Promoting Accountability in Nigeria’s Health System

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A REPORT OF THE
CSIS GLOBAL HEALTH POLICY CENTER

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Executive Summary

The citizens of Nigeria, Africa’s most populous country, are sick. Each year, approximately 58,000 women die from complications due to pregnancy and childbirth, most of them from preventable causes.1 Almost a quarter of a million infants die during their first month of life.2 A majority of children in two of the country’s six regions are stunted due to inadequate diet and insufficient food.3 Nigeria has the largest burden of malaria and the second-largest number of people living with HIV in the world. It has largely failed to detect and treat tuberculosis or respond to a rising tide of noncommunicable diseases (NCDs). Furthermore, Nigeria’s leaders seem largely indifferent toward the health crisis surrounding them. Successive governments have failed to adequately fund the health system and have shown scant interest in the health needs of their citizens. If Nigeria is to attain its dream of becoming one of the world’s top 20 economies by 2020, it must urgently address the poor health of the population whose hard work will be needed to drive that growth.

Nigeria’s health system is lurching toward a moment of reckoning because the donors who have sustained it for decades are wavering in their commitment. Years of broken promises, poor performance, and discontinued initiatives by the host government have taken their toll. Now the donors are resetting the relationship. Their impatience reflects despondency over continued failure, domestic budget pressures, and political change—and recognition that Nigeria is a lower-middle-income country that should be capable of financing a greater share of its health needs. Critical sources of donor funding from the likes of the United States’ President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Alliance for Vaccines and Immunization (GAVI) are expected to sharply decline. The question is: Will this reality prompt Nigeria to get serious about funding its health system?

This moment of reckoning comes at an inopportune moment for Nigeria, which is facing its worst economic crisis in 25 years. It also coincides with the aftermath of a landmark moment in Nigeria’s democratic development: the country’s first successful political transition from one party to another. The administration of President Muhammadu Buhari was elected on a promise to break the cycle of corruption and poor governance that characterized previous governments. In some ways, the hardening stance of donors and the threats of cutbacks and conditions to development assistance are ill-timed, placing unnecessary pressure on an administration that is trying its best in testing circumstances. However, now is precisely the time for donors to impress upon the host government the need for meaningful changes to the health relationship. Besides, early optimism that the Buhari government would represent a clean break from its predecessors has faded with each political misstep. President Buhari may be a leader of personal integrity, but he is only one individual operating in the same,

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unreformed political system. Donors need to be as realistic as ever about the prospects of making—and sustaining—development gains.

These notes of caution are not the prelude to a call for development assistance to be scaled back from Nigeria. On the contrary, Nigeria is—and will remain—arguably the most important country in Africa and a critical partner for the United States in health and much else. Nigeria’s vast health needs are only likely to increase as the population swells and the country struggles to overcome insurgencies in the northeast and Niger Delta, as well as violence in the Middle Belt and chronic conflict between farmers and pastoralists. These disturbances leave health crises in their wake, most notably a food emergency and a resurgence of polio in the northeast. The potential spillover consequences for the rest of the continent must also be considered. If Nigeria sneezes, the rest of Africa catches a cold.

The United States and other donors face the unenviable task of maintaining a constructive relationship with a vitally important but unreliable development partner. To extract maximum impact from their engagement, they must be laser-focused on performance and look for ways to strengthen accountability at all levels of their programs. They must also be alert to the opportunities. The U.S. private sector, for example, has been slow to grasp the investment potential of Nigeria’s health sector. Nigeria is vast, complex, diverse, and full of innovative, highly skilled people. While broad-brush portraits present the country as a dysfunctional, self-destructive mess, there are pockets of excellence in the health system, as in all other sectors. After all, Nigeria is a country that acted quickly to contain a potentially catastrophic Ebola outbreak, has made significant progress on malaria, and is home to state governments that are managing to buck the national trend by providing good-quality maternal and child health (MCH) services. Donors should take the time to learn from these examples of success and work out how to scale them up. The United States simply has no option but to work in Nigeria, with Nigerians.

The United States can reset its health relationship with Nigeria by:

- Elevating its health diplomacy with the host government to a more senior, sustained level. The new administration in Washington can signal its desire for high-level dialogue by sending a senior State Department official to Nigeria at the earliest opportunity for talks on the bilateral relationship and the central role that health cooperation will play within it. Health discussions could include strategies to:
  - Increase domestic health financing, accompanied by costed, realistic plans;
  - Boost the role of the Nigerian and U.S. private sector in delivering quality, affordable health services;
  - Accelerate cooperation on health security and pandemic preparedness;
  - Plan a smooth PEPFAR transition so that Nigeria can withstand reductions in U.S. funding for HIV.
These discussions can be the prelude to a longer-term shift in U.S. health engagement with Nigeria that:

- Achieves better results from health programs by elevating accountability and providing incentives to partners to deliver desired outcomes;
- Expands its range of health partners at the national, state, and local level;
- Cultivates stronger relationships with the private sector, as well as lawmakers, civil society, the media, and the Nigerian diaspora;
- Places a sharper focus on improving health outcomes in the north.
Promoting Accountability in Nigeria’s Health System

Richard Downie

Introduction

When Muhammadu Buhari was sworn in as president of Nigeria in May 2015, he assumed the leadership of a nation that had changed a great deal since he previously held the office, from 1983–85. Nigeria had recently overtaken South Africa to become Africa’s largest economy, with a GDP of $510 billion in 2013.1 Benefiting from its position as one of Africa’s leading oil producers and capitalizing on a boom in the banking, telecoms, construction, and retail sectors, Nigeria symbolized the new mood of optimism about Africa in the West. Nigeria’s population had also ballooned in size, surging from 80 million in 1983 to more than 180 million today.

President Buhari’s personal journey appeared to reflect the changes around him. His previous tenure as head of state had been at the helm of a military government that seized power in a coup d’état. Now he took office as a self-proclaimed “converted democrat,”2 dropping the title of major general to represent his changed circumstances. Furthermore, the civilian government he led emerged from Nigeria’s most successful election of the democratic era. Dire warnings that violence, rigging, and unrest would mar the polls proved overly pessimistic. Instead, the elections of March 2015 were a landmark moment in Nigeria’s democratic development that saw a peaceful transfer of power from one party to another for the first time in its history.

While much had changed in Nigeria since President Buhari’s first administration, much remained the same. The new president had the misfortune to inherit an economic crisis that paralleled his experience in 1983, and that ultimately hastened his downfall. A slump in the global oil price triggered a slowdown in an economy that derives 95 percent of its export revenue from crude. The downturn was accelerated by falling production in the Niger Delta due to pipeline sabotage by armed groups. The situation was compounded by policy missteps from an administration that was slow to assemble its economic team and made futile efforts to buttress a weakening currency before accepting the inevitable and allowing the naira to float—or sink—to its natural level. By 2016, Nigeria’s economy was confirmed to be in recession for the first time in a quarter of a century. At the subnational level, the economic situation was even bleaker. The governors of Nigeria’s 36 states had been on a spending spree during the boom years and, as the hard times hit, were unable to meet their

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obligations or even pay their public-sector workers. In one of his first actions in office, President Buhari agreed to a financial bailout for 27 state governments, ending the immediate crisis but setting a bad precedent for fiscal stewardship in the future.

These and other governance shortcomings would have been depressingly familiar to President Buhari. Nigeria’s system of “big man” politics—favoring informal patronage networks over institutions—has endured. Politics offers plentiful money-making opportunities that attract unscrupulous actors over committed public servants. While President Buhari belongs in the latter category and is known for his personal probity and ascetic lifestyle, he inherited the same corrupt governance networks. Furthermore, as the head of a broad political coalition, the president was forced to accommodate the ambitions of those whose money and influence had helped him win the election. These political realities meant that the shine quickly came off an administration that was drawn from a party whose campaign emblem—a broom—had promised a new era of clean government. In October 2016, President Buhari’s wife Aisha made the startling admission that the president “does not know” many of the members of the government he had appointed.3

Other enduring problems have made the task of governing Nigeria uniquely challenging. The religious, ethnic, and regional cleavages that were Nigeria’s colonial inheritance and that carried over into the independence era remain as strong as ever today. Most alarming of all, President Buhari took power in the middle of a full-blown insurgency in the northeast, where Boko Haram, a terrorist group motivated by hatred of the government, incensed by the marginalization of their region, and fueled by a singular interpretation of Islam, had seized control of large chunks of territory from a demoralized military.

This is the nation President Buhari inherited in May 2015. Understanding this broad context helps explain why the challenge of funding and delivering quality health services has been insurmountable.

Nigeria Is Sick

Nigeria’s dismal health landscape and the shortcomings of its health services are well-documented and do not require lengthy explanation.4 It is indicative of the low esteem in which the country’s health system is held that soon after taking office, President Buhari flew to the United Kingdom for treatment of an ear infection rather than seek care at home.5 Nigeria’s own health policy makes no attempt to airbrush the failures of a health system that it describes as “weak,” “underperforming,” and “largely unresponsive” to the needs of patients.

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Health services, it adds, are inefficient, unaffordable to the poor, and available in limited quantity. The result is a system that is held in “low confidence” by consumers.⁶

Nigeria has several advantages compared with many of its neighbors. The World Bank classifies it as a lower-middle income country, it has a large cohort of health workers, and has a well-qualified and engaged diaspora of medical professionals. Yet Nigeria’s health indicators show that despite positive movement in some areas, health outcomes remain poor.

