranteed. Local authorities or communities should be allowed to set their priorities based on their peculiar needs and problems of their locality, but such should not go against the main objective of the health reform. The approach of "basket funding" should be continued to ensure quality monitoring and evaluation of the health system in general and assuring the quality of health related data.

**Key words:** Health sector reforms, Reproductive health, Health financing mechanism, Nigeria

## Introduction

Women in Nigeria suffer preventable premature loss of life as a result of inadequate provision of health facilities, ignorance and cultural taboos. According to UNICEF rating, Nigeria has one of the highest mortality rates in sub-Saharan Africa. Maternal mortality rate is about 704 per 100,000. Women's reproductive role has continued to expose them to health risks, (WOCON, 2004). Sexual and reproductive ill health accounts for one-third of the global burden of disease among women of reproductive age (Singh *et al.*, 2003). Improving the reproductive health is one of the most critical and difficult development challenges. It is "critical" because, in addition to being fundamental to 'life, liberty and the pursuit of happiness,' reproductive health is ultimately and intimately related to economic and social development from the household to national and societal levels.

The fact that interactions of policies, services, household resources, community institutions, and individual characteristics are factors that can improve reproductive health makes the need for embarking on a holistic health reform necessary more than ever before. The present administration in the country has been interested in embarking on reforms in general and as such it is expedient that the health sector is not left out.

The need for sexual and reproductive health services, and thus the potential benefit of meeting the need, is greatest among the poorest women, men and children in the world's lowest-income countries (Singh *et al.*, 2003). The significance of reproductive health initiatives within the context of reform is particularly relevant since many of the millennium development goals are reproductive health related. Bringing sexual and reproductive health services to the millions of people living in countries which still suffer from short life expectancies, high levels of child and maternal mortality, child labour, illiteracy and poor overall health remains a major challenge for governments and donor organizations.

Despite considerable rhetoric, there has been relatively little investment by governments and international institutions in primary and preventive sexual and reproductive health interventions other than contraceptive delivery. The reality is that development agencies are still struggling to turn rhetorical commitments to gender equity and equality into concrete sector program initiatives and to integrate gender concerns into health reform programmes.

This paper provides an overview of sexual and reproductive health services, the reproductive health policy of Nigeria. This is followed by analysis of health sector reforms in general and gives an insight into the vision of health sector reforms in Nigeria. This is followed by an examination of some reform issues and efforts that are being put in place at ensuring the success of the health sector reforms, including the implications the reforms will have on the reproductive health situation. The paper ends with some recommendations for enhancing the process of reforms in order to improve the quality and range of reproductive health services.

## Theoretical and Comparative Overview

### Sexual and reproductive health services

Sexual and reproductive health services refer to a set of health services related to issues of reproduction and sexuality. According to the International Conference on Population and Development (ICPD) Programme of Action, reproductive health is the state of complete physical, mental, social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. It implies that

individuals will have: satisfying, safe sexual life; access to appropriate, safe, effective, affordable, acceptable methods of family planning based on informed choice and dignity. There should also be the provision of services for safe pregnancy and childbirth. There should also be interventions and programmes aimed at prevention, diagnosis and treatment of Reproductive Tract Infections(RTIs), Sexually Transmitted Diseases (STDs), Human Immuno-deficiency virus (HIV). The elimination of harmful practices (Female Genital Mutilation, domestic violence, sexual trafficking) are also core to ensuring that the citizens have good reproductive health. It is equally important for there to be an emphasis on: poverty alleviation, girls' education, women's empowerment. Some of the key reproductive health services include provision of qualified assistance during delivery. In response to all these reproductive health demands, the Federal Government in 2001 developed a National Reproductive Health Policy, which identified the Reproductive Health care needs and prescribed broad strategies for intervention to address the following:

