Annual Commentary

HPRG's health sector 2023 roundup: Evidence, knowledge, politics

December 2023

The transition to a new government led by President Bola Tinubu with an agenda of **'renewed hope'** was a significant moment in 2023. It is expected that the agenda drives growth and development in Nigeria, inclusive of the health sector. Health Policy Research Group (HPRG), University of Nigeria has for the past two decades contributed to Nigeria's health sector through the generation and implementation of research evidence to significantly inform health policies and practices.

In February 2023, HPRG published a synopsis of the health contents of the manifestos of the top contenders for the presidency. A common argument was that Nigeria's health sector needed dramatic reforms and investments to attain Universal Health Coverage (UHC). The manifestos also agreed that health-related research would be pivotal to the UHC journey – a commitment that has been restated in the Nigeria's Health Sector Renewal Plan (NHSRP).

Therefore, '**this health sector 2023 roundup**' lays before the public, research evidence from some studies conducted by HPRG in Nigeria. It provides in brevity, distilled evidence for policy and practice interest in five areas that include (a) Evidence use by policymakers (b) urban health (c) sexual and reproductive health (d) inefficiencies in health programmes, and (e) corruption and accountability.

The use of evidence by health policymakers

Our work with the Results4Development (R4D) and the Gates Foundation explored the evidence-to-policymaking culture among health policymakers in Nigeria. Although we were more interested in health policymakers' usage of evidence from mathematical and economic models, we also permitted conversations on other kinds of evidence from qualitative and non-modelling quantitative enquiries.

Generally, we found poor relationships and weak communication between researchers and policymakers, weak translation of evidence for easy understanding by policymakers, as well as poor attitude of policymakers toward seeking for, funding, and making use of research evidence. It leaves us worried that most of policymaking in the health sector may not be tied to evidence, which contrasts best practice. Nevertheless, we found that the Nigeria Centre for Disease Control and Prevention (NCDC) was an exception, especially as evidence was at the core of its engagements in containing COVID-19.

Urban health: Health and healthcare in urban slums

HPRG under the CHORUS Urban Health Consortium has an ongoing large piece of work in Nigerian urban slums, which currently accommodates about 50 percent of the urban population. We have seen first hand the amount of deprivation in slums and the dominance

of healthcare by informal providers like Patent Medicine Vendors (PMVs), bone setters, Traditional Birth Attendants (TBAs), herbalists, etc. In some cases, we have found abandonment of health facilities by slum residents for reasons pertaining to the inefficiencies and cost of receiving care in the health facilities and/or the trust and confidence slum residents have over the years built in informal providers.

At the heart of our research is the consensus among formal and informal health stakeholders on the need to pull the informal health providers into the formal health system, while ensuring the effectiveness of catchment PHCs around the slums. We are already working with health authorities in Enugu State to implement this co-created intervention which evidence has shown will strengthen healthcare in slums. Interestingly, we recognise that the Federal Ministry of Health and Social Welfare (FMoHSW) is also thinking in this direction. Thus, we recommend that our intervention can be monitored for feasibility/adoptability, and where practicable, should be scaled.

Transformative approaches to sexual and reproductive health of adolescents

Over 50 million Nigerians are between 10 and 24 years, which is more than a quarter of Nigeria's population. Yet this population does not receive the amount of healthcare attention it deserves. HPRG in recognising this gap, is working with the International Development Research Centre to pursue a transformative approach that will support adolescents to receive youth friendly sexual and reproductive health (SRH) services in their communities. We are doing this by working with adolescents and community stakeholders in Ebonyi State to further understand the prevalence of the consequences of risky sexual behaviours and identifying how health facilities can function to become attractive to adolescents in need of SRH services.

With our evidence, health workers are currently trained to provide youth friendly SRH services to adolescents. Yet this speaks to the human resource shortage in our PHCs, as none has been seen to have qualified social workers and psychologists. Laboratory professionals are also scarce, leaving us to worry about if PHCs are comprehensively positioned to deliver quality and comprehensive care under one roof.