In the positive column, under-five mortality and infant mortality are declining, although 240,000 infants still die within 28 days of birth from preventable causes.⁷ Nigeria has made significant progress in reducing malaria, according to the most recent Malaria Indicator Survey. Among children aged between 6 and 59 months, malaria prevalence reduced from 42 percent in 2010 to 27 percent in 2015.⁸ HIV prevalence went down from 4.1 percent in 2010 to 3 percent today, although Nigeria still accounts for 9 percent of the global HIV burden and discriminatory laws against key populations such as men who have sex with men have hampered progress.⁹ Nigeria has eradicated guinea worm and responded effectively to a potentially catastrophic outbreak of the Ebola virus in 2014.

In other areas, however, progress on health has plateaued or even reversed. An alarmingly high number of women die during or soon after giving birth. The maternal mortality ratio (MMR) of 576 deaths per 100,000 live births, recorded in the 2013 Nigeria Demographic and Health Survey, was even worse than the MMR of 545 in the 2008 survey.¹⁰ The fertility rate remains high, and only 20 percent of women have access to a modern method of contraception.¹¹ Nigeria’s nutrition status has also worsened. Although stunting is slightly down, successive demographic and health surveys show that the percentage of children who are either wasted or have low weight for their age has increased. These statistics are only likely to worsen as the hunger crisis in the northeast caused by Boko Haram continues to unfold. The insurgency has also undone progress toward polio eradication. The World Health Organization (WHO) announced in August 2016 that the disease had paralyzed two children in Borno State, the epicenter of Boko Haram’s attacks. It was the first confirmed outbreak of polio in Nigeria for nearly three years. Nigeria has failed to get to grips with TB. A 2012 national TB prevalence survey found that the disease burden was significantly greater than previously estimated.¹² The WHO estimates that Nigeria’s TB prevalence rate is 322 per

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¹² TB prevalence was two times the previous estimate while incidence was three times the previous estimate.
100,000.\textsuperscript{13} Finding new cases and treating patients successfully, particularly for multidrug-resistant TB, are both serious problems. Finally, Nigeria is only beginning to wake up to the challenge of NCDs and lacks the tools to mount an effective response.

One of the difficulties of analyzing Nigeria is that there are huge regional variations and inequities across the 36 states and the Federal Capital Territory (FCT), where the capital, Abuja, is located. For example, the MMR ranges from 165 in the southwest geopolitical zone to 1,549 in the northeast zone.\textsuperscript{14} Poverty, cultural and social mores, government neglect, and poor education account for the desperately poor health profiles of the three geopolitical zones located in the north of Nigeria.

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<tr>
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<th>Northeast</th>
<th>Northwest</th>
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<th>South-South</th>
<th>Southwest</th>
<th>Southeast</th>
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<tbody>
<tr>
<td>Under-5 Mortality Rate (per 1,000 live births)</td>
<td>160</td>
<td>185</td>
<td>100</td>
<td>91</td>
<td>90</td>
<td>131</td>
</tr>
<tr>
<td>Stunting (low height for age) %</td>
<td>42.3</td>
<td>54.8</td>
<td>29.3</td>
<td>18.3</td>
<td>22.2</td>
<td>16.0</td>
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<tr>
<td>Total Fertility Rate (births per woman)</td>
<td>6.3</td>
<td>6.7</td>
<td>5.3</td>
<td>4.3</td>
<td>4.6</td>
<td>4.7</td>
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<tr>
<td>DPT3 (diphtheria, pertussis, tetanus) Vaccination Coverage, %</td>
<td>20.6</td>
<td>13.9</td>
<td>43.9</td>
<td>69.8</td>
<td>65.5</td>
<td>80.7</td>
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<tr>
<td>Skilled Birth Attendance, %</td>
<td>19.9</td>
<td>12.3</td>
<td>46.5</td>
<td>55.4</td>
<td>82.5</td>
<td>82.2</td>
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There are also significant differences in the quality and accessibility of healthcare in rural and urban areas, with markedly better services available in and around Nigeria’s towns and cities, where resources and healthcare workers tend to cluster.


\textsuperscript{14} Figures for 2015 from the National Bureau of Statistics, presented at meeting of Northern Nigerian Governors’ Forum, United States Institute of Peace, October 18, 2016.
Nigeria’s Anemic Health Budget

One of the most important reasons for Nigeria’s poor health performance is that there simply is not enough money in a health system responsible for meeting the needs of almost 200 million people. Health is not a top funding priority and successive governments have been content to cede responsibility for their people’s wellbeing to others—the private sector, foreign donors, and citizens themselves. The result of this neglect is a system where poor people avoid accessing health services until their lives are in danger. Out-of-pocket expenditure accounts for at least 70 percent of health spending in Nigeria, according to government estimates. Weak domestic health financing also means that the health system is dangerously dependent upon external assistance and liable to collapse if that support is significantly reduced, a once distant prospect that is now becoming a reality.

Health provision in Nigeria is a concurrent responsibility shared between the three tiers of government: federal, state, and local government areas (LGAs). The financial picture is gloomy at all three levels.

At the federal level, the Buhari administration has not placed health at the top of its political agenda and the Federal Ministry of Health (FMoH) struggles to compete for funding with other, more powerful ministries. Despite the dire economic situation in Nigeria, the overall federal budget for 2016 was the largest in the nation’s history, totaling 6.06 trillion naira, or $30 billion. However, the health budget declined on the previous year; at N257 billion, it represented only 4.13 percent of the overall budget. By comparison, infrastructure was allocated 7.7 percent of the budget and defense 7.07 percent. Nigeria is nowhere near achieving the Abuja Declaration, signed in its capital city in 2001, when it pledged to commit 15 percent of its budget to health; instead, the 2016 percentage was the lowest since 2010. Nigeria’s financial commitment to health compares unfavorably with other African countries when its relative wealth is taken into account. Its health budget per capita in 2014 was $118, only slightly above the average for sub-Saharan Africa of $98; South Africa’s was $570.

Closer examination of Nigeria’s health budget reveals that the vast proportion of the funding—86 percent—is eaten up by recurrent expenditure, mostly paying the salaries of health workers. The low level of capital expenditure raises questions about the feasibility of some of the FMoH’s flagship projects, in particular the Primary Health Care (PHC) Revitalization project, which seeks to rebuild or restore 10,000 primary health centers so that each political ward in the country has a functioning health facility. Currently, 60 percent of capital expenditure is spent on the federal ministry itself. It should also be noted that there is

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16 Using a naira-to-dollar conversion rate from the time the budget was proposed, in December 2015. The value of the naira has significantly declined since then.
18 At the time of publication, President Buhari had just submitted Nigeria’s 2017 budget. Under the proposal, which was awaiting consideration by the National Assembly, health was due to receive N304 billion, just under 6 percent of the overall budget.
19 Onigbinde, “Nigeria’s Health Budget: A Case for Improved Financing and Accountability.”
a big disparity between the amount approved in the health budget and what is actually spent. Between 2013 and 2015, an average of only 41 percent of the capital budget allocation for health was utilized.20

The FMoH has made PHC a priority and the National Health Act, passed in 2014, contains legislative efforts to channel more funding to this most neglected part of the health system. Under the act, not less than 1 percent of government revenue must be set aside for a Basic Health Care Provision Fund (BHCPF). The act defines exactly how the fund is to be apportioned: half must be used to provide a basic minimum package of health services to citizens through the National Health Insurance Scheme (NHIS); 45 percent must go toward PHC, equipment, facilities, and human resources, managed by the National Primary Health Care Development Agency (NPHCDA); and the remaining 5 percent must be spent on emergency medical treatment. To date, none of these provisions have been enacted. The BHCPF was not included in either the 2015 or 2016 budgets. A campaign by civil society groups to secure funding for the BHCPF in the 2017 federal budget was also unsuccessful.21

The federal government is not the only tier of government failing to live up to its commitments on health. Even though the subnational levels of government receive almost half of the federal revenue in direct grants, most of Nigeria’s 36 states are indebted due to decades of profligacy, poor governance, and corruption. States are supposed to generate their own revenue through taxes and other sources of income, but most are almost entirely dependent on federal handouts. When the federal allocation sharply declined in 2015 due to declining oil receipts, most of the states quickly fell into crisis. State employees, including health workers, went for months without pay and a wave of strikes crippled public service delivery. President Buhari responded by setting up a bailout program to rescue 27 states. The sum of money handed over—N324 billion—was substantially larger than the national health budget.22 The bailout addressed the immediate crisis but only perpetuated the cycle of dependence and poor governance at state level. One of the biggest problems is that too much power is vested in the state governors, who lack accountability, provide few details about budget expenditure, and wasted vast sums of money on vanity projects when oil prices were high rather than saving funds for a rainy day. In September 2016, it emerged that scores of former governors had saddled their states with unsustainable levels of debt by arranging hefty annual allowances and extravagant pension plans when they left office.23

Financial incapacity at the state level has a knock-on effect on Nigeria’s 774 LGAs, an important level of government responsible for providing PHC and other local services. LGAs

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21 The 2017 federal budget, released shortly before publication of this report, made no mention of the BHCPF. During public remarks in January, President Buhari was vague on the status of the BHCPF, saying that it was “in the process of being operationalized.” See speech by President Buhari on “PHC Revitalization Program,” official Medium Channel of the Federal Ministry of Health, January 11, 2017, https://medium.com/@Fmohnigeria/speech-by-president-buhari-on-phc-revitalisation-program-7e69ce7a0587#nsrx0kss1.
have been starved of funds by governors and in many cases have become entirely nonfunctional. LGAs are supposed to have elected representatives, but many governors have bypassed this level of government altogether by either installing favorites or failing to hold elections at all.