- The unacceptable high levels of maternal and neonatal morbidity and mortality
- The increasing rate of infection with HIV and the prevalence of other STIs.
- Increasing high-risk behaviour of adolescents leading to premature sexual encounters, early marriage, unintended pregnancies, unsafe abortions and the social consequences such as school dropout with subsequent negative intergenerational effects.
- The persistence of harmful practices including imported and dangerous family health values and practices
- The serious consequences of domestic violence and sexual abuse against women and the girl child.
- The current fragmentation of reproductive health activities and the limited impact of existing programmes in reducing sexual and reproductive ill-health, and improving reproductive health and well-being.
- The low level of awareness and utilization of contraceptive and natural family planning services
- Inadequate services for infertility and the associated misery
- Sustaining the implementation of the programme of action of the International Conference on Population and Development (ICPD, ICPD+5).

The overall goal of the reproductive Health Policy is to create an enabling environment for appropriate action and provide the necessary impetus and guidance to national and local initiatives in all areas of Reproductive Health. The specific objectives of the Reproductive Health Policy are as follows:

1. Reduce maternal morbidity and mortality due to pregnancy, childbirth by 50%
2. To reduce perinatal and neonatal morbidity and mortality by 30%
3. To reduce the levels of unwanted pregnancies in all women of reproductive age by 50%
4. To reduce the incidence and prevalence of sexually transmitted infections including the transmission of HIV infection
5. Limit all forms of gender-based violence and other practices that are harmful to the health of women or children.
6. To reduce gender imbalance on available reproductive health services
7. To reduce the incidence and prevalence of reproductive cancers and other non-communicable diseases.

8. To increase knowledge of reproduction biology and promote responsible behaviour of adolescents regarding prevention of unwanted pregnancy and sexually transmitted infection
9. To reduce gender imbalance in sexual and reproductive health matters.
10. To reduce the prevalence of infertility and provide adoption services for infertile couples.
11. To reduce the incidence and prevalence of infertility and sexual dysfunction in men and women.
12. To increase the involvement of the men in reproductive health issues.
13. To promote research on reproductive health issues.

**Definitions and Characteristics of Health Sector Reform**

Health sector reform (HSR) emerged as a major focus in the 1990s (Bates, et.al., 2000). It is not homogenous in content. It covers a wide range of structural and institutional changes. Health sector reform can be defined as a process that seeks changes in health sector policies, financing, and organization of services, as well as in the role of government to reach national health objectives (Leighton, 1998). To health activists, health sector reform is seen as a broad process for streamlining vision, legislations, programmes and projects in health towards improving efficiency, access, financing, quality and equity (Odutola, 2003). Odutola further reported that, to the triumvirate of donors, multilateral and bilateral organizations express health sector reforms as a project to "rationalize health programmes, emphasise basic and population health, promote economic efficiency and rein in public sector spending while promoting increasing privatization". From the view point of Cassels (1997), health sector reform is a "fundamental rather than an incremental change in health system which is sustained rather than one-off and purposive nature".

In theory, sector reforms are meant to promote both equity and efficiency in the delivery of health care services to the largest possible number of people, and to democratize the processes through which decisions about health care priorities are made ( Centre for Health and Gender Equity, 1998; Bates, et al, 2000). The changes expected in Health Sector Reforms have definite consequences for gender equity, sexual and reproductive health, and the general health of the entire population. The aim of the health sector reform is to improve accountability, efficiency and transparency in the sector. Health sector reforms are implemented also as a means of increasing the effectiveness, quality, equity and financial soundness of health systems.

Health Sector Reforms consist of six elements viz: financing, public-private interactions, priority-setting, decentralisation, integration of services, and accountability (Ranjani et al, 2005). According to Cassels (1997), the components of a fundamental health sector reform include the following: decentralization of power and resources; improving function of national health ministries; improving the performance of civil service (and managers); broadening health financing mechanism; introducing managed competition; guaranteeing access, redressing equity and pro-poor orientation; as well as broadening ownership and impact. The fact that the views of Ranjani and Cassels are similar shows that the core objective of any health sector reform process is as highlighted earlier.

