How Social Welfare Services Work: Examining the Maternal and Child Health Care (MCH) Component of the Subsidy Re-Investment and Empowerment Programme (SURE-P) in Nigeria (2012-2015)

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PROJECT DATA

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Region Sub-Saharan Africa	**Sector** Health
Implementation Years 2012-2015	**Implementing Agencies** The SURE-P Secretariat, The National Primary Health Care Development Agency (NPHCDA), The Federal Ministry of Health.
Development Challenge Maternal and Child Health	**Delivery Challenges** Coordination and Engagement; Organizational Capacity; Skilled Human Resources; Culture

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Introduction

This delivery note examines the Maternal and Child Health Care (MCH) component of the Subsidy Re-investment and Empowerment Program (SURE-P) in Nigeria (2012-2015). SURE-P was a social welfare initiative of the Nigerian government that targeted poor, rural, and vulnerable populations, following the government's removal of fuel subsidies in 2012. The MCH segment of the SURE-P program sought to mitigate Nigeria's high rate of maternal and child mortality. In 2010, Nigeria accounted for 14 percent of all maternal deaths globally, and had a child mortality rate of around 82.7 deaths per 1,000 live births in 2011. Maternal and child mortality represented one of the most severe social inequalities that the Nigerian government needed to tackle through the SURE-P program. While maternal mortality in Nigeria remains high at the time of writing, the SURE-P MCH component saw successes in increasing pregnant women's uptake of healthcare services and addressing healthcare workers' attrition through monetary and non-monetary incentives.[1] This experience offers important

1 For instance, following the kick-off of the MCH program, the population of pregnant women visiting the PHCs for at least four antenatal care services went up by 36.3 percent (see EpiAFRIC, 2015 for more indicators of the successes of the MCH program).

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lessons for policymakers on how to design effective healthcare systems for pregnant women.

This delivery note examines on the Maternal and Child Health (MCH) component of the SURE-P program, with a focus on specific interventions such as the Conditional Cash Transfer (CCT) program devised to address gaps in pregnant women's utilization of healthcare services. The note highlights the development challenge addressed by the SURE-P MCH and provides an overview of the component. After this, it turns to the delivery challenges[2] that the project faced. It concludes by offering some potential lessons from the project implementation process.

Development Challenge

The major development challenge the SURE-P program aimed to address was the high rate of inequality and poor welfare services in Nigeria,[3] mostly affecting vulnerable populations such as rural women, youth, and children. Within the larger SURE-P program, the MCH component focused on access to quality healthcare services and high maternal and child mortality in Nigeria. This challenge manifested on both the supply and demand sides. On the supply side, this was partly due to poor social investments and inefficient redistribution of public welfare. On the demand side, meanwhile, there was poor uptake of maternal health services by pregnant women. For instance, between 2004 and 2006, only about 43 percent of women between 15 and 49 years of age had their most recent live birth(s) attended to by skilled health professionals, while within the same period, only 37.5 percent of women in the same age group had their most recent live birth(s) in a health center.[4] Thus, the MCH component of SURE-P aimed to reduce high maternal and infant mortality by providing pregnant women with access to quality healthcare services and incentivizing them to use these services when they became available.

2 That is, non-technical challenges that occurred during the implementation process.

3 As a result, the country has consistently ranked low on key human development indicators.

4 National Bureau of Statistics, 2018, vii.

The Intervention

The overall SURE-P Program was divided into two major outputs: Infrastructure Development Projects and Social Safety Net Projects. Among other things, the safety net programs were designed to serve as a fulcrum for the onset of a nation-wide welfare system targeted at the poor and most vulnerable on a continuous basis. The MHC program was a sub-component of the Social Safety Net Project.

The MCH project was implemented under the remit of the National Primary Health Care Development Agency (NPHCDA), with support from the Federal Ministry of Health and the SURE-P Secretariat

The MCH scheme was made up of several outputs, aimed to address constraints on both the supply and demand sides (see Table 1). The supply side of the project included provisional interventions from the government, including the provision of health care infrastructures and supplies, and the recruitment and training of an adequate number of maternal healthcare workers in the Primary Health Care Centres (PHCs). The demand side comprised government incentives, such as Conditional Cash Transfers (CCT), and outreach and communication initiatives to increase health service utilization.