Faced with these challenges, the goal of the FMoH to achieve universal health coverage is ambitious, to say the least. There is general consensus that some form of health insurance offers the best prospect of achieving sustainable financing in Nigeria but progress so far has been limited. The NHIS began operating in 2005 but the program has been dogged by allegations of mismanagement and corruption. The most damming indictment came from the newly appointed head of the scheme, who admitted in September 2016 that “the NHIS has been sleeping on duty”—that it is “corrupt, inefficient, lacks vision,” and is “not responsible and accountable to enrollees.” Unsurprisingly, the scheme has struggled to attract members and currently covers only 4 percent of the population, mostly federal workers.

Perhaps the biggest design fault of the NHIS is that it is voluntary and does not mandate states to establish similar schemes. While some states such as Lagos and Cross River have set up their own health insurance programs or are in the process of doing so, most are wary of the upfront costs involved. Another challenge is to provide coverage options for the majority of the Nigerian labor force that works in the informal sector. Some states are trying to establish community-based health insurance schemes to cater to this population, but there are doubts over their long-term sustainability. One of the most promising models has been set up by Kwara State, with support from the Dutch Health Insurance Fund, which provides basic health care coverage to members who pay a nominal premium of N500.

Poor Use of Resources

While there is no doubt that Nigeria’s health system could be better resourced, the considerable amount of money that is already in the system is not utilized effectively. Compared with other African countries, Nigeria is not short of health workers and health facilities. However, health resources are poorly allocated, with the southwest, urban areas, and the tertiary hospital system receiving most support while large parts of the system get little or nothing. The failure of resources to permeate the lowest reaches of the health service has upended the pyramid structure that defines a properly functioning health system, where patients enter at the primary level and more serious cases are referred up. Instead, patients have lost faith in the PHC system and clog tertiary hospitals with easily treatable conditions, wasting the time of consultants. Poor governance at all levels of the health system weakens the impact of health interventions and is a decisive factor in explaining Nigeria’s poor health outcomes.

25 Nigeria had 65,759 doctors and 249,566 nurses and midwives, according to 2013 figures from a National Resources for Health profile, cited in “National Health Policy 2016: Promoting the Health of Nigerians to Accelerate Socio-economic Development,” 12.
Lack of funding does not adequately explain why only 20 percent of Nigeria’s 30,000 PHC facilities are operational.\(^{26}\) That such a situation was allowed to develop suggests that neglect, lack of accountability, and disregard for the dignity of patients have penetrated the system from top to bottom. A senior medical professional from Kebbi State in the northwest described visiting a maternity ward where termites had eaten away the roof to such an extent that part of the ceiling fell onto a woman as she gave birth.\(^{27}\) Photographs from the mid-term evaluation of a $90 million U.S.-funded project to improve PHC in Sokoto and Bauchi states showed dirty wards, hospital beds without mattresses, health facilities without toilets, and nurses sitting on chairs while their patients were forced to stand.\(^{28}\) Intermittent power supply forces midwives to deliver babies by the lights of their cellphones at night. Mothers die from eclampsia because hospital pharmacy attendants have sold off supplies of the magnesium sulfate that would have saved their lives. Women wait all day in health centers for a straightforward antenatal appointment, and patients with malaria are forced to make multiple visits, often traveling great distances at personal cost, to get diagnosed and treated. In the tertiary system, only seven radiotherapy machines exist throughout the country to treat cancer, but not a single one was operational at the time of writing.\(^{29}\) Broken supply chains and lack of cold storage frustrate efforts to fill gaps in routine immunization (RI) coverage in the northwest and northeast, meaning that each year, 3 million children fail to receive their full course of vaccines. All of these examples, referenced by Nigerian health officials and medical staff in multiple interviews, are symptoms of system failures as much as scarce resources.

Poor governance and a lack of accountability are common factors in this catalog of failures. Nigeria’s health service produces plenty of plans and strategies, many of them very good, but few are adequately executed. One of the main challenges is to incentivize a bloated and unmotivated civil service that often works at cross purposes to the minister or ignores official directives altogether. The tendency of incoming governments to perform “policy somersaults,” jettisoning previous strategies irrespective of their effectiveness, means that institutional knowledge is not carried over from one administration to the next.

One of the biggest challenges is operationalizing policy across Nigeria’s fragmented and multilayered system of government. In theory, the federal government is responsible for setting policy, enforcing standards, and running the tertiary health system and teaching hospitals. The states are responsible for secondary health provision and technical support to the LGAs, which are responsible for the PHC system. In reality, mandates overlap and there is constant confusion over roles and responsibilities. When the three levels of government are required to work together, progress stalls. For example, the Midwife Service Scheme, a federal program to deploy 2,500 midwives for a year of service in underserved rural communities, has underperformed because it requires the federal government and states to split the cost of salaries and the LGAs to provide accommodation for the midwives. Salaries

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\(^{26}\) Figures taken from speech by Professor Isaac Adewole, Northwestern University, October 6, 2016.

\(^{27}\) Interview with senior health official, Abuja, September 21, 2016.


have gone unpaid and midwives have abandoned their posts after being placed in substandard dormitories.

Weak accountability mechanisms and procurement processes open the door to the corruption and waste that infect all levels of the health system. Poor or insufficient training, inadequate monitoring, and a lack of clearly defined professional standards mean that health workers underperform or in some cases fail to show up for work. A Service Delivery Indicators Survey from 2013 found a diagnostic accuracy rate of only 36 percent among health professionals observed. Only 31 percent of health workers followed clinical guidelines and just 17 percent correctly managed maternal and neonatal complications.30

The government’s failure to establish clear responsibilities and pay grades for health professionals has created inter-professional rivalries within the health workforce that have triggered frequent bouts of industrial action. The failure to pay salaries on time, if at all, has compounded the situation. A health systems specialist in Lagos gave the example of two doctors with the same level of experience and seniority who were paid different salaries because one was employed by the federally run Lagos University Teaching Hospital while the other was on the payroll of Lagos State University Hospital.31 A doctor from Plateau State illustrated how weak accountability mechanisms had a snowball effect throughout the health system. He gave the example of a consultant who ran a private practice during the day, neglecting his duties at the federally run teaching hospital. Health staff on lower pay grades were forced to fill in, and then clamored for promotions because they were taking on the consultant’s responsibilities. The government agreed but then found it had too many consultants and was not able to pay their salaries. Staff went unpaid and began strike action.32 The medical profession in Nigeria is very hierarchical and strongly unionized, and there is resistance to the kinds of task-shifting initiatives that have enabled health resources to be optimized in other parts of Africa.

Trends in Health Governance and Donor Engagement

The United States has supported Nigeria’s health sector for many years and is conscious of the many challenges that limit its chances of success, yet it has persevered because the health needs of the population are so great. The lead agencies engaged in the effort are the U.S. Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC), with support from the Department of Defense Walter Reed Program. Reproductive Maternal Newborn and Child Health (RMNCH) programs have been a big priority of the mission and include efforts—led by USAID—to reduce maternal mortality, increase uptake of family planning services, improve newborn care, and boost immunization coverage. U.S. RMNCH programs operate in all 36 states with a particular focus on Bauchi, Ebonyi, Cross River, Kogi, and Sokoto. Nigeria is also a beneficiary of the major U.S. presidential global health initiatives. It is the single-largest country recipient of funds from the

31 Interview with health systems specialist, Lagos University Teaching Hospital, Lagos, September 23, 2016.
32 Interview with associate professor of obstetrics and gynecology, University of Jos, September 13, 2016.
President’s Malaria Initiative (PMI), having received $419 million between FY 2010 and FY 2016. PMI operates in 11 states across the country, spanning all six regions.

PEPFAR has a similarly large footprint in Nigeria, having invested $4.2 billion since 2004. The program provides antiretroviral (ARV) drugs to 600,000 people in 860 treatment centers, operating in every state except for Abia and Taraba, where Nigeria’s National Agency for the Control of AIDS (NACA) runs ARV programs. PEPFAR’s global pivot toward focusing resources on the most high-burden locations and most at-risk populations has prompted a change of approach in Nigeria. PEPFAR is concentrating efforts on 32 LGAs with the highest HIV burden and prevalence with the objective of achieving epidemic control in 12 of these areas by the end of 2018. PEPFAR’s Nigeria programs have saved and prolonged many lives, but U.S. investments have not been matched by a significant commitment from the host government and there are major question marks over their sustainability. A spending assessment report from 2014 found that the Nigerian government contributed only 27 percent of overall expenditure on the HIV response, with 64 percent coming from PEPFAR. The Nigerian government has said it is committed to implementing the WHO “test and start” guidelines that all newly diagnosed HIV patients begin immediate ARV treatment regardless of the strength of their immune system. So far, the extent of this commitment has been to invite PEPFAR to pilot-test and start in its scale-up LGAs rather than providing significant additional resources of its own.