The language of HSR as expressed by international agencies and governments has changed over the decade from the early 1990s. The "first generation" of reforms was supply-side driven and focused on the health sector (Standing, 2000). One of the top objectives was

to reform the operations of Ministries of Health, specifically their technical and managerial activities. This first generation assigned priority to the following elements: improving health sector management systems; public sector reform; reform of financing mechanisms, cost containment; decentralization; and working with the private sector.

The "second generation" conserved these five elements, and added a broader perspective, emphasizing demand side, anti-poverty interventions and inter-sectoral approaches to health. The following elements were added: partnership with key stakeholders; focus on community/user needs; and health as part of the poverty agenda.

According to the ICPD, governments must make reproductive health accessible through PHC system before 2015, while the Beijing (1995) conference sees autonomy, empowerment and self determination of women as cornerstone of all health and population programmes and encourages a life-cycle approach to sexual and reproductive health.

In China the focus of their health reforms was on financing and provision of health services in general, which may not be far fetched from the 1976 economic reform programme embarked upon by China. While the central focus of health reforms in Zambia was in ensuring equity of access to cost-effectiveness of health services to the citizenry, there was also the emphasis on organizational reforms at different levels. All these were done because the reforms in Zambia were started in a context of great institutional fragility, there were multiple crises (economic and HIV/AIDS epidemiology in the country). The summary is that the reforms in Zambia emphasized democratization, participation and innovations. This implies that the economic and political situation in a country before the onset of health sector reforms go a long way in determining what the central focus of such reforms will be. The seven pillars enunciated by the federal ministry of health also gives an indication of the focus of the entire health reforms.

The health system in Nigeria and the health status of Nigerians are in a deplorable state: Nigeria's overall health system performance was ranked in the 187$^{th}$ position among the 191 Member States by the World Health Organization in 2000. Health status indicators are worse than the average for sub-Saharan Africa. For example, infant mortality rate of 115/1,000, under-5 mortality rate of 205/1,000 (Health Sector Reform Programme, Strategic Thrusts with Logical Framework and Plan of Action, 2004-2007, Federal Ministry of Health), and maternal mortality ratio ranging from 704 (FOS/UNICEF, 2000) to 1,500 (UNFPA, 2002) maternal deaths per 100,000 live births. Thus, improving the quality of health services received by the citizenry is core to the Nigerian health sector reform.

It should be noted that sector reform is by definition sector-wide in that it affects more than one service, supply or clinical policy, and more than one facility, provider, institution, or geographic location. For the purpose of this paper attention will be focused on sexual and reproductive health.

**The Reform Issue and Contemporary Reform Efforts**

The need for reforming the health sector has been long recognized (Ranjani et al, 2005). The declaration of Alma Ata in 1978 called for national governments to shift from provision of curative health services at tertiary level to provision of integrated health services at primary levels of health care. The 1994 ICPD called for reforms in priorities, resource allocation, financing, and organisational mechanisms for managing and delivering health and sexual and reproductive health (SRH) services. The calls for reforms have been rooted in principles of promoting and protecting equity and rights to health and sexual and reproductive

health services. Over the years there has been two main lobby groups with one clamouring that the state should play a major role in health care financing, provisioning and facilitating these reforms; while the other group is deeply rooted in the neo-liberal ideology of the state taking the back sit in health care financing, provisioning and expanding the role of the private sector. The reforms advocated by the latter group which consists of the World Bank, USAID and their allies seek to address issues of insufficient funds, poor quality, high level of inequities, limited access inefficiencies, and lack of accountability (Ranjani et al, 2005).

There are technical and political strategies that can be used in ensuring that the goals and objectives of the health reforms are achieved. These include strategies for improving access and equity; quality; efficiency; financing and sustainability of services and strategies to manage the policy process. The reality is that health sector reform is pre-eminently a political process and not just a technical process. Some of the strategies for improving quality of health services in general and reproductive health include: the creation of incentives to encourage better performance from health care providers; improving supervision skills and frequency; introducing total quality management; instituting new problem-solving practices as well as the strengthening of the referral system.