Health programmatic inefficiencies

Nigeria's health space considerably enjoys donor-funded programmes. While this is a useful resource to scale up the country's underfunded health system, it presents the possibility of crisis and anti-development if not managed. Our work on Cross-Programmatic Efficiency Analysis (CPEA) done in partnership with the WHO office in Nigeria and the Strategic Purchasing Africa Resource Centre (SPARC), has exposed defects in the governance arrangement of health programmes, with knock-on effects on health financing, service delivery, procurement, and health information system.

Among several inefficiencies found in the study, fragmentation and duplications in health programmes, misalignment between health programmes and health priorities at subnational levels, lack of sustainable plans for health programmes when donors exit, poor budgeting and procurement practices, weak practices in communication and enforcement of policies, weak accountability mechanisms, and lack of coherence between evidence and policy

actions/decision making mar health programmes and the overall health system. This study has developed solutions following root-cause analysis of the identified inefficiencies.

Corruption and unaccountability in the health sector

In the health sector, corruption has been rightly identified as the difference between life and death and a clear case of robbing the sick. An incredible amount of time in HPRG has been spent on studying system-wide and facility-centred corruption using a range of research approaches. We have identified absenteeism, informal payments, employment malfeasance, procurement and health financing irregularities as the most common forms of corruption in the health sector. The prevalence of these corruption concerns especially in primary health, frustrates healthcare for the poor and everyone at grassroots.

We used absenteeism as a case study in a recent publication to show how defective systems encourage and sustain corruption. In the NHSRP, social accountability involving civil societies, citizens, and other non-state actors was emphasized, which aligns with our evidence on grassroots-led anticorruption. In addition, the need to rejig and efficiently communicate health sector-specific regulations; improve workplace satisfaction and welfare; deal with information asymmetry in health facilities through public communication and responsive reporting channels; responsive health authorities to reports from service users and local monitors, and use of evidence to produce a sustainable anticorruption agenda for the health sector, lead our pack of proof-of-concept anticorruption evidence.

Where from here? Looking ahead to 2024

We extend commendation to the health sector leadership for the blueprint embodied by the NHSRP. We recognise the need for finance to drive the plan, which is why we commend states like Borno and Abia, among others, that have kept to the recommended 15 percent benchmark of annual budget for the health sector in 2024. However, we urge that beyond budgeting should be timely release of funds and tracking of funds to guarantee value for money. At the same time, we express concerns about the under 5% to the health sector by the Federal Government, which we fear may mar the lofty ideals of the NHSRP. Notwithstanding, we are of the view that some progress can be made by ensuring that Nigerians get commensurate value for what has been budgeted and evidence from several studies of ours points to what the leadership can do, which include:

- Deliberate and improved inclusion of evidence in policymaking and strengthening relationships between the academia and policymakers, while urging academia to distil evidence in non-technical bits for policymakers.
- Aggressively prune ungoverned spaces in the informal health space by mapping and integrating informal health providers into the formal health system, while maximally improving on the efficiency of catchment PHCs within slums and other deprived locations.
- Look toward maximising the potentials of PHCs for sexual and reproductive health of young people, and making sure that PHCs are rightly staffed and deliver comprehensive health services inclusive of psychosocial care under one roof.

- Pay attention to current research on programmatic inefficiencies in the health system and use the results to squarely address identified lapses in vital areas of governance, service delivery, health financing, procurement, and health information system.
- Pursue health-focused anticorruption agenda by addressing management- and facility-centred drivers through health sector specific regulations, curb excessive management discretions of facility managers and health workers, mainstream accountability monitors in facilities, funding, enhanced workplace satisfaction, and enhanced responsiveness of health authorities to accountability concerns from the grassroots.

We look forward to an improved health sector in 2024. On behalf of our team, we wish everyone happy holidays.

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