The arrival of a new federal government in Abuja in May 2015 offered a fresh start for the U.S.-Nigeria health relationship and for a broader bilateral relationship that sharply deteriorated in the closing months of the Goodluck Jonathan administration as corruption scandals piled up and the insurgency in the northeast spiraled out of control. President Buhari won plaudits for his pledge to crack down on graft and defeat Boko Haram, enjoying an extended honeymoon period during his early months in office as domestic and international well-wishers waited to see whether he could fulfil his promises. It was not until early 2016, as the economy nosedived, a catastrophic humanitarian disaster emerged in the northeast, and the president prevaricated in the face of his many challenges, that patience with the new administration began to wear thin.

In the health sector, the United States has established cordial relations with the minister of health, Isaac Adewole, who is well-respected and has laid out a coherent reform agenda. However, U.S. officials are clear-eyed about his ability to drive and sustain reform. There have been several capable health ministers over the years whose reforms have ultimately fallen away because of the wider political and organizational system failures outlined above.

33 U.S. President’s Malaria Initiative, “Fact Sheet: Nigeria” (information provided by U.S. Embassy Abuja).
34 President’s Emergency Plan for AIDS Relief (PEPFAR), “Fact Sheet: Nigeria” (information provided by U.S. Embassy Abuja).
36 Ibid., 7.
Donors will be looking closely for signs that Minister Adewole can deliver on some of his priorities, such as securing a budget for the BHCPF.

In their day-to-day engagement with the Nigerian government, donors struggle to coordinate their activities with multiple ministries and agencies, identify the real sources of authority in a system defined by powerful informal networks, and bypass those who are opposed to change. Officials at the U.S. embassy illustrated the coordination challenges by bemoaning the glacial progress in implementing the Global Health Security Agenda that aims to improve preparedness to deal with pandemics and other health emergencies.38

The legacy of previous failures has shaped donor expectations of what is possible in their health engagement with Nigeria and what must be avoided.

- There is a suspicion of new strategies that are not accompanied by detailed implementation plans. As a senior U.S. health official put it, “Most of the donors have formed a ‘no more plans’ chorus.”39

- There is a strong desire for Nigeria to get serious about increasing domestic financing for health, irrespective of the tough economic conditions nationwide. Donor fatigue is palpable following the Nigerian government’s persistent failure to live up to funding commitments on health. This includes broken promises made in the five-year Partnership Framework signed with PEPFAR in 2010, in which Nigeria agreed to take on 50 percent of HIV funding by 2015 but has struggled to surpass 25 percent.40 It extends to pledges made at the 2011 London Summit on Family Planning to provide an additional $34 million for the procurement of contraceptives, on top of existing commitments. Nigeria is so far away from meeting this target that, according to a group of health NGOs, the family planning budget in 2017 faces a shortfall of $111 million.41 Remarking on this failure, the head of one the largest U.S. health programs in Nigeria said: “I find it hard to understand how a government with an annual budget of 6 trillion naira cannot afford to fund this completely.”42

The demand for greater host-government ownership has assumed even greater urgency in light of the contracting donor funding outlook. The PEPFAR budget, for example, is expected to decline from $503 million in FY 2016 to $409 million in FY 2017.43 Also, GAVI will enter an accelerated transition process with Nigeria in 2017 to reflect the fact that it is a lower-middle-income country that should be able to assume more responsibility for its RI program. As a result, Nigeria will face an

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38 Meeting with senior officials from USAID, CDC, PEPFAR, and other agencies, U.S. Embassy Abuja, September 19, 2016.
42 Interview with country director of leading U.S. NGO implementing health programs in Nigeria, Abuja, September 20, 2016.
'immediate gap of $181 million for vaccine procurement in 2017. Political transitions in the United States and the United Kingdom have fueled uncertainty over both nations’ commitment to development funding. In short, the moment of reckoning is approaching for Nigeria to show that it is seriously committed to funding its health needs. Efforts to establish an effective NHIS and similar schemes at the state level will take many years to achieve, even with sustained political will. Other financial options that are more achievable in the near term, such as introducing sin taxes on alcohol and tobacco, will realize only modest returns. Tapping into sources of private capital such as the Nigerian sovereign wealth investment facility, and broadening engagement with the private sector through organizations such as the Private Sector Health Alliance of Nigeria, are potentially promising options that have yet to be explored in detail.

- Donors are weary of corruption and determined to be more aggressive than ever in demanding accountability from the host government. The theft of $3.8 million of grants from the Global Fund to Fight AIDS, Tuberculosis, and Malaria to NACA caused funds to be frozen in May 2016. The scandal came on the heels of an audit into the misuse of GAVI funds that ended with the Nigerian government agreeing to repay $2.2 million. The Global Fund scandal was seen as the final straw by some donors, who considered pulling out of Nigeria altogether. As a minimum step, they demanded the removal of the chief executive officers of the health parastatal agencies they held responsible. President Buhari responded by firing five agency heads in July 2016.

- Finally, there is a strong desire to explore new modes of engagement, test new ways to improve outcomes, diversify partners, and expand programming at the subnational level, where the vast majority of health services are delivered. Donors are concerned that their considerable health investments in Nigeria have produced suboptimal outcomes. For example, the USAID Targeted States High Impact Project spent $90 million between 2009 and 2015 trying to integrate PHC services in Bauchi and Sokoto states yet had a negligible impact on health indicators. Its final evaluation noted, for example, that “Routine Immunization remains stubbornly mired at unacceptably low levels,” and expressed doubts about the commitment of state governments to sustain improvements in the future. These kinds of disappointing program outcomes are forcing the United States and other donors to explore other approaches that incentivize better performance.

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46 U.S. officials said they conducted intense outreach with other donors to persuade them to stay in Nigeria. Discussions with staff at U.S. Embassy Abuja, September 19, 2016.
A Tale of Two States: Ondo and Borno

The diversity of Nigeria’s health landscape and the contrasting capabilities of state governments produce very different health outcomes at the subregional level. A glance at two states in different corners of the country—Ondo in the southwest and Borno in the northeast—illustrates this diversity. Ondo State has established a functional, efficient, health system that is responsive to the needs of its population. Meanwhile, Borno State faces a near-term challenge of providing healthcare amid insecurity and mass displacement combined with the enduring challenge of improving health outcomes in one of the poorest, most underserved populations in the country. The fortunes of these two states suggest that good results are possible when the right ingredients are in place—capable health leadership, sustained financial commitment, accountability, and performance incentives. The case of Borno State demonstrates the existence of areas of dire need in Nigeria that rival the worst conditions to be found anywhere in Africa—conditions that require sustained assistance from the Nigerian government and international partners.

Ondo State

Ondo State, located in the southwest of Nigeria, is home to approximately 3.5 million people, predominantly from the Yoruba ethnic group. It has the sixth-largest GDP of the 36 states, sustained by agriculture, oil, and natural gas. Ondo State has been governed since 2009 by Olusegun Mimiko, a medical doctor by training who has taken a personal interest in improving health services, to the extent that he attends quarterly meetings to discuss health data. State officials are convinced of the links between good health and a productive economy and have made a strong investment case for health. According to the state commissioner for health, Dr. Dayo Adeyanju, “We made a deliberate attempt to focus on maternal and child health and road accidents because they are leading causes of avoidable death [in Ondo State] that hit young, productive people to a disproportionate degree.”

Approximately 85 percent of health financing in Ondo State comes from the state government, which commits 12 percent of the state budget to health, compared with 2 percent under the previous administration. The funds have been used to assist the most vulnerable citizens; for example, outpatient visits are free of charge for the under-18s, and women receive free maternity care. The budget has also been used to reconstruct an ailing PHC system, rehabilitating clinics in each of the 18 LGAs to encourage patients to enter at the right level instead of heading directly to tertiary facilities.

Investments have also been made higher up the Ondo State health system. Two mother and child referral hospitals handle critical maternal and neonatal emergency cases. A fleet of ambulances has been stationed near accident blackspots, coordinated by an emergency call center, so that victims of traffic accidents can be stabilized on site and promptly transferred to a newly established trauma hospital. The state has a sophisticated diagnostic center, a

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48 Material from this section is drawn from site visits and interviews conducted in Ondo State from September 21–22, 2016, and Maiduguri, Borno State, from August 3–5 and September 25–26, 2016.
49 Governor Mimiko completed his second, and final, term in office in February 2017.
50 Phone interview, August 30, 2016.
kidney center, and other specialized facilities located in a ‘Medical Village’ in Ondo town. The ambition is to attract medical tourism from outside the state, encouraging private patients to use these facilities and bring money into the health system. The supporting infrastructure of the health system appears to be in place. A well-maintained cold storage unit, located in the state capital, Akure, has plentiful stocks of vaccines and drugs. A fleet of 20 Toyota Hilux pickup trucks distributes the medicines statewide.

The flagship effort of Ondo State’s health leadership has been to improve health outcomes for mothers and young children.51 When the current administration took office, the MMR was 775 deaths per 100,000, the highest in the southwest. An inquiry into maternal mortality in the state discovered that the leading cause of death was from mothers who shunned public health facilities, choosing instead to rely on the services of traditional birth attendants (TBAs). When complications occurred during labor, TBAs lacked the skills to respond appropriately. In the worst cases, by the time mothers arrived at a health facility, it was too late to save their lives.