According to Leighton (1998), the focus of strategies aimed at improving access and equity is to determine who benefits from which services, who pays for them, and how much they pay. There are indeed a plausible variety of financing and non-financing approaches that can be used to increase access and equity. Some of the non-financial strategies mentioned by Leighton include policy reforms that place greater emphasis on providing primary and preventive care, use of promotional campaigns and social marketing to change health practices, promote changes in the distribution of providers between urban and rural or underserved areas. Leighton cited the situation in South Africa where legislations were made to address maldistribution of medical doctors by requiring service in rural areas following medical school.

On the financing strategies, Leighton suggested the establishment of a more progressive financing mix, more effective targeting of subsidies, prepayment plans to help families with irregular incomes and when necessary allow some exemptions from user fees. This has been done in Bolivia, where all fees from key maternal and child health services in the public sector were dropped as a strategy to increase access and equity for those services, and ultimately to improve reproductive health. It is worth mentioning that a similar thing was done by the Government of Nassarawa State of the Federal Republic of Nigeria, who started the rendering of free maternal services in 2005, this was reported by the Nigerian Television Authority – Network News in January 2006. Indeed, some studies have found that introduction of user fees were associated with a 56 per cent rise in maternal deaths and a 46 per cent decline in hospital deliveries in the Zaria region of Nigeria (Standing, 1999). In Zimbabwe also there was a decline in the use of maternal and child health services in Zimbabwe in the early 1990s as a result of user fees (Kutzin, 1995).

Health sector reforms have been criticized for failing to fully support women's reproductive health and rights (CHANGE and Population Council, 1998). In practice, reproductive health services tend to focus on family planning, limited prenatal care and obstetric care and to cover interventions in women's childbearing activities. Some programmes include a minimum of counseling and gender training. In practice, the relevance of men in reproduction is barely reflected in reproductive health priorities.

Decentralization and community participation represent an opportunity to overcome the lack of sensitivity to women's dignity, needs and preferences and to encourage women to use public health facilities. This could be achieved by "involving women at the design and planning stage to take care of issues of privacy, and other facilities" (Ramachandran, 2000).

Aitken (1998) reported that several countries have different forms of decentralization. In Nicaragua, decentralization was carried out by transferring authority and responsibility to lower levels within the government health system. In the Philippines, power over health services has been devolved to municipal and provincial governments that are actually separate from the central Ministry of Health. In Nigeria, the states have responsibility for hospitals, while power over primary health care and family planning is given to the local government authorities.

The common factor in the ways different countries have implemented decentralization is that to varying degrees, management and/or financial authority has been passed down to levels below the central authority. At the local government level, operations are more flexible to tailoring of sexual and reproductive health services to suit local needs. While decentralization opens possibilities for further development of the district health system, it also poses new challenges, particularly to primary stakeholders. Aitken (1998) questions the impacts of decentralization on sexual and reproductive health when government commitments to the 1994 Cairo Agenda are not implemented at the local level, either because resources are not budgeted or because of conflicting interests and views between the center and the periphery.

Paradoxically, as more power is conferred upon local representatives, the power is brought closer to the people, and thus the power and the nature of the administration actually is legitimized. However, conferring power on incompetent local representatives can also have the undesired effect of deepening existing health inequities. In addition, local will can be influenced by conservatism and prejudice, particularly in the case of services such as management of incomplete abortions or sexual health services for adolescents.

**Vision of the Health Sector Reforms in Nigeria**

The vision for the health sector reform in Nigeria is "to improve the health situation of all Nigerians, and to attain a level of health care that would permit all to live a socially and economically productive life. The objectives of the reforms programme in Nigeria include:

1 Expand and strengthen primary health care services throughout the country.
2 Eradicate, eliminate and control childhood and other vaccine preventable diseases through adequate routine immunisation activities.
3 Integrate and strengthen all disease control efforts and health promotion activities into health care at primary care level.
4 Address the demographic problems through the provision of family and reproductive health services including the necessary services to reduce the incidence of STD and HIV infection.
5 Reduce environmental and occupational health related morbidity and mortality.
6 Rapidly resuscitate and improve the services of secondary health care to serve as an effective referral for PHC.
7 Improve investigative, diagnostic and treatment capability of tertiary health facilities to serve as an effective apex referral system to all health facilities in the country.