In October 2012, the federal government launched the pilot program in 500 PHC facilities that had been designated as SURE-P MCH centers across 36 states and in the Federal Capital Territory FCT of Abuja. The second phase of the program brought on an additional 500 PHCs in November 2013, bringing the total number of SURE-P PHCs to 1,000. The PHCs were subsequently equipped with essential supplies and renovation of medical infrastructures to ensure quality health services. To address the shortage of healthcare professionals, health infrastructure investment was complemented with the recruitment and deployment of 5,400 midwives, 14,100 Community Health Extension Workers, and about 38,700 Village Healthcare Workers across the 1,000 PHCs.[5]

While this provision made healthcare services more available for pregnant women, the Nigerian government also needed to incentivize women (rural women especially) to utilize the healthcare services. This challenge led to the introduction of a conditional cash transfer (CCT) program for pregnant women who

5 World Bank- Development Impact Evaluation [DIME), 2013, p.10.

Table 1. The MCH Project Structure

SURE-P: 2012- 2015 - Scope: nation-wide (36 States and Federal Capital Territory, Abuja); - 500 PHCs on first stage; scale-up to 1,300 by 2015	
Supply-side	Demand-side
- Recruitment, training and deployment of 5,400 midwives, 14,100 CHEWs and 38,700 VHWs in needy communities - Provision of essential supplies, commodities and refurbishment of PHCs infrastructures - Provision of incentives to tackle health workers' attrition (both monetary and non-monetary) - Monitoring the availability of supplies at the PHC level	- CCT: pregnant women given a total cash payout of N5,000 conditional on attending antenatal care, skilled birth attendance, and postnatal care - Informational outreach for awareness-creation and demand promotion

Source: World Bank- Development Impact Evaluation [DIME], 2013, p.12.

completed enrolment in primary health care services, from antenatal to postnatal stages. The CCT component of the MCH began in 2012 with a testing phase in two area councils in Abuja and was thereafter piloted in 2013 in eight of the 36 states in Nigeria, with a total of 40,000 pregnant women as beneficiaries.[6] A sum of US$30 (NGN5,000 at the time) was given to pregnant women who completed every stage of antenatal and postnatal health services. In September 2013, another dimension of the conditional cash transfer program was introduced, known as the "midwives retention strategy." This strategy comprised a set of monetary and non-monetary incentives targeted at increasing midwives' retention rate in the primary health centres (see the following section.

Addressing Delivery Challenges

The MCH program faced a number of delivery challenges as it rolled out both phases of the PHC facilities and the CCT programs. This meant that policy implementers had to adjust their approaches in addressing these challenges. Two of these challenges are particularly noteworthy: coordination and engagement problems among various stakeholders, and midwives' attrition.

Coordination and Engagement

During the early months of the program, the project was beset with the challenge of poor stakeholder engagement. Although the public service system in Nigeria is characterized by interlinked institutional structures within the three tiers of government and among several ministries, departments, and agencies (MDAs),[7] state and local governments did not show strong engagement at the initial stage, since the project was being coordinated at the federal level by the Ministry of Health and the National Primary Healthcare Development Agency. Many stakeholders in the state ministries of health, as well as primary healthcare centers in local councils, also did not fully invest their energy into the project in areas under their respective authorities. This was especially the case in the northern part of the country, where many viewed modern healthcare with some distrust.

To address this challenge, the SURE-P through the NPHCDA devolved the administration of the MCH to state secretariats of the NPHCDA. Specifically, the NPHCDA introduced the use of Village Healthcare Workers (VHW) and the Community Health Extension Workers (CHEW) in PHCs in rural areas to ensure better local ownership of health services. Recruited in two different cohorts

6 C. Oduenyi, V. Ordu, and U. Okoli, 2019, p.2.

7 The World Bank, 2015, p.96.

(2013 and 2014) through each village's health development committee, the VHWs were attached to various rural PHCs — mostly in the northern part of Nigeria — and were put under the leadership of the CHEWs for monitoring and training.[8] Among other things, VHWs' primary duties were to visit rural PHCs for a specified number of hours weekly, encouraging pregnant women to participate in antenatal and postnatal care and educating rural communities about the healthcare services being provided. An important contribution of the CHEWs and VHWs to the MCH program was the integration of local communities' perspectives into healthcare delivery as well as improved uptake of healthcare services in rural PHCs.[9]

Maintaining skilled human resources: Midwives' attrition in rural areas

Efforts to increase the number of skilled healthcare workers in rural areas predated the SURE-P MCH program, and in 2009, the federal government of Nigeria had launched the Midwife Service Scheme (MSS) to this end.[10] The MCH program aimed to build on the already existing MSS, since both programs were managed by the NPHCDA.[11] However, at the start of the MCH program, midwife attrition was by far the most pronounced challenge the MCH program faced, especially in rural areas. Many midwives were demo- tivated to commute or relocate from their places of residence in the cities to the new PHCs where they were required to work, but which were largely located in rural areas. Indeed, many midwives left their jobs if the work meant they would have to relocate to very remote areas. Since their continual engagement was key to the success of this intervention, the attrition of midwives therefore represented a significant challenge to this project.