As a result of these findings, the government has set up two programs, known by their Yoruba titles Abiye (Safe Motherhood) and Agbebiye (Safe Birth Attendant), to track down pregnant women in the community and link them up with health rangers, a type of community health extension worker who follows their progress, ensures they attend antenatal appointments, and—most importantly—makes sure they attend a health facility to give birth. TBAs are encouraged to buy into the new approach with the offer of incentives and training. For an interim period, TBAs are given a small cash reward for every mother they accompany to the health center to give birth. Over time, they are offered microfinance loans and training in artisanal skills as a path toward alternative livelihoods.

Health data suggests Ondo State is on the right track. With an MMR of 317 at the time of the last 2013 National Demographic and Health Survey, mothers have better life chances during and after delivery than any other state in the southwest. This outcome may be linked to the fact that more than 94 percent of mothers give birth at a health facility, compared with a national average of 38 percent.52 The referral system is now working more effectively. According to Dr. Adeyanju, "We save money by catching people early, not when they come in late with complications."53 About 80 percent of births take place at the PHC level, while at the tertiary level, the Mother and Child Referral Hospital in Akure delivered 6,000 babies in 2015–16, down from 7,600 two years previously.

Ondo State’s efforts to build incentives into its health system have attracted the interest of the World Bank. Health centers in Ondo State were among 964 selected across three states to receive support under a World Bank performance-based financing program, the Nigeria State Health Investment Project (NSHIP). Under the program, health centers are given more autonomy to manage their finances and offered bonuses for delivering more services—such

52 Interview with Dr. Dayo Adeyanju, Akure, Ondo State, September 21, 2016.
53 Interview with Dr. Dayo Adeyanju, Akure, Ondo State, September 22, 2016.
as delivering babies and administering vaccines—that can be used to reward medical staff, purchase medical supplies, and make facility improvements.

Ondo State does not have a perfect health system. Question marks remain over the sustainability of the improvements, particularly with the passing of the current administration and the election of a new one in late 2016. The financial position of Ondo State is shaky and health workers went five months without pay in early 2016, leading to strike action and locked doors at the State Specialists’ Hospital in Ondo town. Nevertheless, the experience of Ondo State demonstrates that significant progress on health is possible if resources are deployed, leaders are engaged, plans are executed, health workers are motivated to do well, and the community is consulted. Dr. Adeyanju ascribes progress to a shift toward a more outcomes-driven approach that is measured over time. His message for the United States and other donors is to demand accountability from their Nigerian partners: “Before funds are released, recipients need to lay out clearly what they will do with it, how they will perform. You can’t just pump money in and hope everything works out.”

Borno State

Borno State has become synonymous with Boko Haram, the Islamist sect that originated in the state capital, Maiduguri, at the turn of the century. Launching an insurgency in 2009, it went on to devastate Borno and neighboring states in the northeast and morphed into a regional threat affecting parts of Niger, Chad, and Cameroon. However, its epicenter was in Borno State and at the height of the insurgency in 2014, Boko Haram occupied 21 of the state’s 27 LGAs. Today its power is diminished, but the group remains a serious threat and continues to launch lethal attacks, including suicide bombings in Maiduguri. The human consequences of its predations—in terms of lives lost, homes and livelihoods destroyed, people displaced, women and girls sexually abused, and boys forcibly recruited as child soldiers—are still emerging, as areas previously occupied by the group open up. An acute food crisis has developed because insecurity prevented people from farming for three consecutive years in the worst-hit areas. Civilians in LGAs held by Boko Haram have suffered enormously as a result of the Nigerian military’s strategy of choking off access in an effort to starve out the fighters. Food insecurity is so severe that famine conditions may be occurring in some parts of the state.

Responding to the health catastrophe that Boko Haram unleashed is beyond the means of an incapacitated state government and a federal government that has been focused on military rather than humanitarian operations. Accusations that food rations have been diverted and sold by corrupt officials from the national and state emergency management authorities have

55 Phone interview, August 30, 2016.
prompted angry demonstrations by internally displaced people (IDPs). International relief organizations have also been slow to respond to the food crisis, hampered by the unsafe conditions, the scarcity of capable local partners, and the difficulties of attracting donations to a humanitarian response plan that by the end of 2016 was only 52 percent funded. The country director of a leading UN agency said Nigeria’s northeast was a far more difficult operating environment than his previous post, Afghanistan: “We were well-established there and the security situation was very well managed. Here, there’s no system.”

On top of resource constraints, there are immense logistical challenges to organizing the response to a food emergency that is affecting an estimated 3 million people. Approximately 1.5 million people have been displaced by the conflict, with two-thirds of them living in squalid conditions in Maiduguri. Around one-tenth of the displaced are in formal camps, some of which are administered by the Nigerian government and supported by international relief agencies. Maiduguri alone contains 17 such camps. Inhabitants of the camps receive meals and basic healthcare, although there have been problems with delivering even these services. There have been multiple reports that women have been abused by soldiers from the Nigerian military, which controls access to the camps, and who have been accused of trading food for sex.

A visit to one of the largest camps, Bakasi, revealed three small clinics, each run by different humanitarian agencies, serving the PHC needs of approximately 16,500 people. None of the clinics had running water or functioning toilets. An average of seven women per week gave birth in these conditions. The coordinator of the UNICEF-operated clinic explained that her team saw roughly 100 patients with malaria each day but received only 120 doses of artemisinin combination therapy (ACT), the standard treatment for the disease, each week.

Conditions are worse for the approximately 90 percent of IDPs who do not reside in the camps and live instead in host communities, informal settlements that receive no sustained support whatsoever. During a visit to one of the settlements, Abba Ganaram, in August, a community leader explained that three people had died of starvation in the previous two days. Just 10 toilets and two boreholes serviced the needs of 3,000 people. Frequent downpours turned the settlement into a muddy swamp and the flimsy one-room shelters—some of which housed up to 10 family members—provided little protection from the elements. The risk of waterborne disease was obvious.

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59 Interview with head of operations for leading UN agency, Maiduguri, August 4, 2016.
The immediate food insecurity crisis in Borno State cannot be separated from the underlying, longer-term challenge of addressing poor health in Borno State. Malnutrition rates were high even before the insurgency broke out, and, as a clinic coordinator in Bakasi camp explained, poor nutrition is an underlying factor in virtually every sick patient she sees.\(^{62}\) Children with malaria, measles, or diarrhea are much less likely to survive when they are also malnourished. There is an urgent need for improved nutrition screening and surveillance in Borno State that extends beyond the current crisis. Also, the expansion of programs such as Community-based Management of Acute Malnutrition (CMAM), that allow parents to treat their malnourished children directly with Ready-to-Use Therapeutic Food (RUTF), should be twinned with efforts to educate people so that they can spot the signs of malnutrition in family members.

For the state ministry of health, the most pressing priorities are to assess the damage done to the health system by Boko Haram, produce a health sector response strategy for donors to support, and then begin the reconstruction effort. Boko Haram fighters deliberately targeted health facilities and health workers, viewing them as symbols of the government they despise. Initial assessments by the FMoH in May 2016 suggest that 51 percent of health facilities across the state were damaged or destroyed and 80 percent of LGAs lack sufficient health services to meet patients’ needs.\(^{63}\) Untold numbers of health personnel were killed or displaced. Efforts to fill the personnel gap include upgrading the state medical training schools, bringing former health workers out of retirement, and expanding the reach of the remaining workforce by deploying mobile clinics to underserved areas. All of these efforts are in their early stages and will require sustained funding to succeed.

Another pressing priority is to respond to an outbreak of polio that resulted from several years of interrupted inoculation programs in areas controlled by Boko Haram. The scale of the response is immense, requiring a wave of mass vaccination campaigns across the state and into neighboring countries—activities that potentially place volunteers in harm’s way. In Borno State alone, 1.6 million children must be vaccinated before the end of the campaign.\(^{64}\)

In parallel with the emergency health response in Borno State, health workers struggle to improve health outcomes in a region where poor education and cultural mores limit access to services, particularly for women. Husbands often require their wives to obtain their permission before seeking medical help and insist they are treated by female doctors, of which there are few. TBAs are commonly used, as in other parts of Nigeria. Many conditions, such as eclampsia, are attributed to spiritual, rather than physical, illness. The very high fertility rate is a big health concern in the northeast, where inadequate birth spacing puts women’s health at risk. Women find it hard to access modern methods of contraception, even if they are allowed to do so by their husbands. Women have faced additional health challenges since the insurgency broke out. One midwife explained that she had encountered high rates of eclampsia among displaced mothers since the conflict began and speculated

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64 Ibid., 1.

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that the stressful conditions in which they lived were responsible for the elevated risk. Women and girls who were kidnapped and sexually abused by Boko Haram require specialist care for the physical and mental trauma they have suffered, but these services are in very short supply. Female survivors of Boko Haram abuses, particularly those who gave birth in captivity, face social stigma and suspicion that prevents them from returning to their former communities.