8 Ensure the attainment of the goals and objectives of the National Drug Policy (NDP), which focuses on self reliance in essential drugs, vaccines and biologicals through local manufacture and an effective drug administration and control system.
9 Protect the public from the harmful effects of fake drugs, unregistered medicines and processed foods.
10 Ensure that the support given by donors, NGOs and UN agencies is provided within the framework of the national health policy and plans.
11 Broaden financing options to expand and improve access to affordable and adequate health care to a majority of Nigerians.
12 Strengthen policy formulation, general management, financial management, and planning capacity of the Federal Ministry of Health and parastatals.
13 Strengthen the capacity to develop, implement, monitor and evaluate evidence-based national health policy, planning, programmes and activities.
14 Institutionalize managed competition, public-private partnerships and National Health Accounts.

These fourteen objectives form the core of Nigeria's 2004-2007 health sector reform agenda (Odutola, 2004), thus implying that the health sector reforms are still at the beginning phase. Aside from these objectives the Federal Ministry of Health has identified seven strategic pillars of the health reforms. These include: defining the stewardship roles of the three tiers of government; strengthening the national service delivery system and its management; reducing the disease burden due to priority health problems; ensuring adequate health resources are available and that better management systems are put in place; improving access to quality health services; enhancing consumers' awareness and community involvement in health; as well as promoting effective partnership and coordination (FMOH, 2005).

Within the overarching framework of the National Economic Empowerment and Development Strategy (NEEDS), Nigeria has made progress by revising its national Health Policy, agreeing a Health Sector Reform (HSR) Programme. The degree of attention that is given to sexual and reproductive health will go a long way in determining how far Nigeria will go in meeting the millennium development goals most of which are not only health related but are basically sexual and reproductive health related.

**Implications for Reproductive Health**

The fact that the HSR is still at the early stages of implementation reduces the chances of being able to examine the impact. In the words of Aitken (1998), reproductive health requires policies that not only include safe motherhood, control of sexually transmitted diseases (STDs), and family planning programmes to become organically integrated.

The issue of financing and indeed user fees has implications for reproductive health services uptake for some studies have found that introduction of user fees were associated with a 56 per cent rise in maternal deaths and a 46 per cent decline in hospital deliveries in the Zaria region of Nigeria (Standing, 1999). Also, in Zimbabwe there was a decline in the use of maternal and child health services in the early 1990s as a result of user fees (Kutzin, 1995). It is worth mentioning that the Government of Nassarawa State of the Federal Republic of Nigeria started the rendering of free maternal services in 2005, and this was said to have led to an increase in the number of people who are taking advantage of the services, this will

definitely affect the health status of the state, this was reported by the Nigerian Television Authority – Network News in January 2006.

The gender implications of cost recovery have also been documented and it shows that there could be a decline in the uptake of maternity services, particularly at the hospital level due to service charges (Kutzin, 1995). As a result of the reforms the capacity and capability of various personnel will be enhanced. Other studies (Schneider and Gilson, 1999) show that government removal of user charges for MCH services may not necessarily result in any increase in the use of maternity services, when the quality of the services that are being provided are not guaranteed.

Some of the advantages of decentralization include local ownership, responsiveness to local needs, and efficient management of resources. However, negative examples of decentralization remain forceful reminders of its complexities. Aitken (1998) argues that "the most resistant barriers to the successful implementation of reproductive health programmes may be the innate conservatism and resistance to change of health workers themselves. The culture-based reluctance to provide services to teenagers or to women with incomplete abortions is a familiar problem. The implication of this is that decentralization increases the number of people and institutions involved in policy formulation, which could be detrimental to attaining the reproductive health agenda. This is because an opinion may be encouraged by one and opposed by the other due to cultural or religious biases.