To address this challenge, the SURE-P introduced the "midwives retention strategy" in 2013. This strategy included quarterly monetary and non-monetary benefits for the midwives, and this helped improve work attendance.[12] The effectiveness of the strategy was verified using a randomized trial approach. Based on baseline data from surveys across the initial 500 SURE-P MCH health centers, midwives were randomly assigned into four study groups, with three treatment groups and one control group. One group was allocated non-monetary incentives, such as uniforms and souvenirs, every three months in a year. At the same time, the second group of midwives received monetary benefits of 30,000 naira (equivalent to about 25 percent of their salary) every three months as bonuses for their work. Midwives in the third group were given both the monetary and non-monetary benefits, while the fourth group, which served as the control group, was given nothing and were unaware of the intervention. Midwives were monitored by the MCH staff for monthly attendance at their place of work, and anyone not found in attendance was disqualified from the benefits. Overall, both the monetary and non-monetary schemes were very effective in increasing the attendance of midwives at the primary health centers, with the monetary benefits having the most effect (20 percent reduction in midwife attrition).[13]

Lessons Learned

The SURE-P program's MCH component, as a large and ambitious initiative to improve maternal and child health, offers some potential lessons for similar undertakings in other developing countries.

Designing Multi-Purpose Social Welfare and Phase Testing (Piloting)

While researchers and policymakers have noted that fuel subsidies have huge costs for the economy, removing them can present a potential shock to household income and increased cost of living for the poor.[14] Thus, the SURE-P MHC component represents a classic example of how subsidy reduction in low-income countries can be accompanied with social welfare programs (e.g., cash transfers), to mitigate the impacts of subsidy removals. Designed as a multi-purpose government reform, the overall SURE-P program, made up of two components and 12 sub-components in total, was a multifaceted initiative that integrated a range of interventions addressing multiple social issues at the same time.

8 S.E, Findley, et al., 2016, p.1.
9 Ibid, p.6
10 E. Okeke et al., 2017, p.3.
11 C. Oduenyi, V. Ordu, and U. Okoli, 2019, p.3
12 World Bank- Development Impact Evaluation [DIME], 2015, p.3
13 Ibid, p.3
14 Siddig, K., Aguiar, A., Grethe, H., Minor, P., Walmsley, T., 2014, p.165

Particularly, using pilot schemes for important aspects of the MCH program — such as the primary health care facilities, the CCT programs, the midwives' retention strategy, and the VHW and CHEW programs — demonstrates how phase testing can be a cost-efficient way to preview the successful performance or otherwise of large government welfare programs. It is also a more effective approach to implementing social services in countries with large and heterogenous population like Nigeria. Importantly, the pilot phases provided the necessary information on how the MCH project could work when fully implemented and revealed the micro level challenges that needed to be addressed for the program to achieve its goals.

Aligning development objectives with global priorities

In terms of development aspirations for developing countries, this case suggests the importance of policymakers in developing countries aligning their policy priorities to specific SDG indicators. The SURE-P MCH addressed SDG 3: Ensure healthy lives and promote well-being for all at all ages (in particular indicators 1, 2, 3, 8) — a crucial policy priority in most low and middle-income countries. The Nigerian government was thus able to galvanize substantial international support for the MCH project, ranging from funding to technical support such as impact evaluation and project documentation from organisations such as the World Bank, the Bill and Melinda Gates Foundation, and research institutes at the University of Sussex and the University College London.[15]

15 See World Bank- Development Impact Evaluation [DIME], October 2016. This is not to say that some development challenges are more relevant than others, but rather that, due to the gravity and urgency of their impact, some development challenges (such as maternal mortality) tend to attract the attention of international partnerships. Policymakers in developing countries such as Nigeria may therefore be strategic in leveraging such partnerships for long-lasting solutions.

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