A desperate shortage of resources is at the root of Borno State’s health challenges. Maiduguri’s health infrastructure cannot cope with the demands of its swollen population. Residents of Maiduguri are increasingly resentful of IDPs, who are entitled to free health care while they have to pay for substandard services. There are critical shortages of medicines, health workers, and functional health facilities at all levels of the system. The size of the task is only getting bigger, as the state government moves back to liberated areas and begins the task of restoring services. The Borno State commissioner for health, Dr. Haruna Mshelia, put it simply: “Our resources have dried up here. We’ve been feeding people now for three years, putting up IDPs. It’s unsustainable.”

Donors supporting the health sector in Borno State face the challenge of mounting an urgent response to a fast-evolving humanitarian crisis while laying the foundations for a sustainable health system that can help address the state’s abysmal health outcomes. Emergency responses are by their nature reactive and inefficient. The funding shortfall for the humanitarian appeal means that the early recovery and resilience-building parts of the strategy are being neglected in favor of the near-term urgency of feeding the hungry. This approach is understandable but it is unlikely to lead to permanent health system gains once the immediate crisis has passed. Borno State faces a difficult future even if it ultimately defeats Boko Haram.

The Future Health Relationship: Identifying Promising Models and Opportunities in Nigeria’s Health Sector

Nigeria is a strategic partner of the United States and although the bilateral relationship has experienced its share of ups and downs, few question the importance of sustained engagement. While Nigeria is unlikely to be a top foreign policy priority of the new administration in Washington, its economic significance, dynamic private sector, and status as Africa’s largest democracy underline its continued relevance. Nigeria’s enduring governance, economic, and security challenges will also ensure continued attention from the United States. The security situation in the northeast is likely to attract particular scrutiny from a U.S. administration that has pledged to step up the fight against international terrorism. Boko Haram’s alliance with Islamic State and its expansion into neighboring countries in the Lake Chad Basin has given the group international reach and profile, placing it firmly in the sights of U.S. counterterrorism officials.

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65 Interview with midwife from Borno State Specialist Hospital, Maiduguri, September 25, 2016.
66 Interview, General Mamman Shuwa Hospital, Maiduguri, September 26, 2016.
67 It is debatable whether Boko Haram has derived material or operational benefits from this allegiance, other than gaining access to a bigger platform to publicize its activities.
On the health front, Nigeria’s high disease burden and the poor health status of women and children mean that the country is a “must-win” for global health.\(^6^8\) Hence, U.S. assistance in tackling malaria, HIV, and MCH will endure. However, this does not mean that the United States is content with the status quo or that development assistance will remain at such elevated levels in future. U.S. officials express considerable dissatisfaction with the state of the development relationship and are actively seeking new ways to achieve better outcomes, not only to improve the lives of Nigerians but to persuade taxpayers back home that their dollars are being used to good effect.

U.S. officials working on health programs in Nigeria describe several objectives that define their approach.

First and foremost is a desire to improve the performance of health programs, which to date have not reflected the size of the investment put in. Accomplishing this objective means demanding more from partners, strengthening accountability mechanisms, improving coordination on health between the different tiers of government, and looking for ways to incentivize better outcomes by—for example—turning to new modes of engagement that include the private as well as the public sector. It also requires capturing quality data that measures outcomes rather than merely outputs and that penetrates the lowest reaches of the health system—LGA, ward, and facility level—where there are enormous information gaps.

Second, there is a recognition that U.S. support can succeed only if certain conditions are in place. Basic requirements include political will and capable leadership from host-country partners, whether at the federal, state, or local level. This, in turn, means being more selective and strategic about whom to partner with and encouraging the private sector to become a more active participant in delivering quality health services at an affordable price. The country director of a U.S. health implementation organization explained that donors had poured money for years into Kano State, partly because of its importance as the most populous state in Nigeria, but had little to show for it because the political leadership was not sufficiently invested in their efforts. As a result, donors had more recently focused on other states that offered better prospects of success, like Cross River and Jigawa.\(^6^9\) For example, Cross River State was chosen by USAID as the location for Saving Mothers, Giving Life, a public-private partnership to reduce maternal and newborn mortality that recently expanded into Nigeria.

Third, the United States wants to see that the benefits of its engagement will endure when its support ends. Does Nigeria have a plan to sustain programs and take on more responsibility for financing health services over time?

Finally, there is a strong sentiment that addressing the health inequities that drive Nigeria’s poor health outcomes means focusing efforts on the northern states. In the near term, there


\(^6^9\) Interview with country director of a U.S. nonprofit health organization with operations in Nigeria, Abuja, September 20, 2016.
is an urgent need to tackle the health emergency in the northeast. This final objective exposes a tension in the approach toward development in Nigeria. Should U.S. assistance focus on those in greatest need or try to pursue targets of opportunity instead? After all, poor health outcomes in the northeast are inextricably linked to poor governance, which reduces the likelihood that development programs will succeed in the long run. The reality is that the United States is obliged for strategic and humanitarian reasons to pursue a mixed strategy that combines a hard-headed insistence on results with the imperative to save lives.

As it surveys the health landscape in Nigeria, the United States can seize upon some encouraging initiatives and programs that depart from previous practices and offer potential models for future support and engagement. Some have been trialed by other donors, some are Nigeria-led initiatives, and some have already attracted the interest and involvement of U.S. policymakers and program implementers. These initiatives share the common objective of inspiring better outcomes in the health sector but use different methods to get there, including accountability mechanisms, performance incentives, bureaucratic reforms, community engagement, and the deployment of information and communications technology (ICT). They demonstrate that good practices do exist in the Nigerian health system; the main challenge is to support, sustain, and expand them.

Increasing Accountability in the Health Sector

- **The Bringing PHC Under One Roof process**, initiated by the FMoH’s National PHC Development Agency in 2011, has sought to consolidate authorities and streamline responsibilities within the PHC system, with the objective of improving performance, accountability, and efficiency. Under the policy, states are required to form State Primary Health Care Development Agencies or Boards to organize, budget, manage, and monitor PHC services. The policy has been adopted by roughly two-thirds of Nigeria’s states and has been applied in different ways in different locations, with mixed results. At its best, Bringing PHC Under One Roof has decentralized health services, rationalized the health bureaucracy, and placed more responsibility with health managers rather than political officials, leading to better budget execution and improved health outcomes. In Jigawa State, one of the poorest in Nigeria, the proportion of the state budget allocated to health rose from 4 percent in 2007 to 15 percent in 2011, after it formed a single entity called the Gunduma Health Services Board to manage both its PHC and state health care services.70

- There have been some positive efforts to improve health service performance and accountability at the ward level, the lowest rung of the governance ladder. Ward Health Development Committees (WHDCs) are informal bodies composed of volunteers either selected or elected by the community, such as religious leaders, traditional authorities, and women and youth representatives. In areas where WHDCs are active, they have played an important supervisory role over the PHC system, channeled health information and advice to the wider population—particularly

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pregnant women—and effectively advocated for better health services. In Kebbi State, for example, members of a WHDC sent photographs of a dilapidated PHC center to the governor, prompting him to take remedial action. Supporting the WHDC system and reviving committees in areas where they are dormant has the potential to improve citizen engagement in the health system, strengthen accountability, and increase the likelihood that health service improvements will be sustained.

- At the legislative level, efforts are under way to improve fiscal accountability and transparency by giving LGAs direct responsibility for their budgets. Under the existing arrangement, state governments routinely withhold or divert money owed to LGAs. However, in November 2016, a bill that would repeal the State Joint Local Government Account passed its second reading in the House of Representatives. In principle, handing more fiscal autonomy to LGAs could stimulate investment in public services at the local level, but robust accountability mechanisms will be needed to ensure that corruption is not merely supplanted from one level of government to the next.

- Civil society in Nigeria is applying pressure on the government to become more transparent about health budgets and expenditure. Organizations like the Lagos-based BudgIT have used technology tools such as social media and easy-to-understand infographics to explain the Nigerian budget to ordinary citizens, expose gaps in the data, and push the three tiers of government to provide more information about public finances and spending, including in the health sector. Other organizations, such as the ONE Campaign, have launched advocacy campaigns to demand that the government devote a larger share of the budget to health and that the FMOH spend the health allocation more effectively. These organizations are helping to stimulate public demand for better services and giving citizens more tools to hold their elected officials to account.

Delivering Quick Wins

- The FMOH under Minister Adewole has tried to respond to donor demands for better performance by instituting a more outcomes-driven approach to business. In July 2016, Minister Adewole announced the start of a Rapid Results Initiative (RRI), with U.S. support, to deliver tangible health service improvements within an ambitious 100-day time frame. In addition to rehabilitating 110 PHC facilities in 100 days, there were plans to operationalize a Nigerian version of the CDC, provide nutrition support to 200,000 malnourished children in the northeast, perform up to 10,000 surgeries on poor Nigerians, and inaugurate 30 mutual health associations. In addition, through a partnership with the pharmaceutical company, Novo Nordisk, the Ministry said it would screen 500,000 Nigerians for diabetes at no cost to the patient. The aim is to

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71 Interview with senior health official, Abuja, September 20, 2016.
73 For more information on the Rapid Results Initiative and how progress will be measured, see Federal Ministry of Health, “Technical Brief on the Rapid Results Initiative (RRI) of the Federal Ministry of Health,”
convince Nigerians and donors that the health system can deliver, but the onus is now on the ministry to show that it can meet the demanding targets contained in the RRI. The 100-day deadline passed in October, and data collection was under way to measure the impact. It will be important for the FMoH to release information in a timely and transparent fashion.74

Incentive-based Health Initiatives

- The World Bank has experimented with performance-based financing models in Nigeria, with some encouraging results. As mentioned above, the NSHIP handed greater financial autonomy to selected health facilities in Ondo State and two others—Nasarawa and Adamawa. Good performance was rewarded with extra funding that could be used to pay staff bonuses and make facility improvements. The project suggests that clinics can provide more—and better—services when they are granted more financial autonomy. However, the quality of management at the facility level remains patchy, suggesting a need for similar projects to focus on training health administrators. Currently, most chief medical directors in Nigeria are senior doctors rather than professional managers.