**The Way Forward**

The place of advocacy cannot be over emphasized. There is the need for all stakeholders in reproductive health to continuously put the following demands at the table of governments; the need for governments to take responsibility for women's health; develop more gender sensitive policies; an increase in health budgets earmarked for sexual and reproductive health; the prioritization of quality of health services over targets; health be recognized in a holistic and integrated manner (preventive, promotive, curative); and asking for more participation of women in all levels of decision making.

There is the need for higher level of community participation and decentralization especially as it affects the provision of contraceptives. It should be noted that due to cultural and religious differences among Nigerians in the various geo-political zones, some types of contraceptives are acceptable while some are not, and with the previous method of having a National Central Store and Zonal Stores and employing the principle of quota to effect the distribution of contraceptives, explains why in some Zonal contraceptive stores, some contraceptives get expired without being demanded for and in another geo-political zone that is favourably disposed to such contraceptives will experience stock-outs. This may also be due to the fact that bottom-up approach is not being generally used in most of the state and zonal contraceptive stores.

In taking advantage of the benefits of decentralization in ensuring a reduction in the incidence of gender inequity to service and quality of service, local authorities or communities should be allowed to set their priorities based on their peculiar needs and problems of their locality, but such should not go against the main objective of the health reform.

It should be mentioned that a lack of capacity in decentralized governance structure and the presence of undemocratic local level interests can undermine the proposed benefits of decentralisation for health sector performance. Therefore, there is the need to have a

programme that ensures that personnel have the opportunity of improving themselves. The situation of equity may deteriorate in a situation where there are no resource allocation mechanisms to move funds from richer to poorer areas, as such the necessary resource allocation mechanisms must be put in place to optimize the use of available scarce financial resources. There is also the need to have an adequate capacity and mechanisms of feedback, evaluation and accountability at the local level.

Though health is regarded as a public good and presently is on the concurrent list in the Nigerian constitution, implying that all the three levels of government, the Federal, State and Local Government Areas have responsibilities for the provision of healthcare. The defining of the stewardship roles of the three tiers of government is an important cornerstone of the current HSR. There is the need to earmark certain funds and give them to the local government levels who have more responsibilities in primary health care in ensuring that primary and reproductive health services that had been given priority will be implemented.

It should be mentioned that in terms of accountability and coordination of funds from donor agencies, the FMOH now has a central pool for all funds and the activities of various donors are now better coordinated, and every person knows what the other is doing and their efforts are now being targeted at the objectives of government. Thus reducing the pattern before in which the efforts of different donors go on different issues and as such the results do not show significantly, also the former pattern reduces sustainability of various projects once donor support ceases. The current approach of "basket funding" should be continued in that this ensures that the interest of government is also taken into consideration rather than what it was before now when the sole determining factor at embarking on a project is the interest of the donor. This approach will also enhance the quality of our monitoring and evaluation and the quality of health related data.

It should be mentioned that in the course of training in the medical school, medical students in the University College Hospital (UCH), Ibadan and other universities normally embarks on rural posting for some weeks. This should be encouraged after graduation from medical school and it should not just be limited to medical students alone but should include all paramedical personnel so as to improve access and equity to reproductive health services to rural areas.

**Conclusion**

There have been various reforms in the various sectors of the Nigerian economy, and the health sector is not excluded. The reforms in the health sector is hinged on seven strategic pillars with principal focus on issue relating to access and equity, quality of health care, financing and partnerships. The ensuing health sector reforms have implications for the reproductive health situation of Nigerians.

It is hoped that as there continues to be improvement in the economy, the fruit will become obvious in terms of financing for reproductive health situation, though the financing will not solely be the responsibility of governments. All efforts must be made to implement and on a continuous basis review the reform agenda, such that the dividends of the reforms will manifest in our quest for meeting the millennium development goals.

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