- Saving One Million Lives (SOML) Performance for Results (PforR) is a new twist on the flagship health policy of the previous administration, led by Goodluck Jonathan. In its original form, SOML used the health-related UN Millennium Development Goals as a stimulus to prioritize improvements to MCH. The revised version, supported by a World Bank credit of $500 million over four years, incorporates performance incentives into the program in an effort to accelerate progress. All of Nigeria’s states and the FCT have received an initial payment of $1.5 million to be used for MCH programs. Progress will be measured over time across six different areas, including improving child nutrition and preventing mother-to-child transmission of HIV. States that improve on benchmark indicators collected in the first year of the scheme will receive bonuses of up to $3 million per year. The program also introduces an element of competition between states. The best-performing state within each geopolitical region will receive an additional $500,000 (two states in the northeast will be entitled to a “zonal champion” prize to acknowledge the extreme health challenges in that region). Finally, the best-performing state in the nation will receive an extra $1 million. The SOML PforR scheme is a promising and innovative scheme on paper but its success will depend upon strong accountability mechanisms and the collection of high-quality data that can be independently vetted.

- The Bill & Melinda Gates Foundation has also built incentive-based structures into its health programs in an effort to achieve better results. The Gates Immunization


74 In January, President Buhari inaugurated a revitalized PHC facility in the Federal Capital Territory and announced that improvements had been completed for the first 109 of 10,000 facilities earmarked for refurbishment. See Speech by President Buhari on “PHC Revitalization Program,” official Medium Channel of the Federal Ministry of Health, January 11, 2017, https://medium.com/@Fmohnigeria/speech-by-president-buhari-on-phc-revitalisation-program-7e69ce7a0587#.nsrx0kss1.
Leadership Challenge, launched in 2011, not only offered bonuses for states that made progress on RI and polio programs, but also emphasized the importance of political leadership by requiring governors to play a visible role in prioritizing vaccination programs.

- The Nigerian government has incorporated some of these incentive structures into its own programs in an effort to promote greater financial responsibility and accountability. For example, the BHCPF, if enacted, will only release project funds to states that commit their own counterpart funding of 25 percent to the project. Funds can also be withheld from states and LGAs that have failed to implement national health policies and standards.

Technological Innovation

- Nigeria has a burgeoning ICT sector and cities like Lagos are hubs for innovation and entrepreneurship. Until recently, few of these technologies had been applied to the health sector, but the situation is beginning to change. The Nigerian government is trying to stimulate activity. In September 2016, Minister Adewole announced the formation of an eHealth Steering Committee to consider how ICT solutions could be applied to health system challenges such as data collection and management, human resources, and health insurance. In the same month, a health advocacy organization, Nigeria Health Watch, hosted a conference in Abuja that brought together tech entrepreneurs and health officials to stimulate closer collaboration between the sectors. The Health Innovation Challenge Reward, a competition launched by the Private Sector Health Alliance of Nigeria to find the five most promising innovations in healthcare, attracted 1,000 applications. They included a urine test to check the effectiveness of malaria treatment in patients, a solar power pen that provided audible translations of health information for illiterate people, and a mobile phone application for pregnant women to monitor the health of their unborn babies.

Beyond the incubation stage, concrete projects are already under way that use technology to improve efficiencies and make health services more accessible and user-friendly. The health system strengthening organization, MSH, is using online training tools and mobile applications such as WhatsApp to support and mentor health NGOs and health workers in hard-to-reach areas. Telemedicine has enormous growth potential in Nigeria, where the majority of the population owns or has access to a smartphone. Even simple SMS technology can be used to good effect, for example in Kwara State, where MSH set up a project to monitor pregnant women with diabetes. The women were taught how to check their blood sugar at home and text their results to their health worker, who could follow up with a phone call if treatment

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was required. The exercise saved time, cut unnecessary trips to the hospital, and reduced the number of patients lost to follow-up.

One of the biggest opportunities for ICT to transform the health sector is in setting up a digital healthcare information system. Establishing an electronic patient health record would improve efficiency, increase accountability, reduce corruption, and provide a ready-made database for the NHIS.

Strengthening Partnerships with the Private Sector

- The Nigerian government is aware that it cannot come close to funding the health system on its own. Therefore, efforts have been stepped up to expand relationships with the private healthcare sector, which provides the majority of health services in Nigeria and is used by the poor as well as the better-off. The FMoH is increasingly turning to public-private partnerships as a way to finance and run capital projects in the health sector, as well as deliver services. The ministry is also making concerted attempts to attract private investment and engagement in the health sector. Some interesting partnerships have developed as a result. They include an effort to develop commercial production of Ready-to-Use Therapeutic Foods (RUTF) to address cases of severe acute malnutrition (SAM). Until now, Nigeria has had to import RUTF, but a number of companies, banks, and investors have come together with support from the Gates Foundation to secure a domestic license, financing, and expertise to begin domestic production.77

A few U.S. companies—mainly the larger multinationals—are engaging in Nigeria’s health sector. General Electric (GE), for example, has developed health diagnostic services for pregnant women, launching a program in 2016 to expand access to digital antenatal screenings. Working with the FMoH and USAID, GE is training midwives on how to use its portable ultrasound scanners and aims to reach 2 million women by 2020.78

Breaking the Cycle of Poor Health in the North

- The health situation in northern Nigeria is dire, particularly in conflict-afflicted parts of the northeast but also in the northwest, where MCH outcomes are dismal even though the region has been less affected by Boko Haram. Addressing these challenges requires a strategic effort by political, religious, and traditional leaders in the north. After decades of poor governance, there are at last signs of an emerging consensus among northern leaders that something must be done to prevent the north from falling further behind. The Northern Nigeria Governors Forum is a promising vehicle for building momentum for reform—one that the United States should continue to engage with at the highest level. During a visit to the United States

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in October 2016, a dozen governors spoke of the need to address the root causes of the Boko Haram insurgency, including poverty, poor education, and inequality. Furthermore, leaders such as Borno State Governor Kashim Shettima emphasized their own responsibility to improve the quality of governance and acknowledged the importance of delivering better services, including healthcare.79 The Northern Nigeria Governors Forum is an important entry point for U.S. engagement on development in the north and a potential venue for strategic discussions on health and MCH in particular.

- The scale of the humanitarian disaster in the northeast provides an opening to propose radical reforms to help address the underlying health crisis of poor nutrition. For example, the Office of the Vice President of Nigeria is considering how a nationwide school feeding program might be funded and operationalized. The proposal has assumed more urgency and attention because of the hunger emergency in the northeast, although many obstacles must be overcome before it can be fully implemented.

### Recommendations

The United States can play a galvanizing role in improving Nigeria’s health outcomes by:

- Intensifying and elevating to the most senior levels its health diplomacy with Nigeria and other development partners to secure stronger health financing and better performance;

- Taking a single-minded approach to achieving better results in its programs by adopting creative solutions that incentivize partners and promote accountability;

- Expanding its range of partners at national, state, and local level; facilitating opportunities for the U.S. private sector to invest in Nigerian healthcare; and

- Placing particular emphasis on improving health outcomes in the north.

The following suggestions explain how these broad goals might be achieved in more detail.

### Health Diplomacy

The new administration in Washington should signal its desire to reinvigorate and elevate the bilateral relationship by sending—at the earliest opportunity—a senior official from the Department of State to Abuja for talks about the bilateral relationship and the central role of health cooperation within it. The talks should focus on devising strategies to

- Ensure a smooth transition for PEPFAR as budget declines accelerate from FY 2017;

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• Fold the PEPFAR dialogue into a larger discussion on increasing sources of domestic health financing, accompanied by costed, realistic plans;

• Boost the role of the Nigerian and U.S. private sector in delivering quality, affordable health services;

• Accelerate cooperation on health security and pandemic preparedness.

These initial discussions would set the tone for longer-term health diplomacy by the United States toward Nigeria. This engagement should:

• Reassure Nigeria that the United States remains committed to its health investments; note that the global health agenda cannot be significantly advanced unless Nigeria’s health outcomes improve as well; empathize with the economic, political, and security challenges facing the nation; and acknowledge that the Buhari administration has made some effort to address Nigeria’s governance and accountability shortcomings. However, make it very clear that in the health relationship, a business-as-usual approach will no longer work. Confidence has been undermined by a history of poor performance and broken promises. Henceforth, the United States will be a more demanding partner, relentlessly focused on results, and will not hesitate to pull funding or divert support to other Nigerian partners if its investments continue to deliver poor outcomes.

• Help Nigeria strengthen its investment case for health and do more to attract both domestic and foreign private-sector investment in its health system. In its health diplomacy, encourage President Buhari to publicly state that health is a national priority that is intrinsically linked to the wealth of the nation and deserves a significant budget commitment. Prepare briefing materials that help the FMoH lobby the Ministry of Finance for a greater share of the national budget. For example, highlight the value of malaria investments in a country whose citizens spend an estimated $3 billion a year on malaria treatment and prevention and lose countless days of economic productivity due to sickness. Use high-level diplomatic channels to make the case for health to other agencies of the Nigerian government and explain how they can help the minister of health deliver on his agenda.

• Encourage Nigeria to abide by its financial commitments to health. In particular, urge the Nigerian government to fully implement the 2014 National Health Act by committing at least 1 percent of the Consolidated Revenue Fund to establishing the BHCPF in the 2018 budget. Monitor the budget to check that any money used to revive PHC is not merely taken from other parts of the health budget. Press Nigeria to come up with sustainable, costed plans to fund RI, family planning commodities, and progressively scale up its financial commitment to HIV. These plans should be cautious and realistic in light of Nigeria’s economic woes, but they should also

demonstrate a commitment to taking on greater financial ownership of its health needs over time and ultimately meeting the Abuja Declaration on health.

- Rally other donors around a sustained commitment to improving health in Nigeria. Some of Nigeria’s external partners are disillusioned by years of poor returns and development scandals. Other traditional donors, such as the United Kingdom, are waver in their commitment due to domestic political pressures to reform development assistance. Regardless of its own uncertain political transition, the United States has an important role to play in galvanizing the donor community in Nigeria, coordinating its activities, and unifying health engagement around a set of common goals.

- Assist Nigeria in presenting itself as a more attractive funding opportunity for donors and investors by providing a clear strategy that orders priorities for health-sector support. Articulating a strategy aligned with the UN Sustainable Development Goals provides a good hook for potential investors—focused on financial and social impact—to rally around; particularly the detailed targets related to Goal 3: Good Health and Well-being.81

### Incentivizing Better Program Outcomes

- Support legislative and bureaucratic efforts to de-fragment the health sector by giving a preference in its funding decisions to states that have enacted the Bringing PHC Under One Roof reforms.

- Loan an official from the U.S. Department of the Treasury to the FMoH to assist with budget planning, execution, and transparency measures. Request that this official takes part in a project to help compile and publish National Health Accounts as a way of building a complete picture of the sources of health funding and expenditure in Nigeria.

- Engage in public finance reform and governance programs at the subnational level that work with state governments to help generate more of their own revenue, diversify their economies, improve transparency, and gradually reduce their dependence on the federal allocation. Support National Assembly efforts to grant more financial autonomy to LGAs.

- Launch in-depth studies of previous health programs in Nigeria to examine what works where, and why, in an attempt to understand—and overcome—roadblocks to success. Why was the Ebola response successful? Why did the national campaign to eradicate guinea worm succeed? What accounts for Nigeria’s progress in reducing malaria prevalence and lack of progress in tackling TB?82 Why is Ondo State succeeding in cutting maternal mortality? Deploy more U.S. development officials out

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82 For thoughts on this, see the forthcoming CSIS report “Tackling Infectious Diseases in Nigeria: Turning the Tide on Tuberculosis and Accelerating towards Malaria Elimination,” by Audrey Jackson and Deen Garba.
of Abuja in order to better understand the political economy of Nigeria’s states so that engagement opportunities and risks can be assessed more easily.

- Build more incentive structures into programs in an effort to increase program accountability. Closely follow the progress of the World Bank SOML PforR, and try to complement or amplify its activities by offering additional support to top-performing states.

- Incentivize overdue reforms of the health workforce. Urge Nigeria to develop a more flexible, adaptive health workforce by allowing states to set their own health worker salaries (within parameters) that take account of the different working conditions and cost of living across the country. Lend short-term support to federal programs like MSS in an effort to kick-start progress, contingent on Nigeria producing budgets to sustain them in the longer term. Facilitate the exchange of best practices between Nigerian health officials and counterparts from countries like South Africa and Ethiopia, where task sharing has increased health workforce flexibility and productivity.

- Extend support for the collection of more, better quality data. Extend support for the Standardized Monitoring and Assessment of Relief and Transition (SMART) surveys, annual household surveys that gather data on MCH and nutrition to supplement the quadrennial demographic and health surveys. Seek to expand data collection down to the LGA, ward, and facility level. Take incremental steps to strengthen the Health Management Information System (HMIS) so that it can be ultimately converted into an electronic record. Prioritize the gathering of data that sheds light on the quality of healthcare, such as patient satisfaction surveys and service delivery indicators, and train local community volunteers to collect this data rather than outside consultants.

Expanding Partnerships

- Convene a summit bringing together senior officials from the Nigerian and U.S. governments and representatives from the U.S. private sector for a discussion about business opportunities in Nigeria’s health sector. The summit could be convened by White House staff and would include Nigerian counterparts from the federal government and officials from some of the most business-friendly states, such as Lagos and Delta. The summit would showcase opportunities for private-sector involvement in the provision of health services, infrastructure, equipment, and training; and troubleshoot ways to unlock barriers to investment in Nigeria’s health sector. The summit could be given higher profile by enlisting the support of former and current senior Nigerian leaders such as Amina Mohammed, deputy secretary-general of the United Nations, and former Finance Minister Ngozi Okonjo-Iweala. The summit could also be expanded into a broader dialogue looking at how the United States’ public and private sectors can best engage on health with lower-middle-income countries.

- Provide seed funding on a competitive basis to Nigerian entrepreneurs whose innovations can be applied to the health sector. Encourage U.S. technology
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companies to invest in Nigeria’s health sector and stimulate a data revolution in healthcare.

- Facilitate stronger relationships and deeper cooperation between Nigeria’s public and private sectors. Offer assistance in the development of common standards of practice so that the performance of public and private health facilities can be compared. Encourage private health facilities to record data in the HMIS.

- Promote community engagement in the health sector by scaling up financial support and training to WHDCs so that they can create demand for better services and channel health information to households, particularly women.

- Support and sustain civil society organizations engaged in healthcare advocacy, extending funding to groups that push for more transparency in health budgeting and expenditure.

- Fund the establishment of a health unit at one of Nigeria’s leading media organizations that can support and grow a corps of specialist health journalists. The Bhekisisa Centre for Health Journalism at South Africa’s Mail & Guardian newspaper, partly funded by the Bill & Melinda Gates Foundation, is one potential model to emulate.

- Encourage Nigeria’s legislature to perform a more active oversight role over the health sector. Stimulate the interest of the National Assembly in health and promote the development of a cadre of lawmakers with health expertise by offering training on health policy, systems, and financing.

- Engage U.S.-based Nigerian medical professionals; help cultivate and facilitate their efforts to lend expertise to health projects and training back home.

Emphasize Health Improvements in the North

- Prioritize long-promised plans to reestablish a U.S. consulate in northern Nigeria, so that the United States can demonstrate its commitment to understanding and responding to the health needs of this part of the country.

- Urge the Northern Nigeria Governors Forum to establish a working group dedicated to health that engages in dialogue with a broader set of northern leadership, including religious leaders, traditional authorities, and civil society. This should include a subgroup focused on increasing the supply of, and demand for, quality health services for women.

- In its diplomatic engagement on the northeast, encourage the federal government to devote as much attention toward securing the peace as prosecuting the war. This should include committing significant resources to rebuilding and improving the health system so that the next generation of children in the north grows up with better life prospects.
• In engagement with the Nigerian government, argue for a sustained effort to address the enduring health crisis of poor nutrition and undernutrition. Encourage and participate in the search for creative solutions to the problem, such as a nationwide school feeding program and the expansion of CMAM.

• In Borno State and other states affected by Boko Haram, continue to address the humanitarian emergency and encourage other international donors to increase their contributions. At the same time, look for opportunities to bridge the transition from emergency relief to sustainable development by supporting projects that lay the foundations for a durable healthcare system. Priorities include health worker training and retraining programs, community engagement on health, and establishing a Revolving Drug Fund.

• Provide support for specific gaps in health coverage in Borno State, particularly the provision of mental health services and psychosocial support to women who were sexually abused by Boko Haram.

Conclusion

The United States must stay the course in Nigeria, even though the story of its health engagement has often be a case of “one step forward, two steps back.” There is no escaping the reality that Nigeria is a frustrating place to do development. It is a vast, diverse country with complex health problems that do not present easy solutions. Its multi-tiered form of government, with overlapping, unclear responsibilities, encourage inefficiency and unaccountability. The political economy of Nigeria conspires against efforts to harness good performance and public service. Finding ways to capitalize on Nigeria’s many assets—including its immense natural wealth and a talented workforce—have proven elusive. As a result, health gains have been hard to come by and even harder to sustain. However, the fact that health engagement is hard does not mean it should be avoided. Indeed, the enormous health needs of Nigeria demand sustained attention. Instead, new approaches are needed to ensure that the health outcomes of Nigerians are improved and the taxes of American citizens are well spent. It is time for the United States to reboot the bilateral health relationship by demanding more political and financial commitment from the host government and better outcomes from its programs. By diversifying its partnerships, promoting greater private-sector involvement in the health sector, and pushing for more accountability at all levels of the health system, the United States can help lay the foundations for a healthier, wealthier Nigeria.
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